Spire Alexandra Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Spire Alexandra Hospital is operated by Spire Healthcare Limited. The Spire Alexandra Hospital was previously owned by another independent healthcare company. However in 2007, the company sold its hospitals to a private equity company which trades under Spire Healthcare Limited and is now a PLC.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 to 21 December 2016, along with an unannounced visit to the hospital on 3 January 2017.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

The main service provided by this hospital was surgical. Where our findings on surgical services also apply to other services, for example, management and governance arrangements, we do not repeat the information but cross-refer to the surgery core service report.

We rated this hospital as requires improvement overall.

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Monitoring of whether safety systems were implemented was not robust.
- Not all staff were aware of the term female genital mutilation (FGM) and their mandatory duty to report, despite having received a clinical briefing in April 2016.
- Hospital audits showed consistent non-compliance to processes, which suggested action plans were not robust or implemented. For example, there was not always compliance with closure of sharp bins, staff left the operating theatre department doors open, and staff did not always follow hand hygiene and medicines management protocol.
- The "admission and discharge policy", which outlined the clinical risk assessment criteria for patients was not always followed.
- Staff did not always follow the corporate "policy for the safe management of controlled drugs".
- There was a lack of signs to indicate segregation of clean and dirty equipment in some areas within the operating theatre department.
- There was inconsistent practice of agency staff induction, which was not in accordance with Spire Healthcare induction policy.
- There was a lack of dedicated hand washbasins for staff in patient bedrooms. Some hand washbasins did not comply with Department of Health's Health Building Note 00-09: infection control in the built environment. However a documented risk assessment was in place for these.
- There were medical devices which had not had an electrical safety testing, calibration or maintenance within the past year. This meant the equipment might not be fit for purpose.
- Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. Not all could demonstrate they had the skillset and training to enable them to fulfil their role and responsibilities and to provide specialist advice if required.

Summary of findings

- A hospital clinical governance brief meeting was held once a week. The senior clinical team discussed the incidents reported in the previous week and reviewed the progress of any on-going action plans. Clinical incidents were also discussed at heads of department meetings. We saw evidence of this in the meeting minutes. There was no evidence that the termination of pregnancy service was reviewed at any hospital committee meetings.
- The termination of pregnancy service was poor but the provider took immediate action and deregistered the service.

However:

- Staff were encouraged to report incidents. This enabled them to raise all incidents including near miss events. Serious adverse events underwent a thorough review or investigation that involved all relevant staff and people who use services. Following this, appropriate actions were taken. Lessons were learned and communicated widely to support improvement in all areas. Opportunities to learn from external safety events were also identified.
- 100% of staff working within surgical services and 96% of ward staff had completed their mandatory training which exceeded the Spire Healthcare target of 95%.
- The hospital had a local business continuity and lock down in place in the event of potential emergencies. The plan covered major incidents, such as how to respond in the event of widespread fire or flood, electricity failure, gas leak and water failure.
- When people received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Patients received a choice of meals and drinks and the chef catered for patient's individual needs including those that required special diets. The hospital had access to a dietitian and other specialist services.
- Managers supported staff to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. There was a clear and appropriate approach to support and manage staff when their performance was poor or variable.
- Staff responded compassionately when people needed help and support. They anticipated people's needs, and respected people's privacy and confidentiality at all times.
- Patients and relatives feedback was consistently very positive about the care provided. Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- The hospital handled complaints in line with policy. Staff had a good understanding of the complaints process, and staff discussed complaints at monthly meetings. Information about the complaints procedure was available for patients and relatives.
- Facilities and premises were appropriate for the services being delivered.
- Delays and cancellations of operations were minimal and managed appropriately. Services ran on time. Staff kept patients informed of any disruption to their care or treatment.
- At the referral stage, staff identified vulnerable adults, such as patients living with a learning disability, or those living with dementia. Staff took appropriate steps to ensure people were appropriately cared for.
- Surgery at Spire Alexandra was all elective, meaning it was planned, so the hospital cancelled very few procedures.
- We saw staff demonstrated the core hospital values in the care they provided. Staff were positive about the standard of care they provided.

Summary of findings

We found the following issues that the service provider needs to improve:

- The termination of pregnancy services was poor. It did not always reflect evidence based practice from relevant professional bodies or followed the hospitals policies or national guidance. There was no specific strategy for this service or evidence of specific training for staff. There was lack of monitoring or oversight for this service within the hospital's governance processes.

  Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected the termination of pregnancy service. The provider took immediate action and has de registered the activity of termination of pregnancy and no longer provides this service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section of this report. We rated this service as requires improvement because it was effective, responsive to people's needs and caring. However it requires improvement for being safe and well -led.
Outpatients and diagnostic imaging	Good	Outpatient services at Spire Alexandra Hospital cover a wide range of specialities. There were 13 consulting rooms and two treatment rooms. The imaging service provides magnetic resonance imaging (MRI), computerised tomography (CT), mammography, ultrasound and x-ray services. The outpatient physiotherapy department consists of one treatment room and three cubicles An on-site pharmacy team provides a daily service between 8.30am and 5pm, Monday to Friday, and on Saturday mornings. We rated this service as good because it was responsive to people's needs, caring and well-led. We inspected but did not rate effective, as we do not currently collect sufficient evidence to rate this.
Termination of pregnancy	Requires improvement	The termination of pregnancy service was a small part of the hospital's surgical service. The volume of work was up to 20 cases a year. We rated this service as requires improvement for being safe, effective, responsive to people's needs. We rated well led as inadequate. We were unable to rate caring as we had no access to patients.

Summary of findings

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Requires improvement

The Spire Alexandra hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging; Termination of pregnancy.

Summary of this inspection

Background to Spire Alexandra Hospital

The Spire Alexandra hospital was established in 1984 and is operated by Spire Healthcare Limited. It is a private hospital in Chatham, Kent. The Spire Alexandra hospital provides care for adults and children. The hospital primarily serves the communities of Kent and Medway and also accepts patient referrals from outside this area. It has two laminar flow theatres and 32 beds across two ward areas. It has an endoscopy suite, an imaging department, physiotherapy and outpatient consulting rooms. There is an extended recovery unit for patients whom require it. The outpatient department is open six days a week, including evenings, for flexible appointments for patients. Children are seen in outpatients but currently no patients are admitted under the age 18 years of age.

Gillian Coomber is the controlled drugs accountable officer and registered manager. Jean Jacques De Gorter is the Nominated Individual.

The service was last inspected on 6 November 2013 when it was found to be meeting standards and had no outstanding actions.

The hospital registered manager has been in post since the 1st January 2016.

Our inspection team

The inspection team was led by, Elaine Biddle, Inspection Manager, Care Quality Commission (CQC). The team included other CQC inspectors, and specialist advisors with expertise in paediatrics, surgery, radiology, and termination of pregnancy.

Information about Spire Alexandra Hospital

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures,
- Family planning,
- Management of supply of blood and blood derived products,
- Surgical procedures,
- Termination of pregnancy,
- Treatment of disease, disorder or injury.

Surgery services at Spire Alexandra covers a wide range of specialities, including hip and knee arthroplasty, vascular, upper gastrointestinal and colorectal, urology, cranial, gynaecological and breast surgery. The hospital treats adults aged 18 and over and does not currently provide surgical services for children. The hospital held a licence from the Department of Health (DH) to carry out termination of pregnancy procedures..

There are two operating theatres, three recovery bays, two anaesthetic rooms and an endoscopy suite. Both operating theatres have laminar flow. This is best practice for ventilation within operating theatres, and particularly important for joint surgery, to reduce the risk of infection.

The hospital has two inpatient wards. Copperfield Ward has 18 inpatient beds and Pickwick ward has nine day-case beds. All inpatient bedrooms provide single accommodation with ensuite bathroom facilities. The hospital is open seven days a week to care for patients after surgery that need to stay in hospital overnight and the weekend.

The hospital has its own sterile supplies department for the cleaning and sterilisation of reusable theatre instruments.

Consultants who have applied for and been granted practising privileges, used the facilities of the hospital to

provide services to both NHS and private patients. We saw documentation which showed that there were 169 consultants registered as having practising privileges at the hospital at the time of inspection.

Resident medical officers (RMOs) are provided under contract from an external company. RMOs provide 24/7 medical cover for patients.

Nurses, allied health professionals, healthcare support workers and theatre staff were directly employed by the hospital.

During our inspection we visited the operating theatre department; endoscopy suite and inpatient ward areas, the outpatient and imaging departments. We observed practice in the wards, theatres and recovery areas, outpatients and imaging. We spoke with 11 patients, relatives or carers about their experiences at the hospital. We received 24 comment cards with feedback from inpatients and outpatients. We spoke with 18 staff of varying seniority in two focus group discussions plus a range of staff in the clinical environment about their experience within the hospital. We reviewed documentation in relation to the general running of the services and maintenance of equipment and buildings. We also reviewed 11 patient records and four child patient records and information provided to us prior to and during the inspection and follow up visits.

Outpatient services at Spire Alexandra Hospital cover a wide range of specialities including orthopaedics, ear, nose and throat (ENT), gynaecology, dermatology, gastroenterology, neurology, urology, pain management, dietetics and nutrition, ophthalmology, cosmetic surgery, general medicine, psychiatry, vascular and podiatry. Orthopaedics and gastroenterology were the most attended clinics and accounted for 44% of all outpatients' appointments within the reporting period July 2015 to June 2016. The health screening service is offered by an outsourced company and therefore did not form part of our inspection.

There were 41,851 outpatient attendances in the reporting period July 2015 to June 2016. The outpatient and imaging departments saw both adults and children; of which 94% (39,557) were adults and 6% (2,294) children. The hospital had 1467 inpatients attendances and 2158 day case attendances.

The outpatient department was refurbished in 2014. It has 13 consulting rooms and two treatment rooms. It is open Monday to Friday from 8am to 8.30pm and Saturday 8am to 5.30 pm. One of the consulting rooms operated two evenings a week as a 'one stop breast clinic', which enabled breast assessment, investigation and feedback in one appointment. One consulting room is used for consultations for termination of pregnancy.

The imaging service provides magnetic resonance imaging (MRI), computed tomography (CT), mammography, ultrasound and x-ray services. The department is open Monday to Friday from 8am to 8.30pm and Saturday from 8am to 2pm.

The outpatient physiotherapy department consists of one treatment room and three cubicles. It is open Monday to Friday from 8am to 8.30pm and Saturday from 8am to 1pm.

Spire Alexandra Hospital held a licence from the Department of Health (DH) to carry out termination of pregnancy procedures .The licence was publically displayed in the main reception area of the hospital. At the time of our inspection Spire Alexandra Hospital provided surgical termination for patients under general anaesthetic, who have a gestational date of between six and 12 weeks. Patients requiring termination of pregnancy of a later gestation, by medication, or under a local anaesthetic or conscious sedation were referred to another provider. Patients below 18 years of age were referred to another provider. The hospital voluntarily suspended the termination of pregnancy service during the inspection and the provider has since deregistered this regulated activity.

The termination of pregnancy service was provided by a consultant obstetrician and gynaecologist under practising privileges, with support from anaesthetists, the operating theatre department staff and nursing staff. The executive management team and clinical governance manager were responsible for the governance of termination of pregnancy services.

An on-site pharmacy team provides a daily service between 8.30am and 6pm, Monday to Friday, and on Saturday mornings.

There were no special reviews or investigations of the hospital on going by the CQC at any time during the 12 months before this inspection. The hospital has been

inspected twice. The most recent inspection took place in November 2013, which found that the hospital/service was meeting all standards of quality and safety it was inspected against.

The Hospital completed 3625 surgical procedures. The most common surgical procedures being;

Diagnostic colonoscopy (158 procedures)

Total prosthesis replacement of knee joint (142 procedures) and

Injection of therapeutic substance into joint (131 procedures)

Between July 2015 and June 2016, approximately 42% of inpatient activities were NHS funded, and the remaining 58% were privately insured and self-paying. Eighty-three percent of patients required an overnight stay, of those overnight stays 42% were NHS funded and 58% were other funded.

There were 41,851 outpatient total attendances in the reporting period Jul 2015 to Jun 2016; of these 16% were NHS funded and 84% were other funded.

The hospital had 169 Consultants working at the hospital under practising privileges. The hospital employed 28 whole time equivalent (WTE) registered nurses, 16 WTE care assistants and 95 WTE other staff, as well as having its own bank staff.

Track record on safety:

There had been no never events in the last year. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

There were a total of 518 clinical incidents in the reporting period (July 2015 to June 2016). Out of 518 clinical incidents, 68% (353 incidents) occurred in surgery or inpatients and 14% (73 incidents) occurred in other services. The remaining 18% of all clinical incidents occurred in outpatient and diagnostic imaging services (92 incidents).

The hospital reported 0.4% of all incidents as severe or death.

For the reporting period (July 2015 to June 2016), the assessed rate of clinical incidents in surgery, inpatients and other services was higher than the rate of other independent acute hospitals of this type. However, the most common type of incident reported was admission following day case procedure. Not all hospitals would report day case conversions to overnight stays as clinical incidents, therefore this suggested a positive reporting culture.

There were a total of 41 non-clinical incidents in the reporting period July 2015 to June 2016.

Out of 41 non-clinical incidents, 29% (12 incidents) occurred in surgery or inpatients and 51% (21 incidents) occurred in other services. The remaining 20% of all non-clinical incidents occurred in outpatient and diagnostic imaging services (eight incidents).

For the reporting period (July 2015 to June 2016), the assessed rate of non-clinical incidents in surgery, inpatients or other services is similar to rate of other independent acute hospitals of this type.

There were no incidences of hospital acquired MRSA or hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA). There were also no incidences of hospital acquired Clostridium difficile (c.diff), or hospital acquired E-Coli.

The hospital received 32 complaints in the reporting period (July 2015 to June 2016). No complaints were referred to the Health Service Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period. The assessed rate of complaints (per 100 inpatient and day case attendances) was similar to the rate of other independent acute hospitals of this type.

Services accredited by a national body:

- SGS Accreditation for Sterile Services Department
- Breast screening - BUPA

Services provided at the hospital under service level agreement:

- Dietician (nutritional advice and support for patients)
- Specialist nursing services for cancer patients
- Student placements
- Occupational health services
- Emergency care transfer

Summary of this inspection

- Pharmacy services (outside normal hours)
- Cardiac services
- Infection prevention and control support
- Satellite IVF services
- Radiology service
- Paediatric retrieval Services
- Mobile MRI Agreement
- IOL Oncotherapy Radiation
- Fellowship placement
- Clinical and or non-clinical waste removal
- Interpreting services
- Grounds maintenance
- Laser protection service
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. Monitoring whether safety systems were implemented was not robust.
- Hospital audits showed consistent non-compliance to processes, which suggested action plans were not robust or implemented. For example, staff did not always close of sharp bins, they left the theatre doors open, and processes were not always followed in relation to hand hygiene and medicines management.
- The hospital did not always follow the corporate "policy for the safe management of controlled drugs"
- There was a lack of dedicated hand washbasins for staff in patient bedrooms. Some hand washbasins did not comply with Department of Health's 'Health Building Note 00-09: infection control in the built environment'. However a documented risk assessment was in place for these sinks.
- There were medical devices, which had no evidence of electrical safety testing, calibration or maintenance checks within the previous year. This mean the equipment might not be fit for purpose.
- Not all staff were aware of the term female genital mutilation (FGM) and their mandatory duty to report, despite having received a clinical briefing in April 2016.
- There was no record of any discussion of any incidents or adverse events related to the termination of pregnancy services in any of the minutes we reviewed.
- There was no evidence the consultant was trained in female genital mutilation (FGM).
- Clean equipment used in termination of pregnancy procedures was stored in a dirty utility area.
- The consultant performing termination of pregnancy had completed the revalidation process in accordance with Spire policies in the previous 12 months and had undertaken an appraisal carried out by another surgeon on a Medical Appraisal Guidance Form rather than the Spire revalidation system. The appraisal documentation did not make any reference to termination of pregnancy.

Are services effective?

Requires improvement

We rated the services requires improvement for effective because:

Summary of this inspection

- There was inconsistent practice of agency staff induction, which was not in accordance with the Spire Healthcare induction policy.

However;

- People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- When people received care from a range of different staff, teams or services, this was coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of people's needs.
- Patients received a choice of meals and drinks and the chef catered for individual needs, including special diets. The hospital had access to a dietitian and other specialist nutritional services.
- There were good processes in place to monitor the length of time patients were nil by mouth and went without fluids before having surgery.
- Information about people's care and treatment, and their outcomes was routinely collected and monitored. This information was used to improve care. Outcomes for people who used services were positive and consistent.
- Managers supported staff to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Staff were supported through the process of revalidation where relevant. There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.

Are services caring?

Good

We rated caring as good because:

- Staff responded compassionately when people needed help. They supported them to meet their basic personal needs as and when required. They anticipated people's needs. People's privacy and confidentiality was respected at all times.
- Patients and relatives feedback was consistently positive about the care provided. Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- We observed interactions between staff and patients and their family members. Staff were friendly, polite and professional.

Summary of this inspection

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- RSOP 15: disposal of pregnancy remains states that all providers should have policies on disposal of pregnancy remains, and that information about disposal should be available for women, setting out their choices.The service had a policy in place but it was not known by the relevant staff and was not complied with.
- The pathology department had the correct procedures in place for the correct disposal of pregnancy remains that had been review the policy in 2016 but records showed and the pathology manager confirmed that the correct process for the disposal of pregnancy remains had not been followed for the last 6 years.

However;

- The hospital handled complaints in line with policy. Staff had a good understanding of the complaints process, and staff discussed complaints at monthly meetings. Information about the complaints procedure was available for patients and relatives.
- Facilities and premises were appropriate for the services being delivered.
- Delays and cancellations of operations were minimal and managed appropriately. Services ran on time. Staff kept patients informed of any disruption to their care or treatment.
- Staff identified vulnerable adults, such as patients living with learning disabilities, and living with dementia, at the referral stage. Staff took appropriate steps to ensure they were appropriately cared for.
- Surgery at Spire Alexandra Hospital was all elective planned procedures, so the hospital cancelled very few procedures.

Are services well-led?

Requires improvement

We rated this service as requires improvement for well-led because:

- The risk register management was not robust and did not reflect all the risks present in the surgical service.
- Not all leaders had the necessary experience, knowledge, capacity or capability to lead effectively. They did not always have the skill set and training to enable them to fulfil their role and responsibilities and to provide specialist advice if required.
- Staff and managers did not complete audits, in accordance with their audit timetable.
- Clinical practice in Termination of Pregnancy TOP services did not always reflect evidence based practice from relevant professional bodies.

- There was no specific strategy in place for the termination of pregnancy services. Staff we spoke with could not recall being asked to contribute to any discussion about developing a strategy.
- Minutes of clinical governance meetings within the reporting period and the subsequent six months did not have any evidence that items relating to termination of pregnancy services had been discussed. Staff we spoke with confirmed there had been no such discussion and doctors and nurses delivering the termination of pregnancy service did not attend the clinical governance meeting.
- A hospital clinical governance brief meeting was held once a week. The senior clinical team discussed the incidents reported in the previous week and reviewed the progress of any on-going action plans. Clinical incidents were also discussed at heads of department meetings. We saw evidence of this in the meeting minutes. We asked for evidence that the termination of pregnancy service was reviewed at any committee meetings and were told this was not available.

However:

- We saw staff demonstrating the core hospital values in the care they provided. Staff were positive about the standard of care they provided.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Termination of pregnancy	Requires improvement	Requires improvement	Not rated	Requires improvement	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Surgery

Good

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement

Are surgery services safe?

Good

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated safe as good:

Incidents

- Although, senior staff told us there had been no incidents related to endoscopy, hospital data showed 11 incidents occurred in the endoscopy suite between July 2015 and June 2016. This suggested the department did not discuss incidents and therefore, staff could not learn from incidents to avoid reoccurrence.
- Hospital data showed between July and September 2016, the service investigated and closed 43% of incidents within 45 days. This was worse than the corporate target of 75%. This meant staff may not learn from incidents within a timely manner.
- There were no never events reported between July 2015 and December 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Between July 2015 and June 2016, surgical services reported 518 clinical incidents. Sixty- eight percent of these incidents occurred in surgery or inpatients. Although this number of incidents is higher than the rate of other independent acute hospitals, the hospital reported day case conversions to overnight stay, which many hospitals would not as they do not provide this service.
- Hospital data showed the top three categories of incidents reported for the hospital were: admission following day case procedure, cancellation on the day of service and medication incidents.
- There were 12 non-clinical incidents reported between July 2015 and June 2016 in surgery or inpatient areas. This number of incidents is similar to the rate of other independent acute hospitals we hold this type of data for.
- The hospital followed its corporate adverse event/near miss reporting policy dated August 2015. Staff had a good understanding of the incident reporting system and stated incident reporting was everyone's responsibility. Staff reported incidents and near misses using an electronic reporting system. Staff completed mandatory training for incident reporting. Staff gave examples of the types of incidents they reported. These included allergic reactions to medication and equipment failure.
- Staff received details of the manager investigating the reported incident. This meant staff knew who to contact to discuss the incident if they wished and who would be providing feedback.
- There were four serious adverse events (SAE) reported between July 2015 and June 2016. The hospital investigated all SAEs using a process called root cause analysis (RCA). This process identifies root causes for

failure and areas for improvement to deliver safer care to patients. We saw three completed RCA reports with recommendations and action plans relating to surgery. One SAE involved a patient who tested positive for MRSA, but proceeded with surgery. Actions plans included communication improvement between the pre assessment clinic and the ward, and discussion around RCA findings at the weekly clinical governance review meeting. The action plans we reviewed appeared sufficiently robust.

- Hospital data showed since July 2016, there were six SAEs, of which four occurred within the surgical setting. We saw two completed RCA reports with recommendations and action plans. This included changes to surgical procedures in line with latest evidence based practice.
- There were nine incidents reported for inpatient slips, trips or falls between July 2015 and June 2016. We saw a completed RCA report for a patient fall, which resulted in injury. The service changed its practice by removing all “mule” type footwear for surgical patients and introduced “call-don’t fall” signs, which we saw in patient rooms. The signs reminded patients to ask staff for assistance particularly when mobilising post-surgery and at night.
- Staff reported all surgical site infections (SSIs) as incidents. We saw two RCA reports following SSI incidents, with recommendations and action plans. One recommendation was to update the local MRSA and MSSA policies and circulate these to all departments. The Infection Prevention Control Lead completed this and we saw the policies (dated December 2016) during our visit.The policy stated if the screening results are positive or not available prior to surgery, the hospital cancels the surgery and the patient has to complete the necessary suppression therapy.Suppression therapy is commonly used before planned operations and while patients are in hospital. It is highly effective in reducing infections caused by MRSA or MSSA.
- Staff told us they received direct feedback from incidents they had reported through email. The hospital shared learning from incidents with staff through newsletters, team meetings and on the hospital’s computer system, which all staff could access. Staff also received a “key learning summary sheet”, which shared learning from incidents across the Spire network. The latest sheet contained information about a staff fall. We saw ward, and heads of department, meeting minutes (dated November and December 2016 respectively). These provided evidence that staff received feedback and information around lessons learned from incidents. This process ensured all staff learnt from incidents to help prevent a recurrence.
- Staff discussed all incidents and adverse events at the quarterly Medical Advisory Committee (MAC) meeting, quarterly Clinical Governance Committee (CGC) meeting and the monthly Senior Management Team (SMT) meeting. Minutes of the MAC, CGC and SMT meetings confirmed this. This meant staff shared lessons beyond the affected service, which engaged staff to improve safety.
- Staff described the basis and process of duty of candour (DoC), Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of “certain notifiable safety incidents” and provide them with reasonable support. We saw five examples where the hospital had followed the DoC response process. Staff provided examples of when the hospital had carried out the DoC. For example, a patient developed a blood clot post-surgery so the governance lead for the hospital held a face-to-face meeting with the patient to explain and apologise.
- There were no deaths at the hospital between July 2015 and June 2016. Surgical mortality and morbidity was an agenda at CGC meetings and we saw meeting minutes (dated September 2016) to confirm this.

Clinical Quality Dashboard

- The hospital used the national NHS safety thermometer. This is an improvement tool for measuring, monitoring and analysing patient harms and harm free care. Hospital data showed there were no pressure ulcers and no urinary tract infections for catheterised patients between July 2015 and June 2016.
- Heads of departments received monthly emails with clinical scorecard results and shared this with staff. The hospital used a visual tree chart to display their clinical scorecard results. We saw the results displayed on noticeboards in staff areas.

Good

Surgery

- There were six cases of hospital acquired venous thromboembolism (VTE) in surgical inpatients between July 2015 and June 2016. However, between July and September 2016 the hospital's VTE incidence score was 0.43%. This was better than the Spire Healthcare corporate target of 0.5%. VTE incidence following orthopaedic surgery was on the hospital's risk register. We saw control measures to manage this risk such as the anti-embolism stockings and quarterly audits on anticoagulation prescriptions. Anticoagulation is a medicine used to prevent the formation of blood clots.

Cleanliness, infection control and hygiene

- All the bedrooms on Pickwick ward had carpets, which were not in line with the Department of Health: Health Building Note 00-09. Whilst there is no requirement for independent healthcare providers to comply with the Department of Health building notes, it is advised that independent healthcare providers consider the guidance when planning services and undertaking building maintenance and risk assessments. The hospital acknowledged this in their risk register. There was a refurbishment plan that would see replacement of the carpeted bedrooms with hardwood flooring within two years.
- We saw no dedicated hand hygiene sinks in patient bedrooms. This meant staff had to wash their hands in the sinks in patients' ensuite bathrooms. This is contrary to the Department of Health's Health Building Note 00-09, which states, "Healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes". In addition, the design of some sinks was not in accordance with the Health Building Note 00-09 or the corporate Spire prevention and control of infection manual as they had plugs and overflows.
- We observed the theatre and anaesthetic room door left open before the theatre list started. To maintain clean ventilation in theatre, the doors needed to be closed. The hospital highlighted this poor practice in the clinical review action log 2016. No actions were identified to remedy this issue.
- The ward had reusable bedpans and single use urine bottles and bowls. Staff cleaned these items using the disinfector machine. Once cleaned, staff put the item in an orange bag to show they were clean and ready for use. We saw the machine was dusty in places and did not have a hands-free door opening, which could lead to the spread of infection. Although staff told us there were plans to replace the machine with a macerator, the hospital had not recorded this on the risk register.
- Although we saw evidence of monthly equipment cleaning schedules in recovery, no instructions were available to theatre staff on how to clean the different equipment. We highlighted this to management, who were not aware of any cleaning instructions for theatres. This meant staff may not have been following the manufacturer's cleaning recommendations, which could cause damage to equipment.
- An external party carried out a sharps bin audit in October 2016. A sharps bin is a container used to dispose of medical needles. The IPCL carried out an internal sharps audit on Copperfield ward and theatres in December 2016. Both audits show a consistent theme of non-use of the temporary closure mechanism, inappropriate contents and overfilled sharps bins. We looked at nine sharps bins during our inspection and five were non-compliant. The incorrect use of sharps bins can lead to needle stick injury and the spread of blood borne viruses. We saw evidence from the IPC committee meeting minutes (dated December 2016), there had been two recent needle stick injuries involving surgeons. The hospital-implemented needle stick injury posters and weekly sharp bin audits. We saw needle stick posters on the ward IPC notice board and in recovery to remind staff of the correct processes for sharps disposal.
- Hospital data showed that between July 2015 and June 2016, there were 32 surgical site infections (SSIs). The rate of infections during orthopaedic and trauma, breast, gynaecological, upper gastrointestinal and colorectal, urological and cranial procedures was worse than the rate of other independent acute hospitals we hold this type of data for.
- Staff completed a RCA for a SSI, whereby a patient with MRSA continued with surgery. We saw the action plan, which showed staff had discussed the SSI at the Clinical Effectiveness and Clinical Governance meeting. Staff requested patients were booked into clinic in a timely manner for results to be back and suppressive therapy completed five days prior to surgery.

- There were no reported SSIs for hip or knee arthroplasty procedures and vascular procedures between July 2015 and June 2016.
- The service had a newly appointed infection prevention control lead (IPCL). The IPCL was a member of the national Infection Prevention Society and part of the Spire infection control network. This meant she was able to share and keep up to date with best practice.
- Link nurses for infection control were in place in each department. They completed competencies and received additional training such as aseptic non-touch technique. We saw evidence of this training in all the staff competency folders we reviewed.
- The microbiologist from the local NHS Trust attended quarterly Infection Prevention and Control committee meetings. The IPCL shared information from these meetings with the CGC and health and safety board. Standard agenda items at the link nurse committee meeting were; progress against annual plan, management of infection control risks and feedback from audits. We saw evidence of the infection control link meeting minutes dated June 2016, which confirmed these topics were included.
- The hospital had a corporate “Prevention and Control of Infection Manual” policy (dated November 2015). This included hand hygiene, use of personal protective equipment (PPE) such as gloves and aprons, spillage of body fluids and guidance on infection control within theatres. We saw personal protective equipment (PPE), such as apron and gloves, were available at the entrance of all patient bedrooms. Theatre and ward staff used PPE appropriately.
- We saw there were emergency spill kits and wipes available within the theatres and ward sluices. The theatre yellow spill kits contained PPE, including a full-face mask, to protect staff from inhaling any toxic chemicals. The spill kit on the ward included granules, gloves, scoops and an illustrative instruction card.
- All areas we inspected were visibly clean and there were hand-sanitising gel dispensers available at the entrances.
- Support service teams carried out domestic cleaning. Housekeeping staff cleaned the ward and theatre areas daily using checklists. This ensured consistent cleaning to the expected standard. The housekeeping supervisor carried out monthly observational audits of the cleanliness of these areas. We saw three completed audits (dated January, April and November 2016). Feedback given to the housekeeper included ‘some dust on bumper rails’ and ‘no soap in the ladies toilet’. We did not find issues with these areas during our inspection.
- Housekeeping staff used single use mop heads and cloths to avoid cross contamination. We saw posters displayed in the housekeeper’s cupboard showing the correct use and storage of mops and coloured buckets.This was in line with the hospital’s corporate prevention and control of infection manual.
- We saw carpets were visibly clean and free from stains. We saw a deep cleaning schedule, which showed the wards vinyl flooring and carpets, had a deep clean in January and July 2016. This minimised the infection risk.
- The two operating theatres had higher levels of air filtration (laminar flow) in place, which was best practice for ventilation within operating theatres. This is particularly important for joint surgery to reduce the risk of infection. An external company checked the theatre filtration system. We saw evidence of completed checks in January and December 2016. This ensured the laminar flow worked correctly and cleaned the air to the appropriate standard.
- The theatre area had male and female staff changing rooms. The female changing room was tidy and visibly clean, with all staff belongings put away in lockers and made secure. Clean scrubs and a means of disposal for dirty scrubs were available.
- Between July 2015 and June 2016, there were no reported cases of MRSA, Meticillin Sensitive Staphylococcus Aureus (MSSA), Clostridium Difficile (C. Diff) or E.coli. These infections have the capability of causing harm to patients.
- At the pre-operative assessment stage, staff screened high-risk patients MRSA and MSSA. High-risk patients included those with open wounds or chronic skin conditions, those who had been in hospital within the

past 12 months, and patients who had previously tested positive for the bacteria. This is in line with Department of Health: Implementation of modified admission MRSA Screening guidance for the NHS (2014).

- The hospital monitored hand hygiene compliance by measuring the usage of hand sanitising agents every quarter. We saw the hand sanitising usage audit for June 2016, which showed poor compliance. As a result, an external company had been to the hospital to provide hand hygiene teaching sessions to 27 members of staff.
- The hospital changed its method of hand hygiene monitoring during 2016. It replaced the hand sanitising agent audit with an observational hand hygiene audit. The National Patient Safety Agency states an observational audit is best practice as it is a consistent, reliable and simple method.We saw the audits results for December 2016; theatres were 80% compliant and Copperfield Ward was 90% compliant. The action plan we saw stated the hospital would start in-house hand hygiene training for all staff lead by the IPCL in 2017.
- The hospital scored 100% in the national patient led assessment of the care environment (PLACE) audit 2016 for cleanliness, which was better than the England average of 98% for other independent hospitals.
- We found equipment was visibly clean throughout the department. Copperfield ward had a six page local cleaning schedule, which included instructions on how to clean each piece of equipment. Ward staff demonstrated a good understanding of responsibilities in relation to cleaning and infection prevention and control.
- All equipment we saw had ‘I am clean’ stickers on it, which indicated the date staff cleaned the equipment and the member of staff who did so. We also saw ‘I am clean’ stickers displayed on the front of patient bedrooms. This showed the room was clean and ready for the next patient. This showed staff cleaned equipment and rooms between patients.
- Posters displayed at hand washing basins explained the “Five moments for hand hygiene” in line with World Health Organisation (WHO) guidance. We saw staff washed their hands in accordance with the WHO guidance.
- Staff asked us to change into theatre suits and change our footwear when entering theatres. This is in accordance with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) safety guidance on infection control in anaesthesia. Theatre staff wore pink theatre coats over clean theatre suits when leaving the department. This is good practice as it prevents the transmission of infection between departments.
- There was no segregation of clean and dirty equipment in the theatre sluice. This meant clean equipment could become contaminated with dirty equipment, which could lead to the spread of infection. During inspection, we found an x-ray machine, pathology specimens, equipment on the floor and an emergency eye wash board, which had fallen off the wall. We highlighted these concerns to hospital management, who took immediate action. During our unannounced visit, we found there was clear segregation of clean and dirty equipment. The x-ray machine was gone, the eyewash board was on the wall and equipment was stored on racks or in cupboards.
- The hospital used disposable curtains to separate the bays in recovery. The curtains appeared visibly clean and staff dated the curtains with the change date. This ensured staff changed the curtains at least every six months. This is in accordance with Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015).
- We saw a legionella audit dated March 2016. Legionella is bacteria that naturally occurs in water environments and can cause breathing problems if inhaled.The audit showed the hospital was 93% complaint with the minimum standard of effective legionella control, in line with the recommendations of the Health and Safety Executive (HSE). Action plans included staff training and documentation of annual disinfections.
- We saw “bare below the elbows” posters displayed throughout the hospital. These served to remind clinical staff of the importance of not wearing any clothing or jewellery below the elbows to reduce the risk of infection to patients. The hospital carried out a twice-yearly uniform audit for clinical and housekeeping staff. We saw the results of the December 2016 audit

showed staff were 100% compliant to their uniform policy. This was better than the previous audit in June 2016, which showed 98% compliance. We saw that all staff adhered to this policy.

- Staff completed annual infection control training in an electronic learning system format. Hospital data showed 94% of staff had up-to-date mandatory infection control training at the time of our visit. This was near to the hospital's target of 95%.
- The hospital had a local working instruction for the management of infectious outbreak (dated June 2015). An infectious outbreak occurs if the number of cases for infections or infectious symptoms, such as diarrhoea, is higher than expected. The policy included a definition of infectious outbreak, actions to follow, and contact details of relevant persons, including the local health protection unit. The hospital planned to test the working instruction in a staff scenario in 2017.

Environment and equipment

- We checked nine clinical and domestic waste bins in theatres, recovery and Copperfield ward. We saw all but one bin had waste separated correctly, and in different coloured bags, to signify the different categories of waste. However, we found a pair of gloves and aprons disposed of in one of the domestic waste bins on the ward. This is not in line with the corporate Spire prevention and control of infection manual, which states gloves and aprons should be disposed of as clinical waste.There were posters in the theatre sluice displaying the correct way to dispose of different waste. This was in accordance with the Health Technical Memorandum 07-01: Safe management of healthcare waste and health and safety at work regulations.
- Although the hospital kept waste in appropriate bins, one of the two clinical skips was unlocked during both our visits. This was not in accordance with the HTM 07-01 control of substance hazardous to health (COSHH) which states waste should be stored securely so as to prevent the escape of waste, harm to the environment and harm to human health. However, access to this area was by a master key held by authorised personnel only. This mitigated the risk.
- Staff performed and recorded equipment safety checks at the start of each theatre session. We reviewed the anaesthetic checklist logbook, and found three dates within the past month which had no record of a safety check. We escalated this to the management team who confirmed operations took place in the theatre on all three dates. This was not in accordance with the AAGBI Safety guidelines on checking anaesthetic equipment, which states, "A pre-use check to ensure the correct functioning of anaesthetic equipment is essential to patient safety".
- We checked 12 medical devices for electrical safety testing. This included six intravenous pumps. Only ten out of 12 medical devices we saw had up-to-date testing. This meant the hospital might not have held assurances about the electrical safety of all medical devices.
- We checked five medical devices for calibration testing. This process is to maintain medical device accuracy. Only two out of five medical devices we saw had up-to-date calibration testing. This meant the hospital might not have had assurances about the accuracy of all medical devices.
- We saw servicing certificates for medical equipment. The servicing record provided assurances that an external company checked and maintained medical devices regularly. All medical devices had an asset number for easy identification. It showed 27 out of 29 pieces of equipment on Copperfield ward, and 43 out of 58 pieces of equipment in the theatre department, had an up-to-date service. This meant there were 16 pieces of equipment without a recent service. Therefore, the hospital may not have had assurances that all medical devices were safe to use.
- We saw adult and paediatric non-breathing oxygen masks in the resuscitation trolley and in anaesthetic room two. The packaging of the masks had a hand written date on them. Several staff members were unable to state whether this was an expiry date and therefore had no assurances the masks were fit for purpose. We escalated this to the management team who informed us this was the purchasing date.
- The hospital told us all aesthetic and cosmetic surgeons were aware of the breast and cosmetic implant registry (BCIR). NHS digital designed this registry to record the details of any patient who had breast implant surgery, so that patients are traceable in the event of a product recall or other safety concern. The registry came into

effect on 10 October 2016 but at the time of the inspection, the independent sector were still trying to gain access to submit this information. In the meantime, the hospital kept local records to add once available.

- The wards, endoscopy and theatre areas were visibly clean, well maintained and free from clutter.
- There was restricted access to theatres and only authorised members of staff had the swipe cards needed to enter.
- Housekeeping staff told us the engineering team collected clinical waste regularly during the day and would make additional visits when requested by ward staff. Engineering staff took clinical waste bags to the clinical skips in theatres. We saw four clinical waste bags tied with black tags, in the ward sluice room. Housekeeping staff told us the black tags were for traceability, which is in accordance with the Health Technical Memorandum 07-01.
- The endoscopy decontamination room had a second sink for rinsing of endoscopes following manual cleaning. This was in accordance with the Department of Health's "Choice Framework for local Policy and Procedures 01-06 – Decontamination of Flexible Endoscopes: Operational Management".
- We saw resuscitation trolleys in recovery, endoscopy and on Copperfield ward. All trolleys were locked using seals, which staff checked and recorded daily. Staff checked the contents of the trolley after every use, or monthly if the trolley was not used. We checked the contents of the resuscitation trolley in recovery, and found all drawers had correct consumables and medicines, in accordance with the checklist. We saw all consumables and medicines were in date. We saw evidence the staff cleaned the trolley on a monthly basis with no omissions.
- The hospital audited cardiac arrest trolleys in theatres and on both wards. We saw completed audits and the relevant actions taken (dated June and August 2016). For example, staff to discuss the new contents of the transfer bag following change in line with guidance and new checklist implemented.
- The hospital had recording systems in place. This allowed them to provide details of prosthesis to the product regulator. We saw a folder, which contained individual records for every prosthesis. The hospital sent these documents to the national distribution centre for archiving.
- We saw there was a bariatric risk assessment for surgical patients with a body mass index of 40 or above. The preventative actions taken as a result of the risk assessment included anti-embolism stockings, bariatric bed and hoists.
- The hospital scored 99% in the PLACE audit 2016 for the condition, appearance and maintenance of the hospital. This was better than the England average of 93% for other independent hospitals.
- There was an on-site sterile supplies department (SSD), which was nationally accredited. We saw the accreditation certificate during our inspection. Staff in this department performed sterilisations and other actions on medical devices, equipment and consumables used in the operating theatres. A member of the SSD attended the daily morning briefing in theatres to ensure surgical instruments were available, and to discuss with staff any potential problems.
- We saw evidence of completed daily checks without omissions on the warming cabinet, the difficult airway trolley and transfer bag seal. This was in accordance with the AAGBI safety guidelines.

Medicines

- The hospital did not always follow their corporate "Policy for the safe management of controlled drugs" (dated March 2016) which included information on the storage, access and records for controlled drugs (CDs). CDs are medicines liable for misuse that required special management.
- Managers told us that a CD audit, carried out in November 2016, showed entry gaps of signatures by theatre staff checking and witnessing the administration of CDs. The pharmacist also identified this in a previous CD audit (dated September 2016). We looked at the theatre CD registers and saw evidence of this as part of our inspection. This was not in accordance with Nursing and Midwifery Council (NMC) Standards for Medicines Management, which recommends two signatures for the administration of controlled drugs.

- Although each department maintained a list of signatures for authorised staff that handled CDs, we saw a signature in the CD register that did not match the authorised signature of that member of staff. We highlighted these concerns to the management team, who said they would take corrective action.
- Managers told us there had been a transcribing error in a CD register in the anaesthetic room within the last three months. A transcribing error occurs when someone records information incorrectly. The hospital fully investigated this and shared learning with all relevant staff.
- Although the hospital's corporate "Policy for the safe management of controlled drugs" stated, "Delivery must be made directly to an authorised registered practitioner", we saw evidence this was not followed. Theatre staff had received CDs without having completed the necessary competencies. We escalated this to the management team, who said they would take corrective action.
- Pharmacy managed and clearly documented CDs requiring destruction. Pharmacy stored the CDs for destruction separately from the main stock in pharmacy. However, we saw 12 items of CDs in pharmacy had been waiting for destruction since May 2016. We brought this to the attention of the pharmacy manager, who told us they were aware of the situation and would take corrective action.
- We reviewed five patients' prescription charts on Copperfield ward. We saw that medical staff had completed all charts, including the frequency and dosage of medicines. However, we saw 12 instances whereby staff had not provided a reason when they omitted medication. Actions plans from the drug chart audit (dated April 2016) stated, "Where drugs have been omitted a code must be used to indicate why omission was made. "X" is not acceptable. If under doctors instruction a note must be made as variance". This suggested the action plan had not been effective, as there were still omissions.
- All patients' medical records we reviewed contained prescription charts. We saw clearly documented allergy statuses of each patient. This correlated with any documented allergies in the patient's medical and nursing records.
- Staff kept the CD cupboards locked. There was restricted access to the CD cupboards and they were bolted to the wall. We saw that two members of staff at each shift change checked controlled drugs. We performed spot checks on CD stock levels, which were correct.
- Pharmacy kept an up-to-date list of signatures for staff authorised to order and administer CDs, along with a register of members of the Medical Society. This provided assurances staff deemed competent could order and administer CDs.
- The hospital had an on-site pharmacy. Clinical staff reported that the pharmacy team were readily available to offer support and advice to both staff and patients, maintain adequate stock levels, and dispense prescriptions in a safe and timely manner.
- Out of hours, there was restricted access to the hospital pharmacy. We saw appropriate security procedures in place to ensure only approved staff could access medicines, and that the out of hours arrangements were clearly communicated to relevant staff.
- The hospital had a local working instruction for self-administration of medicine (dated June 2016). Although a pharmacist told us patients rarely administered their own medications, due to the elective nature of the inpatient service. Each patient bedroom had a lockable cupboard for patient medications.
- Pharmacist dispensed all medicines in the hospital pharmacy. Medicines were mainly supplied and administered against a written prescription by a doctor. This included medicines for pain relief and preventive antibiotics to reduce the risk of post –procedure infection.
- Medicines to be used in case of medical emergencies, such as anaphylactic shock, were easily accessible and clearly identifiable. These were checked on a regular basis by practitioners and by pharmacy staff so that they were ready for use.
- The hospital discharged some inpatients with a private prescription. We looked at the storage of private prescription stationery within the pharmacy department. In accordance with good practice, the stationery was securely stored in a locked cabinet. Each prescription had a unique identifier number and

pharmacy issued these on an individual basis to a named prescriber. The pharmacy maintained a register of all private prescriptions issued, in accordance with local policy. This was good practice as it ensured traceability of prescriptions.

- A copy of the current British National Formulary (BNF) was available in clinical areas. The BNF is the national authority on the selection and use of medicines. Doctors used the BNF to ensure they were prescribing medicines safely and appropriately.
- Staff safely stored medicines in accordance with the manufacturers' recommendations, including anaesthesia medicines and medical gases. Staff kept medicines with a temperature storage requirement in the drug fridge.
- Theatre and ward staff completed daily temperature checks of the drug fridges and ambient room temperatures. It is important medications be stored correctly to maintain their function and safety. We reviewed temperature-monitoring records for November and December 2016. We saw that staff had fully completed the records, with no omissions. Where temperatures were outside the safe range, staff recorded the actions taken, in all but one record we reviewed.
- Staff checked the expiry dates of medicines in the theatre department monthly. We saw evidence of completed checks and all 15 medicines we looked at were within their expiry date.
- The pharmacists carried out a range of audits in relation to administration and safety of medicines, including a CD register, departmental checks and a drug chart audit. We saw completed audits and actions taken. For example, staff were asked to record the drug fridge temperature daily and staff to lock drug fridges when not in use.
- The pharmacy team saw most patients with to take-out (TTO) drugs at discharge. We observed this as part of our inspection. This enabled the pharmacist to counsel the patient on the dosage and possible side effects of the medicine before discharge. If the pharmacist was unable to do so, ward nurses explained the TTO drugs to the patient.
- The hospital had a service level agreement (SLA) with the local NHS Trust for the provision of additional pharmacy support in the event of an emergency.
- The hospital had local antibiotic prescribing guidelines (dated July 2015). Relevant staff had antibiotic stewardship. The pharmacists discussed medicines management at ward, medicine management and clinical governance meetings.We saw the clinical governance meeting minutes (dated September 2016) which confirmed this.

Records

- The hospital stated it completed monthly medical health record audits. The hospital selected 20 sets of health records randomly each month and checked for completion and accuracy of care pathways. It included checking completion of the WHO surgical checklist, pre assessment, medication chart and consent. We saw evidence of one completed medical health record audit (dated May to June 2016) with no action plan. However, we did see evidence that staff discussed this at the clinical governance meeting in June 2016.
- The hospital followed the corporate, "Information Lifecycle Management and Patient Records Policy" which had been overdue a review since August 2016. This policy included information about confidentiality of patient records, documentation by clinicians, length of storage and patient records on discharge or transfer.
- The hospital managed patient personal information and medical records safely and securely, in line with the Data Protection Act 1998. When not in use on the ward, staff kept patient notes in a locked cupboard. Although the lock had broken during the inspection, we saw administrative staff transfer the patient records to a lockable trolley to maintain security.
- Staff told us they shredded nursing handover sheets at the end of the shift and the nurse in charge enforced this practice. This meant they maintained patient confidentiality.
- The hospital held medical records for Spire Healthcare patients securely on site. There was an archive facility for patient notes, which would be stored on site for six

months, and then transferred off site to the Spire Healthcare national distribution centre. There was a tracker system in place, which we saw. This meant staff knew where notes where at all times.

- All medical records we reviewed were tidy, with no loose filing, legible, dated and signed, which is in accordance with professional standards for the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC).
- Records showed where staff had completed patient risk assessments. These included risk assessments for falls, malnutrition and pressure ulcers. All risk assessments completed followed national guidance. For example, all patients were risk assessed on admission for their risk of VTE. This was in line with the National Institute for Health and Care Excellence (NICE) QS3 – statement one.
- All nursing and medical records reviewed, showed correctly recorded observations. Each patient had the appropriate care pathway in place and discharges were planned. We concluded completed patient care records were accurate, recorded in a timely manner and contributed to good patient care.
- Medical records for NHS patients transferred from the local NHS hospital to the Spire Alexandra were held on site while the patient was under the care of Spire Alexandra. After discharge, the NHS medical records transferred back to the local NHS hospital.
- The hospital used a secure system when sending and receiving emails containing identifiable patient information. It also sent discharge letters to the patient's GP electronically to reduce possible data loss
- Between January 2016 and November 2016, 90% of staff had completed online information governance training. This is below the Spire Healthcare corporate target of 95%.

Safeguarding

- All staff was able to describe how they would escalate concerns, when they would seek advice, and could identify the safeguarding leads for the hospital.
- We saw safeguarding reporting posters displayed on Copperfield ward to remind staff how to report safeguarding concerns, with details of the local safeguarding team. Although the ward had patient leaflets called "How to protect yourself from abuse", the leaflet stand was in a public area (ward reception desk). This could deter vulnerable patients from reading the leaflet.
- Although we saw posters displaying details on the mandatory reporting of female genital mutilation (FGM), not all staff understood their mandatory reporting responsibilities relating to this area, despite having received a clinical briefing on FGM in April 2016.
- There were corporate policies called 'Procedure for the Care of Children and Young People in Spire Healthcare' (dated March 2016), and 'Safeguarding Vulnerable Adults' (dated January 2016). The policies defined responsibilities at national, regional and hospital level.
- The hospital had a local working instruction, "Safeguarding Adults Process". It identified responsible persons within the hospital and provided contact details of local social services.
- Staff received mandatory training in the safeguarding of adults as part of their induction, followed by adult safeguarding refresher training yearly. At the time of our inspection, 99.5% of staff had completed level one and level two safeguarding vulnerable adults training. This exceeded the Spire Healthcare target of 95%.
- Staff discussed all safeguarding issues, including changes to policy, at the MAC, CGC and SMT meetings. We saw the minutes of these meetings, which confirmed this. The adult safeguarding lead also attended local adult safeguarding meetings.
- Although there was one safeguarding concern reported to the CQC between July 2015 and June 2016, this related to community services rather than the hospital.

Mandatory training

- Mandatory training for all staff groups was comprehensive, with many modules accessed through an on line learning system. Mandatory training modules included: equality and diversity, compassion in practice, manual handling, infection control and fire safety. Other training was role specific. For example, pain management, chaperoning, food safety and blood transfusion. We looked at seven individual training files of theatre and ward staff, which showed completed training certificates.

- We saw records which showed 100% of staff working within surgical services, and 96% of ward staff, had completed their mandatory training. This was better than the Spire Healthcare target of 95%.
- The resident medical officers (RMOs) were required to undertake their mandatory and statutory training with the agency that supplied them as part of their contract. Upon completion, the agency sent the certificates to the hospital.
- Consultants had to complete all annual mandatory training requirements for revalidation, and the Hospital Director could request to see evidence of this.
- Other mandatory training included advanced life support and advanced paediatric life support. Management told us six theatre staff completed the advanced life support course.
- Hospital data showed 96.8% of staff completed online mandatory equality and diversity training at the time of our visit. This ensured staff had knowledge to meet the diverse needs of their patients.
- Staff completed their mandatory training through the Spire online system and attended face-to-face training. This allowed the governance lead to monitor completion rates.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- The hospital did not always follow their corporate “Admission and Discharge Policy” (dated June 2014), which outlined the clinical risk assessment criteria for patients.
- Anaesthetists calculated the patient’s American Society of Anaesthesiologists (ASA) grade, as part of their assessment of a patient about to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels, with level one being the lowest risk. The anaesthetist used this to decide whether the patient was suitable to have surgery at the hospital. Although we saw an ASA grade recorded in all the patient records we reviewed, hospital data showed between May and June 2016, 40% of patients had an ASA score of one, 45% of patients had an ASA score of two and 15% of patients did not have a recorded ASA score. This meant the hospital might not have assurance they did not treat any patient outside their admissions criteria.
- We saw the senior management meeting minutes (dated November 2016) which showed a patient was graded an ASA score of three at pre-assessment, which increased to four following anaesthetic. The patient still underwent surgery at the hospital. This is not in accordance with the hospital’s admission criteria. The hospital told us the patient’s surgery went ahead because the patient was already anaesthetised when the theatre team realised their ASA score had increased to four. However, the hospital changed their practices following learning from this incident and anaesthetists now confirm patients’ ASA scores at the team brief at the start of each operating list. Anaesthetists take a final ASA check when a patient arrives in the anaesthetic room to avoid patients undergoing surgery at the hospital when this may not be safe for them.
- Pre-assessment of patients was in accordance with British Association of Day-care Surgery (BADS).
- As part of the preoperative assessment process, patients completed a comprehensive Pre-Admission Medical Questionnaire (PAMQ). Depending on the information provided in the PAMQ, the pre-assessment nurse would decide if the patient needed an additional short telephone pre-assessment, or a face-to-face pre assessment. Hospital data showed between May and June 2016, 50% of patients required a face-to-face pre assessment, 45% had PAMQ only and 5% required a telephone pre assessment.
- The PAMQ also identified patients with certain medical conditions who might need further assessment. For example, patients with a history of a heart attack who had a pacemaker would be assessed by an anaesthetist, prior to planned surgery.
- At pre-assessment appointments, the pre-assessment nurses would assess the suitability of patients for surgery. They carried out health assessments such as an electrocardiogram (ECG), and had discussions about the procedure. If the discussions (at either a telephone or face-to-face) pre-assessment highlighted a potential safety concern, staff told us they escalate it to the anaesthetist.

Good

Surgery

- We saw as part of the PAMQ, all female patients of childbearing age were asked the date of their last menstrual period, to check their pregnancy status. On admission to the ward, female patients had a urine pregnancy test performed. This was in line with the National Patient Safety Agency 2010 Rapid Response Report, which highlights the 'unreliability of LMP as a sole indicator of potential pregnancy'.
- The hospital used the National Early Warning Score (NEWS), and escalation flow charts. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring. If a patient's score increased, staff responded by increasing the frequency of observations. Staff may request urgent review by the consultant. In all of the five patient records we reviewed, all patients had frequency observations and NEWS recorded and escalated where appropriate.
- All patient notes we reviewed had a completed falls risk assessment recorded on patient admission. Staff reassessed and recorded the patient's falls risk daily.
- Between July and September 2016, 95% of patients had their temperature recorded (corporate target 95%).
- The percentage of patients screened for VTE was equal to, or above, 95% between July 2015 and June 2016. This is the same, or better, than the Spire Healthcare corporate target of 95%. We looked at five sets of patients notes and found fully completed admission VTE risk assessments. This is in accordance with the National Institute for Health and Care Excellence (NICE) Quality Standard Three.
- The hospital used an intentional rounding form which ward staff completed two hourly after they ensured their patients were safe and comfortable. This meant staff could anticipate any potential complications before they happened.
- We reviewed five sets of patient notes and all of them had a pressure ulcer risk assessment recorded (Waterlow score) on admission. Staff reassessed the patient's risk daily. This allowed the service to manage the pressure ulcer risk for patients at high risk. For example, by helping patients to change position regularly and using gel heel cushions to protect patients heels.
- Staff escalated their concerns appropriately. We saw evidence of a nurse who escalated concerns about a patient unable to pass urine post-surgery. Documentation we reviewed showed the nurse contacted the RMO twice and followed their advice. The RMO reviewed the patient and escalated their concerns to the consultant, who arranged for a urology consultant to review the patient out of hours. The consultant reviewed their patient in the morning.
  The theatre team used the 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in surgery, by carrying out a number of safety checks before, during and after surgery. The hospital audited the use and completion of the WHO surgical checklist. We saw the observational audit of the checklist showed 98% compliance, and the documentation audit scored 96%. During our inspection, we observed the theatre team undertake the WHO checklist correctly. We also reviewed five sets of notes and found fully completed WHO checklists.
- All patients saw their named consultant at each stage of their journey. The hospital had a transfer agreement in place. This meant deteriorating patients would be transferred to a local NHS trust. If a patient's health deteriorated, medical staff supported nursing staff to stabilise the patient prior to transfer. We were told the deteriorating patient would receive level two nursing care and advanced life support (ALS) pending transfer. If there was not a person on site with ALS, then the RMO or medical person on call would provide this. We saw in theatres an emergency transfer bag was available and ward staff knew its location.
- As part of their practising privileges with Spire Healthcare, all consultants were required to be able to attend the hospital within 45 minutes, whenever they had a patient in the hospital. Medical and nursing staff told us they experienced no difficulties contacting consultants. We saw up-to-date contact numbers for consultants were available to nursing staff in wards and operating theatres.
- The resident medical officer (RMO) rota was covered by three RMOs who worked on a one week on – one week off rota. This meant there was continuous RMO cover to respond to nursing concerns or deteriorating patients.
- The hospital did not accept unplanned medical admissions. We saw the local emergency admissions

pack (dated March 2016), which clearly listed conditions which were excluded from admission. Any emergency admission required further risk assessment by nurse, consultant or anaesthetist depending on their severity.

- The ward held 'safety huddles' every morning which members of the multi-disciplinary team attended. The ward sister led the meeting and discussed each patient in turn. We observed a safety huddle during our visit. Staff discussed patients' risk of falls, pressure areas, indwelling devices, staffing issues, expected admissions and physiotherapy input. This ensured any staff escalated concerns about patients to the correct person in a timely manner.

Nursing and support staffing

- The Association for Perioperative Practice (AfPP) had recommendations for the numbers of staff on duty during a standard operating list. This consisted of two scrub practitioners, one circulating staff member, one registered anaesthetic assistant practitioner and one recovery practitioner. Although theatres planned the staff rotas to meet AfPP guidelines, we reviewed nine patient operation records and found five did not meet AfPP recommended staffing levels.
- Sickness rates for inpatient nurses were above the average of independent hospitals we hold this type of data for during the reporting period (except for three months where it was lower).
- The hospital told us they had previously trialled a national staffing tool to decide the number of nurses required on shift. They found this too complicated for their needs. The hospital generally employed one nurse for five patients during day shifts, and one nurse for seven patients at night. The ward sister reviewed staffing levels for the following day and adjusted these according to patient needs and acuity. This is in accordance with the NICE Safer Staffing guidance.
- Copperfield ward displayed its staffing levels daily on a whiteboard opposite the ward reception. During our inspection, we saw the board was completed every shift. The number of nurses and healthcare assistants on duty met the expected level.
- Hospital data on 1 July 2016 showed there were 14.5 whole-time equivalent (WTE) nurses and two WTE healthcare assistants (HCAs) on the wards. At the time of inspection, ward management told us there were no ward vacancies. The ward had two critical care nurses working 45 WTE hours, which was over their planned establishment of 37 hours for critical care nursing.
- Hospital data on 1 July 2016 showed there were eight WTE nurses and 9.3 WTE operating department practitioners (ODP) and HCAs in theatres. At the time of inspection, staff told us there were four WTE vacancies for theatres. The hospital advertised the vacancies: one scrub nurse, two HCAs and one surgical assistant.
- Staff told us they worked annualised hours and so staff adjusted their shifts depending on the ward's needs. Alternatively, bank and agency staff worked on the ward to make up any shortfalls in staff numbers. The use of bank and agency nurses in inpatient departments was lower than the average rate of other independent acute hospitals we hold this type of data for in the reporting period (July 2015 and June 2016), except for one month. There was no use of bank or agency HCAs during the same period.
- The hospital reviewed its staffing levels on the ward twice a day, taking into consideration patient numbers, planned activity, acuity and dependency. This meant staff escalated any staffing shortfalls in a timely manner.
- Staffing levels were also reviewed at the 'safety huddle', which was a multidisciplinary team meeting. This was held in the morning on the ward, and at the start of the shift in theatres. This allowed staff to assess the number of patients planned for the following week to ensure the ward filled all the shifts, and escalate shortfalls in staffing.
- We observed a nursing handover at shift change on the ward. Staff passed on effective and relevant safety information, such as pressure areas, fluid status, position on the theatre list and post-operative care. The nurses on the morning shift had pre-recorded their handover, which was listened by staff on the late shift. This meant the ward maintained staffing levels during handover.
- Patients told us there were sufficient staff to meet their needs during their visit to the hospital and the care they received from those staff was extremely good.
- There was no use of agency nurses during the reporting period of July 2015 to June 2016. The use of bank and

agency ODPs or HCAs in theatres was lower than the average rate of other independent acute hospitals we hold this type of data for in the reporting period, except for one month.

- Sickness rates for theatre nurses were variable throughout the reporting period (July 2015 to June 2016), with six months being lower than, and six months being higher, than the average of independent hospitals we hold this type of data for.
- Sickness rates for ODPs, inpatient and theatre HCAs in the reporting period were zero percent, or lower than the average of independent hospitals we hold this type of data for, except for two months.

Medical staffing

- Between July 2015 and June 2016, the hospital granted 169 doctors practising privileges. The term ‘practising privileges’ refers to medical practitioners granted the right to practise in a hospital. Of these doctors only 1% had not carried out any episodes of care between July 2015 and June 2016 meaning those with practising privileges were active in the hospital.
- The hospital had an on-call rota service for anaesthetists, physicians and named consultants to provide medical advice and support out of hours. We saw the on-call rota for theatres. This showed three designated members of staff were on-call overnight until 8am, and all day Sunday to respond to emergency returns to theatre. This rota included a member of staff with anaesthetic competencies. This was in line with Spire Healthcare corporate policy (clinical policy 59).
- Between July 2015 and June 2016, the hospital had five consultants with practising privileges for cosmetic surgery. All these were on the GMC specialist register.
- There was a corporate “consultants handbook” (dated June 2014), which included granting and maintain practising privileges, and defined responsibilities at national, regional and hospital level.
- Operating theatres were generally in use between 8am and 8.30pm, Monday to Friday and 8am to 4pm on Saturday. If a patient was required to return to theatre out of hours due to complications, there was a comprehensive on-call system in place to notify staff.
- The hospital used an agency that provided a RMO on site 24 hours a day, seven days a week, on a rotational basis. This meant a doctor was on site at all times of the day and night in the event of an emergency.
- All staff and the RMO told us there were no concerns about the support they received from consultants and their availability.
- RMOs handed over to each other following a change of shift. They discussed patient situation, background, assessment and recommendations (SBAR). SBAR is an effective and efficient way to communicate information. This meant the overlap time was minimised.

Emergency awareness and training

- The hospital had a local business continuity and lock down plan (dated October 2016) in place, in the event of potential emergencies. The plan covered major incidents, such as how to respond in the event of widespread fire or flood, electricity failure, gas leak and water failure.
- Scenario based training sessions were held regularly to make sure staff responded appropriately to emergencies. Staff told us they had seven stimulation training sessions on resuscitation within the past year.
- Staff told us fire evacuation training happened twice yearly in theatres. In the event of a fire, one theatre member would take a staff registration to ensure everyone had been evacuated. The scrub practitioner would be responsible for the patient.

We rated effective as good:

Evidence-based care and treatment

- Spire Healthcare corporate and the hospital’s governance lead reviewed National Institute of Health and Care Excellence (NICE) guidelines and other national guidance documents centrally and locally.
- Staff could access updated policies and guidance in the management suite. The hospital informed staff of policy

changes and patient safety alerts through 'monthly service quality and safety information' bulletins and at quarterly clinical governance and MAC meetings. This ensured staff kept up to date with the latest guidance.

- The hospital delivered care and treatment in line with the NICE and Royal College's guidelines, for instance the Royal College of Anaesthetics. For example, the hospital used the national early warning system (NEWS) to assess and respond to any change in a patient's condition. This was in line with NICE guidance CG50: Acutely ill adults in hospital: recognising and responding to deterioration.
- Staff assessed patients for the risk of venous thrombo-embolism (VTE) and took steps to minimise the risk where appropriate, in line with NICE guideline CG92- venous thromboembolism: reducing the risk for patients in hospital.
- The hospital followed NICE guidance CG65 for hypothermia: prevention and management in adults having surgery, staff monitored the patient's temperature before anaesthetic, and then every fifteen minutes afterwards.
- The hospital followed NICE guidance for preventing and treating SSIs, NICE guidelines CG74. For example, following discharge staff advised patients and carers on how to care for their wound.
- We saw pre-assessment nurses performed pre-operative tests such as electrocardiogram for patients with pre-existing heart conditions. This is in line with NICE guideline NCG45: Routine preoperative tests for elective surgery.
- The hospital used comprehensive care pathways for patients undergoing local and general anaesthesia. This included quality indicators of anaesthesia such the use of intra-operative warming devices, management of pain and recommendations for the management post discharge complications. This meant there was a standard system in place for each patient.
- Nurses completed the Waterlow and the Malnutrition Universal Screening Tool (MUST) scores for every patient and used the scores appropriately to guide care planning. The Waterlow risk assessment score gives an estimated risk for the development of a pressure sore in a given patient.
- Corporate Spire Healthcare policies were appropriately referenced and signposted to the evidence base. For example, the prevention and control for infection manual referenced NICE guidance QS65: Hypothermia: prevention and management in adults having surgery and QS49: Surgical site infection.

Pain relief

- There was a pain assessment tool within the NEWS chart used within the hospital. Nurses asked patients how they would rate their level of pain on a score of zero to four, with four being the worse. We reviewed five sets of notes, which showed nurses completed these for each patient. We also observed recovery staff assess a patient's pain using the pain assessment tool. The staff member also explained the pain medication and its side effects to the patient.
- The hospital's pain assessment audit for 2015 indicated 100% of patients had a pain score recorded with every set of observations.
- Pain score and assessment prompts were included in the 'quality round form' used by staff, to ensure their patients were safe and comfortable. Quality rounds were undertaken every two hours for all inpatients and day patients. Patients told us nurses routinely asked them about pain as part of these rounds.
- We spoke with six patients who told us nurses met their pain management needs. Two patients told us staff managed their pain very well. Another patient told us "staff offered pain relief before the pain escalated".
- The hospital's patient satisfaction survey for 2015 indicated 93% of patients thought staff did everything they could to control their pain.
- Pharmacists gave patients information leaflets to take home, which provided information on pain relief medication, common side effects, and contact details of the pharmacy department should the patient have any questions.
- Staff contacted specialist anaesthetists for pain management advice. Staff completed yearly pain management competencies. We saw this in the seven competency folders we reviewed. Some staff had attended a pain management course at a local NHS Trust.

- Physiotherapists ward nurses and pharmacists attended and discussed patient pain at multidisciplinary meetings. This ensured staff escalated patient pain in a timely manner and patients received the appropriate treatment. Staff told us they administered pain relief medication before physiotherapists mobilised patients as this aided the patient's recovery.

Nutrition and hydration

- Patient advice followed the Royal College of Anaesthetists guidance on fasting prior to surgery. It recommends patients can eat food up to six hours, and drink clear fluids up to two hours, before surgery. Administrative staff sent admission packs to pre-operative patients before surgery, which included information on fasting times.
- Patients had a daily menu to choose meals from with multiple choices. Catering staff freshly prepared the food onsite. Patients had access to food between meal times as required. This included toast, soup, sandwiches and fruit. Water was available to all patients throughout the day. A member of catering staff spoke with patients daily to discuss any individual needs.
- The patient led assessment of the care environment (PLACE) results between February and June 2016, for organisational food was 100%, and ward food 97%. These scores were better than the England average for other independent hospitals, which were 91% and 92% respectively.
- We spoke with six patients who all spoke very positively about the quality of the food offered; they told us there was a good choice of food and drink. One patient told us the food had improved since their last operation four years ago. Another patient told us the "food was delicious". The chefs were adaptable and accommodating, happy to prepare any specific foods patients wanted, even at short notice. Chefs visited patients on the ward upon request.
- Staff screened all patients for malnutrition and the risk of malnutrition on admission, using the MUST as part of the integrated care pathway record. We reviewed five sets of notes and all had a completed MUST score recorded.
- The hospital provided three meals a day for inpatients. Catering staff served breakfast between 8am and 8.30am, lunch between 12pm and 12.30pm and dinner between 5.30pm and 6pm. Staff encouraged visitors to eat with patients. Visitors brought meals at the hospital's canteen.
- Nutrition and hydration prompts were included in the "quality round form" used by staff, to ensure their patients were safe and comfortable. Quality rounds were undertaken every two hours for all inpatients and day patients. Patients told us nurses routinely offered them drinks as part of these rounds.
- The hospital did not have a dietitian on site, but there was a service level agreement in place to access an external dietitian when required.
- Staff assessed and recorded patients' nausea and vomiting score. We reviewed five sets of notes and found all had a completed score.
- The hospital had a five star rating in the local authority "Food Hygiene Certification Scheme". This gave the hospital assurance staff knew best practice in food hygiene standards.
- The PLACE results between February and June 2016 showed the hospital scored 99% for food quality. This was better than the England average of 91%.
- The hospital audited fluid fast times against recommended guidance. The results showed 69% of patients in 2016 received clear oral fluids within two to three hours of commencing intravenous fluids in theatre. This was better than the provider target of 50%. This suggested practice around fasting was good.

Patient outcomes

- The hospital took part in national audits focussing on patient outcomes. This included the National Joint Registry (NJR), which showed the hospital had a much higher than expected revision rate for knee and hip replacements from 2003 to 2015. A revision is a procedure in which the surgeon removes a previously implanted artificial joint, or prosthesis, and replaces it with a new prosthesis. However, revisions rate taken from the last five years of the registry showed the hospital was within normal range. The hospital also took part in the National Comparative Audit of Blood Transfusion: 2015 audit of patient management in adults undergoing elective, scheduled surgery.

- The hospital submitted Patient Reported Outcome Measures (PROMS) data for hips and knee outcomes on a national data programme. PROMs measure health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery.
- Hospital data between April 2015 and March 2016, showed the hospital's PROMS adjusted average health score for total knee replacement, was 16.4 and 21.6 for hip replacements. This was significantly better than the England average for total knee replacements, of 18.3, and total hip replacements of 24.2. There was a 97.4%, and a 100%, improvement respectively in modelled records for knee and hip replacements. However, the hospital did not have enough data available to calculate average health adjusted scores for PROMS for groin hernias for the period between April 2015 and March 2016.
- The EQ-VAS questionnaire asked patients to describe their overall health on a scale that ranged from "worst possible" to "best possible" health. The EQ-5D profile asked patients to report on their health, based on self-assessed levels of problems ("no", "some", "extreme"). Both indexes are addition measures of patient health outcomes. The hospital's PROMs outcomes are around the national average for EQ-VAS and EQ-5D indexes. The national average compares both independent health care providers and NHS providers.
- For the 12 NHS funded patients treated for groin hernia between April 2015 and March 2016, 58.3% of patients reported their health had improved following surgery. Only 8.3% felt their health had worsened under the criteria EQ-5D.
- For the 13 NHS funded patients treated for groin hernia between April 2015 and March 2016, 30.8% of patients reported their health had improved following surgery. However, 30.8% felt their health had worsened under the criteria EQ VAS.
- The hospital had a service level agreement with a local acute NHS trust. Between July 2015 and June 2016, eight patients transferred because of post-operative complications. The proportion of unplanned transfers was not high when compared to other independent acute hospitals we hold this data for.
- There had been 11 cases of unplanned readmission within 28 days of discharge between July 2015 and June 2016. The proportion of unplanned readmissions was not high when compared to other independent acute hospitals we hold this data for.
- There had been 10 cases of unplanned returns to theatre between July 2015 and June 2016. Reasons for unplanned return to theatre included haematoma, prolonged bleeding and washout of wound. A haematoma is a collection of blood. Hospital data between July and September 2016 showed an improvement in unplanned return to theatre rates from 0.22 to 0.19. This is slightly better Spire Healthcare corporate target of 0.2.
- All private hospitals are legally required to send data on safety and quality indicators to the Private Healthcare Information Network (PHIN). Data submitted is published online and helps patients make informed choices on their care. Spire Alexandra engaged with PHIN and hospital data is being collected centrally.

Competent Staff

- The hospital required all surgical first assistants it directly employed to have a risk assessment and once completed to keep a logbook to demonstrate competency in this area. First assistants worked closely with the surgeon to facilitate the procedure and process of surgery. We reviewed a first assistant competency folder and found they had not completed a risk assessment before they carried out their first assistant role. We escalated this to the management team who explained there was confusion over the hospital policy. Management completed one risk assessment to cover the operating department rather than one risk assessment for each first assistant. Management corrected this practice after an internal clinical review in October 2016, which highlighted the poor practice. Since the review, management has ensured all first assistants have a risk assessment completed. This mitigated the risk.
- Hospital data showed 100% of theatre and ward staff received a performance appraisal between January and

December 2016. We reviewed seven competency folders and saw all staff had documentation of appraisal and a performance development plan where applicable. Staff appraisals linked to the hospital and Spire Healthcare corporate vision and values.

- Managers encouraged staff to undertake continuous professional development (CPD). Staff had opportunities to develop their clinical skills and knowledge through training relevant to their role. For example, a theatre member had applied for a surgical first assistant university course and the IPCL was completing a master's degree in infection prevention and control. We saw four competency folders for nursing staff and three for theatre staff. All certificates were up to date such as immediate life support and manual handling. Managers reviewed staff competency assessments yearly. This provided the hospital with assurances staff were competent to carry out their roles.
- One hundred percent of inpatient nurses and theatre operating department practitioners, who had worked for six months or more at the hospital, had recorded validation of professional registration. This meant the hospital conducted annual checks to make sure nurses registered with the Nursing and Midwifery Council (NMC). This helped ensure that only nurses who had registration and deemed fit to practice worked at the hospital. Staff told us the hospital held revalidation workshops for staff and provided reflection templates to complete. Staff who had completed revalidation would help others.
- The hospital reviewed consultant applications for practising privileges and where the Hospital Director had granted or declined practising privileges the Medical Advisory Committee (MAC) endorsed these. This involved checking their suitability to work at the hospital, registration with the GMC, checks on their qualifications, references, immunisations and indemnity insurance. The hospital only granted practising privileges for procedures or techniques that were part of the consultant's normal NHS practice. The hospital would only consider making an exception to this rule if a consultant provided evidence of adequate training, competency and activity.
- Hospital data showed one percent of all consultants with practising privileges, had not treated patients at the hospital between July 2015 and June 2016. We saw from the MAC minutes (dated October 2016) that the hospital wrote to consultants who had not treated patients at the hospital for 12 months to inform them of the possible removal of their practicing privileges. The MAC removed practising privileges if the consultants did not respond. This helped ensure that only consultants who had up-to-date skills and competencies worked at the hospital.
- The hospital's compliance report (dated 13 September 2016) showed 100% of consultants had supplied evidence of their medical indemnity insurance and 100% of consultants had provided evidence of a Disclosure and Barring Service (DBS) check. As part of maintaining their practising privileges, the hospital expected consultants to meet their continuing medical education requirements for their relevant Royal College, have yearly practice appraisals and have revalidation by GMC every five years. This gave the hospital assurances consultants were competent to perform their role.
- Catering staff told us they completed food hygiene training yearly. This ensured all catering staff were up to date with best practice and handled food safely.
- Staff told us patients rarely required blood or blood product transfusions however staff received face-to-face training on induction then complete mandatory training online very two years. All clinical staff completed 'safe transfusion of blood and blood components' competencies yearly and staff deemed competent signed an authorised signature sheet which pathology stored. Agency staff could not collect or administer blood transfusion. We saw evidence of completed competencies in staff folders.
- New employees received both corporate and local inductions. We reviewed nine agency staff records in theatres and found four incomplete induction checklists. Areas not covered included explanation of Spire policies, curriculum vitae check, awareness of "escalating concerns over deteriorating patient" procedure and awareness of NEWs chart and scoring. This suggested inconsistent practice of agency staff induction, which is not in accordance with Spire Healthcare induction policy. In addition, it meant the hospital might not have had assurances of staff competencies in these specific areas.

- We reviewed documents sent to the hospital by an external first assistant. This included certificate of GMC registration, photocopy of passport, blood results and immunisations. However, the hospital received the documents less than 24 hours before the first assistant worked. This meant there was little time for management to review the documents. The hospital had acknowledged this in the risk register but it lacked details of mitigating this risk.

Multidisciplinary working

- Staff of all disciplines, for example consultants, nursing and physiotherapists, worked alongside each other throughout the hospital. Nursing staff told us they felt confident to ask for assistance from the RMO.
- Physiotherapists pre-assessed patients undergoing back or joint replacement surgery prior to treatment. The physiotherapist discussed the surgery and its effects on mobility with the patient. This ensured patients understood the impact the surgery would have on their lives.
- Physiotherapists reviewed patients on the ward daily. We saw good documentation by physiotherapists following the assessment of patients with reduced mobility post theatre.
- Throughout our inspection, we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals during the safety huddles. We saw effective arrangements were in place for collaborative working between consultants, nursing and operating department practitioners. For example, recovery staff called the ward before transferring post-surgical patients and handed over to the ward nurse in the patient's bedroom. We saw evidence of multidisciplinary working in the six patient records we reviewed. Staff described the multidisciplinary team as being supportive of each other for example a physiotherapist may help a nurse to make a bed. Staff felt consultants were approachable and friendly, and consultants felt nurses were caring.
- The preoperative assessment nurses liaised with anaesthetists and surgeons to coordinate preoperative investigations and discussed investigation results.
- Staff sent discharge letters electronically to the patient's GP on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided. This allowed continuity of care in the patient's community.
- Theatres held a team brief before each operating list started. These were brief face-to-face meetings with staff involved in the operating list. Staff discussed any concerns about safety and individual patient needs. Staff documented this discussion and completed records were stored in the theatre office.
- Consultants, pharmacists and nurses completed electronic patient discharge letters. The hospital sent discharge letters electronically to GPs. Staff printed and gave a copy to the patient and one copy stayed in the patient's medical records. This ensured continuity of care for the patient once discharged.
- We reviewed discharge arrangements and saw staff discussed this with patients as soon as possible. We saw five fully completed discharge letters, which included admission details, clinical assessment and medication on discharge.

Seven-day services

- The “Spire Consultants Handbook” (dated June 2014) stated named consultants must take full responsibility for their patients at all times. It required the consultants to be available by telephone, and in person if required, 24 hours a day, whenever they had a patient in the hospital. This ensured inpatients recovering from surgery over the weekend had 24-hour access to consultant input if needed. If a consultant was not available, the handbook required them to arrange for another consultant to provide cover.
- The hospital had on-call rotas for clinical and non-clinical staff. Anaesthetists provided on-call cover 24 hours a day, seven days a week. Surgeons provided cover 24 hours a day, seven days a week whenever they had a patient under their care in the hospital.
- Physiotherapy and imaging services were both open six days a week. An on-call system was in operation 24 hours, seven days a week for critical imaging. This allowed staff to access diagnostic services in a timely way to support clinical decision making and meant patients had weekend access to therapies.

- The hospital had an on-site pathology laboratory, which provided services to other Spire hospitals and GP surgeries. An on-call system was in operation 24 hours; seven days a week to ensure staff received urgent patient results immediately.
- The hospital pharmacy team provided cover Monday to Friday from 8.30am to 6pm and Saturdays 9am to 12pm. The local NHS Trust provided an on-call telephone service for advice through a service level agreement. Outside of these hours, the pharmacist told us there was a procedure for the RMO and senior registered nurse on duty to obtain access to medicines. We saw a copy of the corporate “Management of Medicines in Spire Healthcare” (dated April 2016), which the hospital followed, which reflected this.
- Operating lists in theatres one and two ran Monday to Friday from 8am to 8pm, and Saturday from 8am to 4pm. The theatre manager managed the theatre schedule. There was an on-call theatre rota in place for unplanned readmissions or returns to theatre. We saw theatre on-call rotas with three members of staff, including one with anaesthetic competencies. This was in line with Spire Healthcare corporate policy (clinical policy 59).

Access to information

- There were comprehensive pathway records available to staff that contained all the information staff needed to deliver effective care and treatment. These included risk assessments for venous thromboembolism (VTE), falls and nutrition, and medical notes. We saw completed VTE risk assessments in the five sets of notes we reviewed.
- Patients were required to complete a comprehensive pre-admission medical questionnaire prior to surgery, which included their past medical history and their current medications. Dependent upon a patient’s history, patients may receive either a nurse-led telephone assessment or a face-to-face meeting with pre assessment staff. At this meeting, a number of investigations could take place. Staff might refer patients for an anaesthetic review. This would provide staff with information of the patient’s current health status and help them meet patients’ individual care needs.
- Staff told us they had access to policies and procedures via the intranet and management suite. Staff felt the management team kept them informed through monthly governance newsletters, which updated them about events and incidents at the hospital.
- Only senior staff had access to electronic results of diagnostic imaging reports. This allowed staff to access patients’ results in a timely way to support clinical decision-making.
- For NHS patients, the local NHS hospital transferred the notes to Spire Alexandra. The hospital held the NHS notes on site while the patient was under the care of Spire Alexandra. After discharge, Spire Alexandra transferred the NHS notes back to the local NHS hospital. This allowed staff access to all relevant medical information and assisted in continuity of care.
- Discharge planning was discussed pre operatively to ensure appropriate post-operative caring arrangements were in place. We saw examples of written information that staff gave patients to take home such as “Patient information: caring for surgical wounds” and “Information leaflet for pain control”.
- Staff sent patients detailed information about the surgery with the admission letter, which included admission date and time, payment details and pre-operative instructions such as fasting times. We saw examples of this information and it was in clear, simple language.
- Administrative staff sent admission packs to pre-operative patients before surgery and this outlined details of the hospital and aspects of their care. This meant that patients were informed about the hospital facilities and their treatment before arriving at the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw corporate Spire Healthcare policies on “Deprivation of Liberty Safeguards” (dated April 2016), and “Consent to Investigation or Treatment” Policy (dated January 2016). Although, staff had little experience in the mental capacity act MCA), staff we spoke to knew how to access relevant information and

policies. Staff completed an online MCA and Deprivation of Liberty Safeguards (DoLs) mandatory training package. The hospital required relevant staff completed the training once.

- We reviewed five consent forms and all showed patients signed their consent in advance and confirmed their consent on the day of surgery. This practice was in line with the General Medical Council guidance for consent and meant patients had sufficient time and information to make an informed decision about surgery. The consent forms we reviewed showed consultants discussed the risks and proposed surgery in line with GMC guidance.
- Staff told us if there were concerns over a patient's capacity to consent, they would seek further advice and assistance from their line manager or Matron. A manager told us a patient lacked capacity and had a power of attorney who signed the consent form on the patient's behalf. This is in accordance with the Department of Health's Guide to Consent for Examination or Treatment.

Are surgery services caring?

We rated caring as good:

Compassionate care

- The hospital actively encouraged inpatients to complete a Patient Satisfaction Survey prior to discharge. Hospital data from October 2016 showed 100% of patients were likely to recommend the hospital to friend and family. Patients scored the hospital 97% for the quality of the service.
- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. This was in accordance with NICE quality standard QS15: Patient experience in adult NHS services.
- We spoke with six surgical patients on the ward. All patients we spoke with said the care they received was of a very good standard. One patient told us "the whole service was outstanding. I've attended the hospital many times and the standard is always the same". Another patient said, "The consultant is very good- he came in on Sunday to see me".
- We observed many positive interactions between staff and patients during our inspection. We saw staff approach patients rather than waiting for requests for assistance. A patient told us, "The nurses are lovely. They always introduced themselves and explain what's happening next".
- Patients we spoke with were very positive about the way staff treated them. Patients told us staff were "very attentive", "friendly", "caring" and "staff made me feel at ease".
- Nursing handovers took place in a private room and the whiteboard, displaying patient information such as name, was in the ward office. This maintained patient confidentiality.
- We saw staff treat patients as individuals and staff spoke with patients in a kind and sensitive manner. For example, we heard nurses ask if the patient wanted their bedroom door closed or open. We observed physiotherapists supporting a patient to walk along the corridor and provided verbal encouragement and positive feedback.
- We saw that chaperones were available. The hospital followed the corporate "Chaperones Guidelines" (dated February 2013). This document outlined the roles and responsibilities for chaperoning, including training, and documentation.
- We saw posters on display in the main corridor of the ward informing patients that chaperones were available. Staff gave patients the opportunity to accept or decline a chaperone during their stay.
- The hospital's patient satisfaction survey for 2015 indicated that 100% of patients felt they were treated with respect and dignity while in hospital.
- Patients and their relatives knew the name of the consultant managing their care and knew how to contact them. This is in accordance with NICE quality standard QS15: Patient experience in adult NHS services.

- We received 19 comment cards from patients who have recently had surgery at the hospital. All were very positive about the care and treatment they received. Comments included, "I have had an exceptionally good experience here", "I was treated with the utmost respect and dignity", "I felt like I was in safe hands", and "All [my] needs [were] responded to".
- Hospital data showed 97.2% of staff completed on-line mandatory training called "compassion in practice". This meant staff had training to help them deliver compassionate care.
- Theatre staff, throughout the patient's journey, considered their dignity and privacy. We saw staff covered patients throughout transfer from the ward areas to theatres. Patients were only uncovered once in the operating theatre.
- The recovery nurses kept patients covered and spoke to patient with kindness and respect following their procedure. We observed recovery staff supporting and comforting patients showing symptoms of post anaesthetic agitation within recovery.
- Patients told us staff were "caring", "listened to my concerns" and "the hospital worked as a team".
- The hospital scored 84% in the PLACE audit 2016 for privacy, dignity and wellbeing, which was slightly better than the England average of 83% for other independent hospitals.
- The hospital actively encouraged patients to provide feedback about their experience with a patient satisfaction questionnaire. NHS patients also completed the NHS Friends and Family Test. Between January and June 2016, 98.8% of patients were extremely likely or likely to recommend the hospital to family and friends. This was similar to the England average for NHS patients. However, the hospital's response rate was below the England average for the same reporting period.
- In the patient satisfaction survey 2015, 99.6% of patients rated their care as good, very good or excellent. Spire Alexandra ranked third compared to the other Spire hospitals in the patient satisfaction survey.
- During our inspection, we saw five thank you cards to the staff from patients, expressing their gratitude for "making me feel so relaxed before and after my operation" and thanking "all the receptionists who were always very pleasant".
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction with the care they received. The test data for all patients between January 2016 and June 2016 showed the hospital had consistently high scores (99% or above). This showed that most patients were positive about recommending the hospital to their friends and family. The response rates for this test varied between 13% and 44%. The hospital was worse than the average England response rates for NHS patients of appropriately 40%, except for January and February 2016.

Understanding and involvement of patients and those close to them

- We saw five patient records and saw they included pre admission and pre-operative assessments that took into account individual patients' preferences for example dietary requirements.
- We saw staff introduced themselves to patients, explained their role and the examination that was about to be performed. All inpatients had a named nurse. This ensured continuity of care.
- We saw a variety of literature and health education leaflets produced by Spire Healthcare displayed on the entrance to the ward. We also saw a range of patient information available to help patients understand their medicines in pharmacy, and pharmacists provided leaflets in larger print for patients with visual impairment.
- All patients we spoke with told us staff discussed their care in detail with them. Patients told us they were given time and were able to ask questions, and felt included in the decisions that were made about their care. One patient told usStaff listened to my concerns and acted upon them"
- Call bells were accessible for patients on the ward to enable them to call for assistance if required. We spoke with six patients who told us, nursing staff answered the call bells promptly. We also saw staff answer call bells promptly during our visit.

- Staff told us about a patient who had a needle phobia. Staff applied numbing cream and administered the patient pain relief prior to cannulation. This eased the patient's anxiety.
- The ward displayed the names and photographs of the clinical and non-clinical team on noticeboards in the corridor. This helped patients and visitors identify key staff encountered during their visit.
- We saw staff explaining patient's treatment and care with them on discharge. For example we listened whilst one pharmacist explained to a patient what medications they were taking home, what the medications were for, how to take them and how much to take. We then listened whilst one nurse explained to the same patient the dates of the follow up appointments and answered the patient's questions. The nurse gave the patient a copy of the discharge letter, a wound care leaflet, a copy of consent form and an information leaflet about deep vein thrombosis.
- The hospital told us it undertook post discharge courtesy calls. The nurse enquired about the patient's wellbeing. They did this for all patients nursed as an inpatient for 48 hours or more.

Emotional support

- The hospital had a service level agreement with the local NHS Trust to provide cancer nurse specialists. Staff told us that if a patient with cancer was going to receive bad news from a consultant, the consultant arranged for the cancer nurse specialist to attend to provide additional support.
- We saw a list displayed in the main ward corridor of contact details for people from different religious groups in the local area. Religions included Hindu, Roman Catholic and Muslim.
- Clinical and non-clinical staff checked on patients' well-being regularly and spent time with patients to discuss concerns and provide support and reassurance prior to their procedure. Staff told us about an anxious patient who contacted the hospital with their concerns. The hospital arranged for the patient to visit the ward and meet the staff before their day of surgery to ease their anxiety.
- Staff we spoke with told us they were able to access counselling services which provided confidential emotional support if required.
- The hospital offered long visiting times for all patients from 8am to 9.00pm. This allowed relatives to be involved in the patient's care and provide emotional support during their recovery from surgery.

Are surgery services responsive?

Good

We rated responsive as good:

Service planning and delivery to meet the needs of local people

- The hospital, established in 1984, was under the ownership of a different provider as a purpose built private hospital. In 2007, the hospital changed ownership. Whilst the focus had remained on the core of private patient business, the hospital treated NHS patients through local contracts with NHS trusts and commissioners in Kent. This allowed local people to receive NHS-funded surgery at the hospital.There were 3,622 overnight and day-case patients admitted to the hospital between July 2015 and June 2016. Thirty-eight percent of these were NHS funded.
- All admissions for planned surgery were elective procedures, which included private and NHS patients. Due to the surgery being elective at the hospital, service planning was straightforward as the workload was mostly predictable.
- Theatre managers told us they scheduled high risk patients such as diabetic patients, at the beginning of the theatre lists in case they developed complications during their procedure.
- The hospital offered free of charge parking for its patients. The hospital acknowledged limited patient parking spaces at busy times and had a staff parking policy in place. This ensured prioritised parking for patients. There was disabled parking access and a drop off point near the hospital entrance for patients with limited mobility.

Good

Surgery

- GPs referred patients to the hospital via the "choose and book" system, or the local NHS Trust referred patients directly to the hospital.
- The pre assessment nurse called or met patients before their operation date. At this appointment, staff and patients discussed any issues concerning discharge planning or other individual needs. Any potential problems were escalated to the ward prior to the patient's admission.
- The ward offered patients a variety of appointment dates and times. We observed ward staff rescheduling a patient's follow up outpatient appointment.
- Hospital data between July and September 2016 showed 45% of day case patients were discharged within six hours of admission. Since the inspection the provider has removed this target from their clinical score card because of significant variations across the Spire group due to geographical location and facilities on site at each hospital
- Signage around the hospital was clear for visitors; however, we found a lack of signage in theatres. For example, theatre one, theatre two and the theatre sluice did not have signage. This may have been disorienting to new staff members or agency staff.

Access and flow

- There were 3,625 visits to the operating theatre between July 2015 and June 2016. Hospital data showed the service cancelled 16 operations on the day of surgery, for a non-clinical reason within the same period. This showed the hospital cancelled 0.4% of operations during the reporting period. Non-clinical reasons for cancellation included emergencies in theatre and complex operations that took longer to perform than anticipated, causing operating lists to overrun. The hospital offered 94% of these patients another appointment within 28 days of their cancelled appointment. This is in line with the NHS Constitution pledge.
- Theatre staff had a daily morning brief, which ensured all staff had up-to-date information about scheduling issues or cancellations. During our inspection, theatre lists generally ran on time. Patients and staff we spoke with did not have any concerns in relation to admission, waiting times or discharge arrangements.
- We saw evidence of rotas covering nights and weekends outside of normal theatre operating hours.Consultants also had on-call arrangements when they had a patient in the hospital under their care. The consultant had to be able to review the patient within 45 minutes of the patient deteriorating. Staff told us they did not have any difficulties contacting consultants. This meant the hospital ensured patients had speedy access to services.
- We saw nurses gave patients a direct telephone number to the ward on discharge. Patients could call this number and speak to a nurse, if they had any concerns, and the service was available 24 hours per day, seven days a week.
- Hospital data showed between July and September 2016, the ward discharged 49% of patients before 11am. This was slightly worse than the Spire Healthcare corporate target of 55%. However data for July 2015 to June 2016 show that the ward discharged 60% of patients before 11am.

Meeting people's individual needs

- Staff assessed patients individual needs at the pre-assessment clinic including any cultural, linguistic, mental or physical needs.
- The Pre-Admission Medical Questionnaire (PAMQ) highlighted patients with special dietary requirements including food allergies. Catering staff catered to patients' individual needs throughout their stay.
- Patient menus offered a good variety of choices, and included healthier and vegetarian options. We saw a note on the menu, which stated, "Patients should check ingredients with a member of staff if they have any food allergies". This ensured the hospital catered for all dietary needs. The hospital provided a dietitian service upon request.
- All staff we spoke to knew about the translation service and knew how to access it. Information gathered at the referral stage identified patients who would need the assistance of the translator service. Administrative staff booked either telephone or face-to-face translator service for the patient's pre-assessment appointment. Ward staff told us they arranged face-to-face translators for the day of surgery.

- Staff told us they attended external face-to-face dementia training and completed online mandatory dementia training yearly. The completion rates were unavailable at the time of our inspection.
- Administrative staff ensured patients living with dementia had a longer clinical appointment. Staff told us if they identified a patient as having dementia at pre-assessment, the pre-assessment nurses completed a "This Is Me" passport. This is a simple and practical tool for people living with dementia, and their carers, to use. It told staff about their needs, preferences, likes, dislikes and interests. However, we were unable to review completed "This is me" passports as there were no patients living with dementia in the hospital at the time of our visit. Staff told us a patient living with dementia was recently admitted for surgery. The ward allocated the patient a named healthcare assistant throughout their stay and allocated a room opposite the nursing station. This meant the patient received one to one care which met their individual needs.
- The Patient Led Assessment of the Care Environment (PLACE) results between February and June 2016 showed the hospital scored 91% for dementia. This was better than the England average of 80% for other independent hospitals. The PLACE audit dementia measure focused on key issues proven helpful to patients living with dementia. These included, flooring, decoration (for example contrasting colours on walls), and signage, along with seating and availability of handrails. However, at the time of our inspection, there were no dedicated rooms specifically equipped for patients living with dementia.
- The dementia champion was a senior ward administrator. This meant ward staff had direct access to advice on dementia. The hospital was involved with two local Dementia Alliance Groups whose aim is to connect, share best practice and take action on dementia.
- The dementia lead and dementia champion told us the hospital used a butterfly scheme, which discreetly identified patients living with dementia. Staff placed butterfly sticker's on patients' notes and next to the patient's name on the whiteboard. This ensured all clinical staff knew the patent required additional support and had individual needs during their stay. Dementia friendly menus were available. The butterfly menu is in pictorial format and description in bold, making it easier for patients living with dementia to make food choices.
- The hospital acknowledged the National Dementia Action Week by inviting a speaker to talk to staff. The speaker also walked around the hospital and provided advice on how to improve the environment and facilities for patients living with dementia. They suggested hospital painted the toilet doors are blue for male and pink for female to make it easier to distinguish. The hospital instead made all public toilets unisex to eliminate any cause for confusion. The hospital also improved signage at reception, mad a large print menu available and provided training for hostesses to assist with making meal choices for patients living with Dementia as a result of this visit.
- One member of theatre staff explained the steps taken to meet the needs of a patient with learning disabilities. The hospital allocated the patient a morning theatre slot to lessen the patient's waiting time and anxiety. The member of theatre staff spent time with the patient to answer any questions and explain the procedure. Theatre staff invited the patient's relative to stay with the patient in the anaesthetic room before surgery and to wait for the patient in recovery after surgery. This allowed the patient to see their relative as soon as they woke up following general anaesthetic.
- Staff told us the hospital used a rainbow scheme, which discreetly identified patients with learning disabilities. Staff placed rainbow stickers on patient's notes and next to the patient's name on the whiteboard in the nurses' office. This ensured all clinical staff knew the patent required additional support and had individual needs during their stay.
- The PLACE results between February and June 2016 showed 92% compliance with providing suitable services for people with a disability. This was better than the England average of 81% for other independent hospitals.
- The hospital provided patient leaflets, which explained the payment options, procedure, and gave advice of who to contact if there were any queries. We saw documentation of quotes and costs of procedures in patient medical records. The hospital website also

clearly described the different payment options available. This meant patients understood the cost they would incur having treatment at the hospital and could make an informed decision about their care.

- The hospital had a service level agreement for specialists for specific patient groups, for example stoma nurses, cancer services team and dieticians. This meant the hospital could meet the complex needs of patients.
- Pharmacy staff told us they provided leaflets in large print upon request. They also provided bold and enlarged labelling on medication boxes for patients with visual impairment. However, there were no resources for people with learning disabilities, for example leaflets in easy read formats or communication tools.
- We saw a hoist on the ward and three sizes of slings for patients who required assistance to transfer. There were raised toilet seats for patients who had back, hip or knee surgery. Staff told us patients could take these home to use while they recovered from surgery.
- Staff told us they called medical stores to obtain air mattresses for any patient at high risk of developing pressure ulcers. They said they experienced no issues with supply.
- The hospital displayed various patient information leaflets at the ward entrance. The leaflets were all in English. However, staff told us these were available in other languages and in braille.
- Staff told us patients undergoing endoscopy had to walk past the hospital offices from the day surgery ward in their hospital gowns to get to the endoscopy suite. This did not protect the patients' dignity.
- We saw some patient ensuite bathrooms had a level access shower with no step to facilitate patients with limited mobility. Other bedrooms had a shower over the bath. We saw baths were on the hospitals risk register and there were refurbishment plans in place to remove the baths.

Learning from complaints and concerns

- The hospital received 32 complaints between July 2015 and June 2016. No patients escalated their complaints for independent review outside the hospital. The Care Quality Commission (CQC) had assessed the level of complaints to be similar to other independent acute hospitals.
- Staff we spoke to were aware of the corporate 'Complaints Policy' (dated January 2014). We saw "Please talk to us" complaints leaflets provided patients with information about the hospital's complaints processes. . It explained the three-stage process used for complaints handling. The provider's website had a section detailing how to make a complaint. The patient leaflets advised patients the process of escalating their complaint in the event of an unsatisfactory response from the hospital.
- Staff informed us the nurse in charge would speak to anyone raising a verbal complaint at the time they raised it. The aim was to try to resolve the issue at the earliest opportunity. If the patient was not satisfied, staff escalated to the ward manager or matron.
- The Clinical Governance Committee (CGC) reviewed all complaints and discussed possible trends. If the complaint involved a consultant, staff raised this with the chair of the Medical Advisory Committee (MAC) to take forwards.
- We saw staff discussed complaints at the senior management team, quarterly clinical effectiveness and monthly departmental meetings. This meant that the hospital shared learning from complaints.
- The hospital shared the summary of complaints in the "Service quality and safety information for staff" monthly bulletin. This meant staff from all departments was informed about complaints at the hospital and knew what aspects of care required improvement.
- Staff told us about recent complaints and described changes in practice for example, to discuss post-operative instructions with every consultant before patient discharge. This demonstrated the service learned from complaints.
- We saw three hospital response letters to complaints involving surgical services. We saw the hospital responded to complaints within the target timeframes and fully investigated complaints. The hospital was

open and transparent about their investigations and provided an apology to complainants when appropriate. This was in line with the corporate Spire Healthcare complaints policy.

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement:

Vision and strategy

- The hospital shared Spire Healthcare's corporate vision "To be recognised as a world class healthcare business". Its mission was to "bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care". We saw the vision displayed on notice boards and staff spoke about the Spire Healthcare values, which were, based around six core areas. These were "caring is our passion", "succeeding together", "driving excellence", "doing the right thing", "delivering on our promises" and "keeping it simple". Theatre management demonstrated 'doing the right thing' by being open and honest to patients when their surgery is cancelled.
- We saw copies of staff appraisals, which the hospital linked to its values and the Spire Healthcare corporate mission.
- The hospital embedded the Department of Health's Compassion in Practice, which involved the six C's of nursing. These were competence, caring, compassion, commitment, communication, and courage. Our interviews with patients and staff outlined that staff were working in a way that showed a commitment to the hospitals values and the six C's of nursing.
- The hospital held staff forums, which gave staff the opportunity to network, raise issues, learn about the hospitals strategy and its progress.
- The hospital had plans to gain Joint Advisory Group (JAG) accreditation for endoscopy. The endoscopy lead was fully aware of the stages of this process and was committed to gaining JAG accreditation. However, we were told there was no written strategy document for this.

Governance, risk management and quality measurement

- The hospital had a risk register with 168 risks identified. The risk register allowed the hospital to record any risks to the service with actions and plans to mitigate these risks. The Spire Healthcare corporate head office initially compiled the risk register. Staff told us there was not a local risk register for each department but the hospital risk register could be filtered by department to enable heads of department worked with the governance lead to update and maintain their own risks.The risk register we reviewed did not reflect all the risks that staff told us were present in the surgical services.
- However, the risk register we reviewed (dated September 2016) did not appear up to date as it contained information about services the hospital no longer provided such as chemotherapy. This meant there might not have been regular review or mitigation of all relevant risks to the service.
- Between July 2015 and June 2016, the hospital granted 169 doctors practising privileges. The term "practising privileges" refers to medical practitioners granted the right to practise in a hospital. Of these doctors only 1% of consultants with practising privileges had not carried out any episode of care between July 2015 and June 2016.
- The hospital had an audit timetable, which showed a rolling programme of national, corporate and local audits. These included medication chart audit and hand hygiene. The hospital showed us two audit timetables for 2016; on review, both timetables had different audits and timeframes. It was unclear to us which timetable the hospital was following.
- We saw patient leaflets and advice regarding post operative care varied. This reflected the practice and expertise of individual consultants. This posed a risk that ward staff would advise patients incorrectly as there were different post operative pathways to follow depending on which consultant was responsible for the patient's care.
- We also saw the contents of patient leaflets for postoperative care were not standardised. for example, one leaflet contained advice about pain relief and to advised patients not to do any heavy lifting. The other leaflet did not make any reference to this.

- Staff discussed safeguarding but it was not a standard agenda item in two of the four sets of clinical governance committee minutes the hospital provided. We saw examples of discussions such as the commencement of the adult and children safeguarding lead roles. This meant the hospital missed learning opportunities.
- The hospital had a clinical governance structure in place with clear accountability and information flow pathways. The Medical Advisory Committee (MAC) and Senior Management Team (SMT) fed directly into the Hospital Director. The MAC ensures clinical services; procedures or interventions are provided by competent medical practitioners. The next tier down was the Clinical Governance Committee (CGC). The CGC provides the hospital director with assurances around quality and safety. We saw the governance structure displayed on the governance noticeboards. This meant staff had awareness of the accountability pathways. The hospital followed the corporate Spire Healthcare clinical governance and quality assurance policy (dated October 2014).
- The hospital had six committees, which included the MAC, Clinical Governance Committee, health and safety committee, hospital transfusion committee, paediatric committee and, medicine management and pain committee. These committees met regularly and fed back to the hospital director.
- The MAC met quarterly and we saw the minutes of the last five meetings. The committee discussed regulatory compliance such as medical patient safety alerts, practising privileges, quality assurance such as incidents and complaints, and proposed new clinical services or techniques.
- The MAC reviewed practising privileges every two years. This included a review of annual appraisal, incidents, revalidation, compliance with the consultant's handbook and agreed scope for practice. We saw the last five minutes of the MAC, which showed the committee reviewed consultants practising privileges in line with policy. Hospital data showed six consultants had failed to supply documentation and five consultants voluntarily retired or resigned. This meant 11 consultants had had their practising privileges removed between July 2015 and June 2016. This process ensured the hospital had experienced consultants that were to care for patients.
- The senior management team (SMT) met monthly and we saw the minutes of the last six meetings held before our visit. The team discussed clinical matters including incidents, updates from other committees and meetings, regulatory updates, recruitment and complaints. This demonstrated quality had sufficient coverage at SMT meetings.
- The Clinical Governance Committee met quarterly and we saw the minutes of the last five meetings. The committee discussed clinical reliability including infection control, patient safety, governance including audit results and practising privileges compliance, staff and patient empowerment. It was the responsibility of the quality compliance manager to update the consultant compliance database. The quality compliance manager shared a snapshot of consultant compliance rates at these meetings.
- The hospital held meetings between the heads of department and the hospital director regularly. This allowed the hospital director to monitor each service and plan ahead. It enabled the heads of departments to escalate issues and review current practice.
- The hospital introduced weekly clinical governance briefings in 2016. This enabled the senior clinical team, which included the theatre manager and the clinical nurse manager, to discuss the incidents reported in the previous week and review the progress of any on-going action plans. This is in line with the local adverse/ incident reporting process policy (dated January 2016).
- The hospital held team meetings in each department including theatres and the wards. Staff used the meetings for two-way information sharing. We looked at the minutes of the last three ward meeting which demonstrated managers shared information and learning from clinical governance meetings with staff.
- The hospital had a policy for the investigation of serious adverse events. Staff completed detailed root cause analysis (RCAs) and subsequent action plans. Ward

managers and nurse leads told us that they had attended root cause analysis (RCA) and risk training. We saw copies of RCA investigations, which showed the relevant staff carried out RCAs appropriately.

- Theatre staff told us, they feel supported by senior management. For example, they escalated concerns regarding low theatre staffing levels and senior management supported their decision to cancel the theatre lists and reschedule the patients.

Leadership of the service

- The hospital employed a new hospital director in 2016. Staff said they felt the hospital director was, "a breath of fresh air" and "was fully a part of the team".
- The overall lead for the surgical service was the matron, who was also the head of clinical services. The clinical nurse manager led the surgical inpatient wards and the theatre manager led the theatre team. Both managers reported to the matron.
- Staff said all senior managers were available, highly visible and approachable. We found there was excellent staff morale and all staff felt supported at ward level. Staff told us the senior management team visited departments twice daily to ensure everything was going well and to help with any potential problems. During our inspection, we saw the matron attending to patients and helping a nurse to change bed linen. Ward staff told us senior management provided regular clinical support if required.
- The hospital recognised the learning needs of staff and we saw arrangements in place for a manager to have additional support in their leadership role and additional responsibilities. However, we saw supernumerary staff worked to cover staff vacancies or staff sickness meaning they sometimes had less time than they needed for learning and development. However we were told that supernumerary staff who had stepped in to fill shifts were given protected time on the next month's rota to ensure they had time for learning and development.
- The hospital told us their biggest challenge was the consistency of compliance within the surgical service. Clinical educators and external managers spent time auditing compliance to drive improvements in standards. However, we saw audits relating to the surgical service showed consistent non-compliance to processes, which suggested management had not effectively addressed the issues.
- Staff did not always have the skillset and training to enable them to fulfil their role and responsibilities and to provide specialist advice if required. For example, one member of staff with gynaecology responsibilities had an insufficient awareness of female genital mutilation. This also meant staff might not identify vulnerable patients and provide them with the correct care.
- We saw the Senior Management meeting minutes (dated November 2016) which showed a patient graded an ASA score of three at pre-assessment and increased to four following anaesthetic underwent surgery at the hospital. This is not in accordance with the hospital's admission criteria. The hospital missed opportunities at pre assessment and on admission to prevent this surgery from going ahead.
- Although the hospital promoted internal staff and encouraged staff to undertake more responsibilities, some staff told us they did not receive a handover from their predecessor. This meant staff had to adapt quickly to their role. However, the hospital arranged for these members of staff to have experienced mentors to provide support to embed expertise. During our inspection, we saw a member of senior management within the surgical service providing additional support to staff.

Culture of service

- Junior staff told us that they would feel confident in approaching senior staff to challenge practice, for example, if they were not bare below the elbows. They told us that senior staff actively encouraged them to discuss issues with the member of staff if they saw any poor practice. However, one member of staff told us about a patient undergoing surgery despite a positive infection status because 'the consultant insisted'. Another example provided, involved challenging a consultant about prescribing antibiotics for when a patient has their catheter removed. Staff told us, the consultant was displeased and this resulted patients not

having catheters. Patients returned to the ward having been incontinent of urine. This showed despite junior staff feeling able to challenge senior members of staff, the challenge was not always received well.

- The hospital appointed a new governance lead in August 2016 to focus fully on the governance of the hospital. Staff told us they saw a change in the culture of incident reporting following the governance lead's appointment. One staff member said, "It has become everyone's responsibility, where it used to be mainly managers".
- All staff we spoke with reported their relationship with their immediate managers was positive. Staff felt they could be open with colleagues and managers and felt they could raise concerns. Staff said managers always listened to them and members of the senior management team had adopted an "open door" policy.
- At ward and theatre levels, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of strong collaborative team working on the wards between staff of different disciplines and grades such as physiotherapists, nurses and healthcare assistants.
- Staff told us the best thing about working at the hospital was the teamwork. Staff felt "very proud" to work for the hospital. There is good team spirit and atmosphere, and one member of staff told us, "It's like coming to work and being part of a big family".
- The hospital accommodated the individual needs of staff where possible. For example, a member of staff spoke with their line manager when they had difficulties at home looking after a sick relative. The hospital allowed the staff member to reduce their working hours temporarily to look after the sick relative.
- One member of staff told us, "There was a real appetite for change but the pace of this change was manageable". Staff told since the new Hospital Director was employed, they had seen improvements in interdepartmental communication. Staff felt the staff forums were useful as they learnt about other departments.
- Staff all told us that they felt very valued by the organisation and their colleagues. The hospital highlighted staff achievements in the monthly staff newsletter. Staff nominated each other monthly for the "Spire inspiring people" award. Patients could mention outstanding members of staff in the patient comment cards and managers emailed staff thanking them for their hard work. Staff we spoke with appreciated that management praised them for their work.

Public and staff engagement

- The hospital planned to hold patient forums to increase patient engagement. We saw posters in the hospital advertising the patient forums.
- The hospital encouraged staff including consultants to provide feedback with a staff satisfaction survey. The staff survey 2015, showed improvement in some areas compared to the previous year's survey. The hospital achieved 89% staff response rate. Spire Alexandra ranked third compared to the other Spire Healthcare hospitals in the staff satisfaction survey results.
- The hospital had started regular staff forums, which provided staff the opportunity to interact with one another, discuss any issues or concerns and share ideas and learning. We saw this advertised in both staff and consultant newsletters, which the hospital produced to inform and engage staff.
- With the appointment of a new hospital director in 2016, the hospital engaged with staff through "progress" meetings with all the departments. These meetings gave staff a chance to participate and be involved in re-shaping the structure and methods to achieve the hospital goals. We saw the minutes from 26 internal meetings and saw staff attended meetings consistently. This suggested good staff engagement and a commitment from staff and the SMT to drive improvement.
- The hospital also acted on and made improvements from patient feedback. We saw a "you said, we did" board in the corridor of the ward, displaying some of the improvements the service made. For example, patients said the rooms looked tired and dated, so the hospital planned an extensive refurbishment programme. Staff told us the hospital removed the carpet in patient bedrooms on Copperfield ward and there were plans to remove the carpet in the remaining areas.

Innovation, improvement and sustainability

Good

Surgery

- The hospital was a National “VTE Exemplar Centre”. To gain this status, the hospital had to show they delivered and shared best practice. We saw the hospital produced patient information leaflets called “Help reduce the risk of VTE” and “Why wear compression stockings?” Staff gave the leaflets to patients at discharge. The hospital held regular and extraordinary VTE meetings to discuss recent VTE cases and compliance with risk assessment. Staff at these meetings decided to implement an alert card. Staff would attach these to patient records to remind consultants to prescribe anticoagulation medication. We saw the clinical governance meeting minutes dated September 2016, which stated these were to be implemented.
- The hospital had an "Inspiring People" programme. This encouraged staff to identify innovative ideas to enhance services for patients and their colleagues. The hospital gave a monthly award for the best ideas. The scheme also recognised staff that had gone "above and beyond" for a patient, visitor or colleague. The hospital nominated exceptional ideas or staff performance for the Spire Healthcare group national annual awards ceremony.
- The hospital planned to take surgical patients with higher acuity who would require a higher level of nursing care. We saw the hospital had built a two bedded extended recovery unit within Copperfield Ward. The ward had employed two critical care nurses to develop a comprehensive training programme for all staff to complete.
- The hospital used a corporate clinical benchmarking system, which ensured the hospital regularly reviewed its clinical performance and benchmarked this against other hospitals. This helped the service work towards continuous improvement.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- There were no safeguarding concerns reported to CQC in the reporting period July 2015 to June 2016 for this service.
- In the same reporting period, the hospital reported zero never events related to adults or children in this service. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- The hospital used an electronic computer system for reporting incidents. Between July 2015 and June 2016, the hospital reported a total of 518 clinical incidents. Of these, 18% (92) occurred in outpatient and diagnostic imaging services. We reviewed the incident log and did not identify any common themes. Incidents had occurred across different clinical specialities.
- Of the 92 reported incidents, 1.2% (six) related to children. We saw that two of the incidents involved prescribing errors, and that following an investigation the managers fed back to the relevant staff with lessons learned. In all the reported incidents, there was no harm to the child.
- The reported rate of clinical incidents was higher than other independent acute hospitals that we hold this type of data for in the same reporting period. Managers we spoke with attributed this to increased staff awareness, better reporting and the "no blame" culture supported by the hospital governance committee. Staff demonstrated how they would access and use the electronic incident reporting system which showed they were confident in using the system. We saw incidents discussed as a standing agenda item in the minutes of the clinical governance and medical advisory committee (MAC) meetings.
- There were 41 non-clinical incidents reported between July 2015 and June 2016. 20% (eight) occurred in outpatient and diagnostic imaging services. The reported rate of non-clinical incidents was lower than the rate of other independent acute hospitals that we hold this type of data for in the same reporting period.
- Staff told us they were encouraged to report incidents. This enabled them to raise all incidents including near miss events. Any serious adverse events were fully investigated and appropriate actions were taken. Staff we spoke with demonstrated how they reported an incident and that they were confident in using the electronic incident reporting system. We were given an example of a patient who had a serious allergic reaction following administration of a contrast dye used in diagnostic imaging. The patient was transferred as an emergency to the local NHS hospital by ambulance. Staff were able to describe the outcomes of the investigation and recalled the lessons learnt. Staff explained that key learning outcomes from incidents were shared at departmental meetings and information related to this was accessible to all relevant staff from

the hospital intranet. We saw this documented in the staff meeting notes in May, August and November 2016 and in the heads of departments meeting notes dated December 2016.

- There was one incident reported to the Care Quality Commission concerning the Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R) within the reporting period. We saw this incident was fully investigated and appropriate actions were taken. Staff we spoke with were able to recall lessons learnt. We saw that for patients who had undergone computerised tomography (CT) scans and Magnetic resonance imaging (MRI) procedures, the hospital completed an adaptation of the WHO safety questionnaire and verbal safety checks were made by staff prior to their scans. This helped to assure that potential risks were identified and acted upon.
- Duty of Candour (DoC) is a statutory requirement under the Health and Social Care Act (Regulated Activities Regulations) 2014 for healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person. Staff we spoke with understood that the Duty of Candour legislation is about being open and honest. Staff gave an example of a prescribing error. Even though the patient did not experience harm, staff apologised and explained to the patient what went wrong. We saw the hospital training records that indicated DoC was included in mandatory training for all staff. We saw a poster displayed on the staff notice board describing the process to follow should DoC apply.

Cleanliness, infection control and hygiene

- Overall, the outpatient and imaging departments complied with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015). For example, there were no reported cases of MRSA, meticillin sensitive staphylococcus aureus (MSSA), clostridium difficile (C. diff) or escherichia coli (E. coli) in the last year. These rates are all below the rate of other independent acute hospitals we hold this type of data for.
- All areas we visited were tidy, clean and uncluttered with the exception of consulting room 19. We saw around five sets of patient records stored on the floor, an overflowing waste bin, and disposable paper towels on the floor. We raised this with the hospital management at the time of the initial inspection. At our follow up visit room 19 was clean and uncluttered.
- We looked at a cleaning checklist for the period of two months prior to our visit which showed that the consulting rooms were reported to have been cleaned daily including dusting of desks and surfaces, floors and restocking of dispensers. Our findings were consistent with the Patient Led Assessment of the Care Environment (PLACE) audit for 2016, which showed the hospital scored 100% for cleanliness. This was better than the corporate compliance rate of 98.8% and the England national average of 98%.
- Eight of the 11 consulting rooms we saw had fitted carpets. Carpets in clinical areas prevent effective cleaning and removal of body fluid spillages. This was not compliant with the Health Building Note 00-09 (HBN 00-09): Infection control in the built environment (Department of Health, March 2013) which states, “Carpets should not be used in clinical areas”. However, we saw carpets in consulting rooms were visibly clean and free from stains and staff told us clinical procedures were not carried out in the carpeted rooms. We saw records that showed the carpets had been deep cleaned between 13 and 14 December 2016. We also saw that the hospital programme of works included plans for carpet replacement to outpatient consulting room.
- We saw disposable curtains fitted in consultation, physiotherapy and imaging areas. Each had a label showing the date changed was within the last three months. According to HBN 00-09, using disposable curtains that are routinely changed helps to reduce bacterial cross contamination.
- We saw ‘I am clean’ labels on equipment, which indicated the date the equipment had been cleaned. This meant that equipment was cleaned and ready for use.
- HBN 00-09 states, “There needs to be a clear demarcation between clean/unused equipment and soiled/dirty equipment. Clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined”. We saw clean equipment, specifically unopened swab packs and a portable liquid nitrogen cylinder, stored in the outpatient dirty utility

room. We raised this with the outpatient manager at the time of inspection and the items were immediately transferred from the dirty utility room to an appropriate area. We saw this was maintained during our follow up visit.

- Staff completed infection prevention and control (IPC) training as part of their annual mandatory training programme. We saw infection control posters displayed in the department that reminded clinical staff of the importance of not wearing any jewellery or clothing below the elbows to reduce the risk of infection to patients. We observed that all medical and other staff adhered to this practice. This was consistent with the six monthly hospital uniform audits which showed 98% compliance in June 2016.
- We saw staff using personal protective equipment (PPE) such as gloves and disposable aprons in all areas visited. PPE including all sizes of gloves were readily available in each clinical area. We also saw radiation protection equipment such as lead aprons and glasses were available in the imaging department.
- Hand sanitiser was available in each consulting room and all waiting areas, and we saw staff using the product. Hand hygiene compliance was monitored by measuring the consumption of sanitiser every month. During our inspection, the infection control lead nurse told us that the hospital had replaced the hand sanitiser audit with an observational hand hygiene tool adapted from the WHO's "5 Moments for Hand Hygiene". We saw the observational audit report for the hospital in quarter three showed 100% compliance for the outpatient and, imaging departments. We also saw posters displaying the 5 moments for hand hygiene above each hand wash basin in all the consulting rooms. This acted as a reminder for staff the need for hand hygiene.
- Hand washbasins were installed in all clinical areas. These were medium or large integral basins with mixer taps and no plugs. This complied with the Health Building Notes (00-10 (2013): Part C – Sanitary assemblies).
- We saw bins for the disposal of sharp objects were available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. All the bins we saw were closed with temporary lids, clearly marked and placed closed to work areas where medical sharps were used. Staff had completed labels on the bins which ensured traceability of each container. We saw the hospital 2016 sharps audit showed 100% compliance for outpatient, 85% for imaging and 87.5% for physiotherapy departments. We saw this discussed in the December staff meeting minutes and actions such as training and re-auditing were identified to improve compliance for imaging and physiotherapy departments.
- Waste in outpatient and imaging areas was separated in different coloured bins to identify categories of waste. This allowed the hospital to safely handle biological or hazardous waste and was in accordance with HTM 07-01, Control of Substance Hazardous to Health (COSHH) and Health and Safety at Work Regulations.
- We reviewed the outpatient department's toy cleaning checklist for the four months before our inspection. We saw that staff had cleaned toys daily whenever they were used. Toys in the waiting area were visibly clean. This showed staff had cleaned the toys and followed hospital policy.
- An infection control link person was nominated for each area and their activities coordinated through an infection control sub-committee of the Medical Advisory Committee (MAC). We saw examples of completed infection control audits. These audits helped managers and staff to assess the effectiveness of their infection control measures and to identify any areas that might require improvement.

Environment and equipment

- The outpatient and imaging environments we observed supported the safe delivery of diagnosis, treatment and care. For example, consulting rooms were secured, well lit, air-conditioned and equipped with appropriate levels of sterile consumables held in covered trolleys and storage racks.
- There were no consulting rooms specifically designed for children but staff told us that toys would be made available in a consulting room before commencing a children's clinic. At our follow up visit, we were told the hospital had plans to convert two consulting rooms into dedicated consulting rooms for children.

- All rooms were fitted with call bells so emergency assistance could be summoned.
- Outpatient and imaging staff had access to emergency equipment including oxygen and resuscitation items for adults. Staff also had access to paediatric resuscitation items including pulse oximeters and weighing scales. We saw evidence that staff had inspected and checked the defibrillator and suction daily and other equipment on the resuscitation trolley weekly.
- We saw a total of 48 items of equipment and service records and of these, 45 had regular service maintenance, calibration and safety checks. This followed the Medicines and Healthcare products Regulatory Agency (MHRA) Managing Medical Devices April 2015 guidance , which states “ensure that devices are regularly checked for functionality prior to use by the user in line with the manufacturer’s instructions and throughout the expected lifetime of the device”. However, two examination couches and one ultrasound scanner did not have labels to indicate the most recent safety checks or service dates. We raised this with the outpatient manager who immediately arranged for the two examination couches to be safety checked and serviced. The service record for the ultrasound scanner in room 19 of the outpatient department showed the safety check and service was last undertaken in September 2015. At the follow up visit, managers told us that the ultrasound scanner was withdrawn from service.We saw this device correctly labelled and stored in a locked storage area waiting for collection by the manufacturer.
- Staff told us they had access to equipment that helps with lifting patients such as from a wheelchair to an examination couch. This was stored within the physiotherapy department but the equipment was not frequently required in the outpatient department.
- In the imaging department, we saw a number of installed features designed to prevent or minimise accidental exposure to ionising radiation or magnetic fields. Doors were fitted with electronic interlocks that functioned to prevent access when the equipment was operating; emergency stop buttons clearly positioned within the rooms and illuminated warning signs fitted to doorways and linked to the interlock. Key control systemsfitted to the imaging devices helped to prevent uncontrolled or unauthorised use. We saw records that confirmed these protective measures. The facilities were registered with the health and safety executive (HSE) and audited annually by an HSE approved radiation protection adviser (RPA).
- There was prominent signage outside the MRI suite that warned patients with pacemakers or other surgical devices not to enter due to the powerful magnetic field generated. Signs advising women who may be pregnant to inform staff were clearly displayed in the x-ray area, in line with best practice. Pregnancy tests were completed to confirm status for relevant procedures. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.
- Single use items of sterile equipment were readily available and stored appropriately in all areas checked. All items we saw were in date, such as syringes and wound dressings. Correct storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination reduced. We saw examples of items being used once and disposed afterwards.
- Instruments used for patient treatment that required decontamination and sterilisation were processed through the hospital on-site sterile supplies department.

Medicines

- The hospital had an on-site pharmacy. The pharmacy team were readily available to offer support and advice to both staff and patients, maintained adequate stock levels, and dispensed prescriptions in a safe and timely manner.
- Out of hours there was restricted access to the hospital pharmacy. Appropriate security procedures were in place to ensure only approved staff could access medicines, and that the out of hours’ arrangements were clearly communicated to relevant staff.
- Medicines in outpatients and imaging were stored in locked cupboards. Registered health professionals held the keys. This was in line with standards for good medicines management and prevented unauthorised access to medicines. Pharmacy staff described a comprehensive process of receiving Medicines and

Healthcare Regulatory Agency (MHRA) and NHS Patient Safety Alerts and these were actioned and cascaded appropriately. We saw records of where these were discussed at clinical governance meetings.

- We saw systems implemented to check for date-expired medicines or unused contrast medium and to rotate medicines with a shorter expiry date. All the medicines we looked at were within the expiry date.
- In the outpatient department, each consulting room contained a copy of the British National Formulary (BNF) Issue 72, which was the latest edition in print. We also saw two copies of the British National Formulary for children (BNFC) September 2016 to 2017 which were kept in the staff office and were accessible by staff when required. The BNF is updated in book form twice a year and the BNFC annually, and detail all medicines that are generally prescribed in the UK, with information about indications and dosages, contraindications, cautions and side effects. It is considered an essential resource for safe prescribing and the availability of the latest copy indicted that an appropriate level of support was provided to the consultant in clinic.
- Doctors hand-wrote prescriptions on private prescription (SPF100) forms. Each prescription had a serial number on it. A registered nurse issued prescription forms to each doctor on an individual basis at the start of each clinic session.Any unused prescriptions were checked and stored in a locked drawer at the end of clinic. This reduced the chance of prescription forms being lost or diverted.
- We saw that medicines requiring storage in atemperature-controlled environment were held in designated fridges. These were locked andincorporated digital thermometers with a clear display that allowed temperatures to bemonitored. We saw completed fridge temperature checks recorded daily on a standardised form between August and November 2016, and were within range. Staff we spoke withdescribed the process of dealing with out of rangetemperatures and included reporting any issues as an incident onthe electronic reporting system
- Patient group directions (PGDs) provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines, to a predefined group of patients without them having to see a doctor. In outpatient and imaging departments, PGDs were used to direct the supply and administration of medicines such as flu vaccines and contrast dyes. Records we looked at demonstrated that all PGDs were approved and documented in accordance with local and national requirements.
- The hospital used an electronic system for requesting x-ray, MRI or other diagnostic tests. We saw that the system provided for authorisation. This meant that imaging requests made by GPs or other practitioners were only made by approved persons in accordance with the Ionising Radiation (Medical Exposure) Regulations also known as IR(ME)R.
- The imaging service followed a corporate policy designed to detect and prevent contrast-induced nephropathy (CIN), which is kidney injury in susceptible individuals caused by the use of contrast media in imaging. We saw staff used safety questionnaires which enabled the doctors to check for CIN. This followed the Royal College of Radiologists Standards for Intravascular contrast agent administration.

Records

- The hospital provided information that showed 1% of patients were seen in outpatients without all relevant medical records being available in the reporting period. This is better than other independent acute hospitals that we hold this type of data for in the same reporting period. Staff we spoke with confirmed these figures.
- We reviewed five patient records for adults who had minor procedures. In all five sets of records, we saw staff followed specific procedure pathways. All five pathway checklists had legible entries, were signed and dated in line with general medical council (GMC) and nursing and midwifery council (NMC) guidance.
- Four of the five records for adults we saw did not contain evidence of the doctor’s treatment notes. Staff told us that these were sometimes kept by the consultants or their medical secretaries; several medical secretaries were based on-site and several off-site. This meant that some records were not kept on-site and records that were on-site were not complete and contemporaneous. We raised this with the hospital management who took immediate action to request the treatment notes kept off-site. At the follow up visit, we reviewed one outpatient record for an adult who had a

minor procedure. We saw the record was complete with a pathway checklist, and the doctor's treatment notes and consent form were filed. All entries were legible, signed and dated. This was in line with the completion of accurate and contemporaneous medical records which formed part of the practising privileges agreement for all consultants, who were also registered data controllers with the Information Commissioning Office (ICO) as part of this agreement.

- We were unable to review more than one record at the follow up visit to ascertain practice change due to the service not having any further outpatient minor procedures during the Christmas period. However, staff told us they were informed about changes to practice following our initial visit and were required to ensure that the original notes or copies were kept on-site.
- We reviewed four patient records for children and young people who had minor outpatient procedures. In all four sets of notes, we saw staff followed specific procedure pathways. Children aged three to 16 years had a risk assessment before any imaging or minor outpatient procedure. In the notes we reviewed, we e saw evidence of risk assessments where applicable. Overall, we saw an appropriate standard of documentation for children and young people patient records. We saw staff had signed and dated all entries in line with general medical council (GMC) and nursing and midwifery council (NMC) guidance.
- We saw patient records securely stored in locked storage when not used which meant that only authorised staff were able to access them. This included records for patients who were seen for consultation only. The key to the locked storage was held by the nurse in charge.

Safeguarding

- We saw data that 94% outpatient and imaging staff had completed safeguarding adult level one and two training.This was worse than Spire Healthcare compliance target rate of 95%. Post-inspection data showed that 99.5% of staff had completed the same training at the end of December 2016.
- The hospital had a safeguarding children lead and a safeguarding adult lead. The Matron acted as the hospital's overall safeguarding lead. Staff we spoke with demonstrated a good awareness of what to do if they had safeguarding concerns and could identify the children's and adult's safeguarding lead.
- We saw the hospital's updated safeguarding policy introduced in September 2016. The policy was accessible in the outpatients' policy folder including a staff signature sheet that showed staff had read the policy.
- Records we looked at showed 90% of staff who were involved in treating children had completed safeguarding children level three training. The hospital was enrolling the remaining 10% staff to the level three training course, including the specialist children's nurse that started in November 2016. This showed the hospital was working towards all staff involved in treating children having safeguarding level three training in line with national guidance from the intercollegiate document "Safeguarding Children and Young People: Role and Competencies for Health Care Staff" (March 2014). Data showed that all other clinical staff had completed safeguarding children level two.
- The hospital had systems to ensure children and young people always had a member staff trained to safeguarding level three to care for them during outpatient, imaging and physiotherapy appointments. The lead children's nurse sent out rotas to all areas of the service one month in advance detailing children nurse availability. Staff then only booked appointments for children once they had also booked a children's nurse to attend. Staff we spoke to in outpatients and diagnostic imaging confirmed that the children children's nurse always accompanied children for their appointments. The hospital only allowed consultants with practising privileges to care for children and young people if they provided evidence of level three safeguarding children training.
- We saw completed risk assessment forms for children who needed minor interventional procedures, such as blood taking. The registered children's nurse, who had level three safeguarding training, performed all risk assessments for children who needed to have a procedure performed by a member of staff trained to safeguarding level two. Staff we spoke with told us the department delayed procedures if the registered children's nurse was not available to perform a risk

assessment. However, now that more outpatient staff had level three safeguarding training, risk assessment was often not necessary, as there was usually a member of staff with level three training available to perform the procedure.

- We saw a chaperone policy for older children or adolescents who attended outpatient and imaging appointments without a parent or guardian. Staff knew how to access the policy and gave examples of circumstances in which they may need to apply it. However, staff also told us most children attended with their parents. In all the children's records we reviewed, we saw that a parent or guardian had accompanied their child. We saw posters with information about the chaperone process were displayed in all of the consulting rooms we visited.

Mandatory training

- All staff completed mandatory training using online learning and face-to-face training. This included modules in life support, fire safety, infection prevention and control, safeguarding children and adults, health and safety and equality and diversity.
- We were shown data that indicated imaging and physiotherapy staff achieved 100% compliance with completion of mandatory training which was a higher rate than the Spire Healthcare target of 95%. However, staff in the outpatients department achieved 94% which was lower than the Spire Healthcare target of 95%. Compliance rates were monitored and staff were advised to attend refresher training when necessary. We saw training compliance was reviewed regularly as part of a standing agenda item in departmental meetings and was recorded in the minutes between May and November 2016.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.

Assessing and responding to patient risk

- Immediate or emergency assistance from the hospital resuscitation team could be summoned by the use of the "crash call". Medical assistance was provided by the resident medical officer (RMO) and / or the patient's consultant.
- Where patients required specialist emergency care, there were clear and known protocols in place for the transfer of patients to the local NHS accident and emergency facility by ambulance.
- We saw a hospital "three steps outpatient safety checklist" based on the World Health Organisation (WHO) Surgical Safety checklist introduced in November 2016. This included 'sign in' checks where the patient identity and operative site was confirmed and 'sign out' checks where the instruments used were counted back and any specimens are labelled and sent to the laboratory. The hospital was working towards staff implementing the use of the checklist for patients who had a minor procedure.
- We saw measures in place for reducing exposure to radiation in the diagnostic imaging department. For example, local rules were available in every area we visited and signed by all members of staff, which indicated they had read the rules and understood their responsibilities. We also noted imaging protocols and policies stored in folders in each room and staff demonstrated a clear understanding of these protocols.
- We observed good radiation compliance during our visit. The department displayed clear warning notices, doors were shut during examinations and warning lights were illuminated. We saw radiographers referring to the Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R for patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection advisor was contactable if required, which complied with IR (ME) R.
- The radiation protection advisor performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks. This helped to assure the hospital that imaging equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IRMER 2000. We saw records of these checks during our visit.
- Lead aprons limit exposure to radiation to keep patients safe. We saw lead aprons available in all appropriate areas of the imaging department.

Nursing and radiology staffing

- Managers we spoke with told us nursing staffing levels were calculated dependent on the number of clinics and the numbers of patients attending clinics as well as other factors such as procedure support and chaperoning.
- Registered nurses and health care assistants (HCAs) staffed the outpatient clinics. We learned that either overtime was paid or a bank nurse called in when required. We saw sufficient staff present during our inspection.
- Hospital data showed sickness rates for registered nurses were zero percent. This was better than the average of other independent acute hospitals we hold this type of data for between July 2015 and June 2016, except for October 2015, February, March and June 2016. In the same reporting period, sickness rates for HCAs were variable throughout and were higher than the average of other independent acute hospitals we hold this type of data for in July and November 2015, and January and March 2016. However, the hospital reported that they had no unfilled shifts from April to June 2016. This meant the service had sufficient nursing staff on all shifts to provide appropriate care and support.
- There was no staff turnover for outpatient nurses between July 2015 and June 2016. The outpatient health care assistant turnover rate was similar to the average of other independent acute hospitals that we hold this type of data for in the same reporting period. This meant the team were stable and experienced. The outpatient sister stated that nursing retention was due to positive factors such as promotion.
- In the imaging department, we saw evidence of a competency and induction folder for new and bank staff. This meant that new and bank staff could integrate safely and efficiently into the workforce. There was no staff turnover within this area in the last 12 months and sickness level was low.

Medical staffing

- RMOs working at the hospital had advanced children life support (APLS) training. This ensured the hospital always had a member of staff with APLS training on the premises to respond to any emergencies involving children. We also saw training records, which provided evidence of in-date children advanced life support (EPALS) training for the children's lead nurse. The hospital had a children retrieval service arrangement with a London NHS hospital trust which meant that critically ill children can have immediate specialist transport to the trust if required.
- Radiology consultants were on-site during clinic hours to manage urgent work and the reporting requirements for the hospital. The service used image-sharing computer software to access results.
- Outpatient clinics were timetabled to suit each consultant's availability and obligation as part of the consultant's practising privileges contract. Consultants in clinic were assisted by the RMO in cases where urgent or additional medical support was required.

Emergency awareness and training

- Staff described participating in regular medical emergency simulations, for example, cardiac arrest and reported the learning experience in positive terms.
- We were shown an in-date version of the policy for managing radiation incidents. This demonstrated that the hospital had considered potential risks to safety and had prepared responses for any such eventuality. We also noted a current version of the business continuity policy which was issued in October 2016.
- We saw action cards in the event such as a flood or fire in the hospital business continuity policy. This showed clear processes for staff to follow in the event of a flood or fire.

Are outpatients and diagnostic imaging services effective?

We inspected but did not rate effective, as we do not currently collect sufficient evidence to rate this.

Evidence-based care and treatment

- Policy documents were updated regularly by Spire Healthcare and issued to the hospital for implementation. These were available on the hospital intranet as well as in the policy folder located in the outpatient staff office.
- We also saw local policies and standard operating procedures such as monitoring of fridges, management of patients after a fall and emergency evacuation. We

saw how policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. New national guidance was sent to the hospital monthly by Spire's central governance team. These were assessed within the hospital for their relevance by the medical advisory committee (MAC) and cascaded, including to Consultants. This meant that staff had evidence-based and clear instructions to follow to provide safe care.

- The hospital medical advisory committee (MAC) met quarterly to review clinical performance, incidents and complaints. We saw minutes of MAC meetings from the past 12 months where feedback was obtained from the consultant body on new developments and initiatives from within the various specialities.
- Staff followed the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists standards in the speciality areas we visited. We saw evidence of checks and audits that demonstrated the department monitored compliance with these guidelines which meant that staff provided safe care to patients.
- Audits included environmental, medicine management, hand washing and infection control checks and the results of these were shared among staff. We observed examples shared on staff notice boards and in departmental meeting notes.

Pain relief

- The on-site pharmacy stocked and dispensed "over-the-counter" and prescription only pain relieving medication.
- The hospital used a pain assessment tool where adult patients were asked to score discomfort based on a range from 0-10. Staff told us that they did not get many patients who attended outpatient reported they were in pain and used the pain assessment tool as required. We did not see the tool used by staff at the time of inspection as none of the patients reported discomfort.
- The hospital used age appropriate tools for the assessment of children's pain. We saw a pain assessment scale staff used in the physiotherapy department. The chart had pictures of faces so that young children could easily report their level of pain. The use of a pain scoring system allowed staff to give appropriate medicines or support with alternative pain management techniques and review the effectiveness of the intervention.

Nutrition and hydration

- The outpatient waiting area offered patients, children and parents a choice of refreshments while they waited for their appointment.
- Staff told us that patients would be offered a choice of sandwiches after a minor procedure if required.
- The hospital's Patient Led Assessments of the Care Environment PLACE scores from February to June 2016 for food was 99% which was higher than the England average of 91%. PLACE assessments give patients and the public a voice that can be heard in any discussion about local standards of care, in the drive to give people more influence over the way their local health and care services are run.

Patient outcomes

- The hospital measured performance using a variety of clinical indicators, which enabled the senior manager to benchmark performance against other hospitals in the Spire Healthcare group and the independent sector. The hospital also used a computerised reporting system to provide data on patients who required readmission, transfer to another hospital, unplanned return to theatre, infections, incidents relating to a thrombolytic event or other significant events.
- There were a variety of processes described to measure and audit patient outcomes, including a quarterly internal audit programme and National Joint Register.
- In outpatients, we saw examples of physiotherapy outcomes listed in electronic records. Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and the quality of life measures in order to establish the effectiveness of treatment.

Competent staff

- All new staff had an induction package, which included core competencies and knowledge that was signed off by their line manager. We saw examples of this in the staff files for nurses and radiographers we reviewed.

- Hospital data showed 100% of staff received a performance appraisal between January and December 2016. We saw staff files contained evidence of regular performance meetings between appraisals. Regular appraisals and reviews allowed the hospital to identify and monitor staff performance and personal development.
- There was a clearly defined performance management system in place. Concerns about staff performance were initially dealt with through informal discussions that were documented in the staff file. If concerns continued, the formal process was triggered in consultation with the human resources lead supported by a third party human resources support partnership. We were told this had never been necessary for this service.
- There were processes in place for confirmation of practising privileges. Consultants were offered practising privileges by the MAC only after HR had received the necessary assurance documentation.
- All appraisals were shared by the consultant following their appraisal with the NHS trust in which they worked. Where the hospital director provided information for NHS appraisals, this routinely included data relating to that consultant's practice such as surgical site infections, complaints and morbidity and mortality. The data also included reflected outcomes collected by the hospital as part of their biennial practising privilege reviews.

Multidisciplinary working

- We saw effective multi-disciplinary working between all professions and grades of staff. This

  included housekeeping and pharmacy staff.
- There was consistent evidence of close collaboration across different services within outpatients and diagnostic imaging. Staff told us they felt well supported by other staff groups and there was good communication within the teams. We saw a physiotherapist communicating with an outpatient nurse about a patient's treatment plan.
- We heard positive feedback from staff at all grades about the good teamwork within the hospital generally.

Seven-day services

- The outpatient department is open Monday to Friday from 8am to 8.30pm and on Saturdays from 8am to 5pm for patients that cannot make appointments during the standard working day.
- The imaging department is open Monday to Friday from 8am to 8.30pm and Saturday from 8am to 2pm. A 24-hour on-call service for urgent examination requests was also provided. This allowed staff to access diagnostic services in a timely way to support making a clinical decision.
- The outpatient physiotherapy department is open Monday to Friday from 8am to 8.30pm and Saturday from 8am to 1pm.
- An on-site pharmacy team provides a daily service between 8.30am and 6pm, Monday to Friday, and on Saturday mornings. Out of hours restricted access to the hospital pharmacy was provided. We saw appropriate security procedures implemented to ensure only approved staff could access medicines, and that the out of hours' arrangements were clearly communicated to relevant staff.

Access to information

- All staff we spoke with said they had access to policies, procedures, NICE and specialist guidance through the hospital's intranet and we were shown examples. Computer terminals were located in all consulting rooms and offices to enable staff to do this. Staff were generally positive about the hospital's intranet and reported managers communicated effectively with them via e-mail.
- The imaging department used picture archiving and communication system (PACS) technology. This enabled the hospital to quickly store, retrieve, distribute and view high-quality medical images. For example, the department was able to share images with radiologists at the local NHS hospital, if the need arose. This meant the hospital was able to provide rapid electronic access to diagnostic results.
- The imaging department had a system in place for radiologists to urgently communicate any unexpected findings with GPs. Radiology staff we interviewed told us this system worked well.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Outpatients and diagnostic imaging

- We saw "Spire Healthcare parental agreement to investigation or treatment for a child or young person" forms. Parents or legal guardians signed these consents on behalf of children who were not competent to provide consent. We saw these forms also had a space for children to sign as well as the parent to show their involvement in decisions about their treatment. The associated guidance stated, "It is good practice when a person with parental responsibility signs the consent form to involve the child in the decision making and to allow them to countersign the consent form where the child's level of development allows".
- Consultants took consent and assessed Gillick competence for young people under the age of 16, the statutory process for assessing that children under the age of 16 were competent to make decisions about their own care and treatment. We reviewed three patient consent forms for children and young people. These showed staff had obtained consent appropriately in line with the appropriate legislation and guidance.
- We reviewed five records for adults who had minor procedures. All five records contained a minor procedure pathway form that was completed which stated, "Consent form completed". However, we saw four of five records did not contain a consent form. This meant there was no documentation of a patient's agreement to the intervention and the discussions which led to that agreement. We raised this with the hospital management who took immediate action to request the consent forms. At our follow up visit, we reviewed an outpatient record for an adult who had undergone a minor procedure. We saw the record was completed and included a completed consent form. All entries were legible, signed and dated, and included the doctor explaining the benefits and risks of the procedure to the patient. This showed staff followed the Spire Healthcare consent policy.
- We observed examples of verbal consent demonstrated by patients undergoing diagnostic imaging in the x-ray room.
- The provider had a policy to guide staff in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA) which included Deprivation of Liberty Safeguards. We saw this in the policy folder kept in the outpatient staff office. Staff we spoke with demonstrated awareness of how the Mental Capacity Act 2005 related to their practice and were aware of who to contact if they required guidance.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- The hospital's NHS Friends and Family Test (FFT) scores were similar to the England average of NHS patients across the period January 2016 to June 2016. The response rates were below the England average of NHS patients apart from in January and February 2016. The England scores and response rates are for NHS patients only. The FFT was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way to give views after receiving care or treatment across the NHS.
- We received five comment cards from patients at the hospital. The comments were positive and praised the hospital staff and environment. Comments about staff included "highly professional, knowledgeable, kind and caring" and "treated with courtesy and respect". Patients who used the physiotherapy service commented, "Environment is always clean and tidy", "treatment received from physiotherapy excellent" and staff, "gone the extra mile to help my recovery process".
- Patients told us that staff and their consultants explained things in detail and allowed time for any questions.
- We spoke with the parent of a child patient. The parent told us they were happy with the care they received from hospital staff. The parent described their child's consultant as "pleasant and helpful".
- In the imaging suite, we saw staff ensuring that patients' dignity was maintained despite the need to wear

examination gowns during the process. We also saw curtains were drawn around a cubicle in physiotherapy department which provided the patient privacy and dignity during their treatment.

- We saw posters displayed informing patients of their right to request a chaperone for any consultation, examination or treatment. Staff told us they offered patients a chaperone before any intimate examination or procedure and were able to anticipate requests based on the clinic schedule.
- We observed staff were friendly and professional when they spoke with patients. We saw staff that were polite and respectful of confidentiality. Patients were able to have conversations with staff without being overheard and minimal patient identifiable data was discussed.

Understanding and involvement of patients and those close to them

- Staff photographs and names were clearly and legibly displayed on noticeboards in the main waiting area, outpatient and imaging departments. This helped patients and visitors identify key staff encountered during their visit.
- We saw a variety of literature and health education leaflets produced by Spire Healthcare were displayed in all the waiting areas throughout outpatient and imaging departments. We also saw a range of patient information available to help patients understand their medicines in pharmacy, and this was available in larger print for people with visual impairment.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need. Patients reported that consultants took time to provide an explanation and this made them feel part of the decision-making about their treatment and care.
- Patients we spoke with told us they were informed about the fees for their consultation before their appointment. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.

Emotional support

- Patients told us that staff and consultants working in the outpatient clinics were approachable and “had the time to explain everything”.
- We observed relatives were invited to accompany patients into consultation rooms, which indicated that the hospital encouraged a friend or partner to attend the appointment in order to provide emotional support.
- Staff we spoke with told us they were able to access counselling services which provided confidential emotional support if required.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- A range of outpatient clinics were made available to meet the needs of the client group. According to data the hospital provided, this included orthopaedics, ear, nose and throat (ENT), gynaecology, dermatology, gastroenterology, neurology, urology, dietetics and nutrition, ophthalmology, cosmetic surgery, general medicine, psychiatry, vascular and podiatry. Orthopaedics and gastroenterology were the most attended clinics
- These outpatient clinics were supported by diagnostic imaging services including Magnetic Resonance Imaging (MRI) scans, x-ray, Computerised Tomography (CT) scans and ultrasound scans. These facilities supported clinical decision-making by the treating specialists.
- Outpatients and imaging departments coordinated activities, to provide a ‘one stop breast clinic’, which enabled patients to undergo breast assessment, specialised breast scanning including mammography and feedback in one convenient appointment.
- Evening and Saturday outpatient clinics were routinely offered, which afforded additional choice and convenience to patients.

Good

Outpatients and diagnostic imaging

- The environment provided by the hospital met the needs of the patient, with comfortable seating, toilets and refreshment facilities. Free car parking was also provided on-site.

Access and flow

- GPs referred the majority of new patients who used the service. We were told that referrals from physiotherapists and other registered healthcare practitioners were also accepted by insurers. A patient we spoke with confirmed this.
- For each month in the reporting period July 2015 to June 2016 the service exceeded the target of 92% for NHS patients beginning treatment within 18 weeks of referral. During the same period, no patients waited six weeks or longer from referral to test for MRI, CT or ultrasound.
- Patients we spoke with said that their first appointments from referral were a matter of days. They also reported that they did not wait long to see a nurse or a doctor when they attended for a clinic.
- Follow up appointments were arranged according to the request of consultants and the needs of patients.
- Opening hours for outpatient clinics varied and specific clinics were held on different days and at variable times to ensure that there was provision for patients with restricted availability.
- We were told that delays in outpatients did not happen often and we were shown appointment lists that supported this. Staff and managers expressed strong commitment to the efficiency of the departments and gave examples of their responses when clinics ran late. Patients were kept informed and personal apologies made when there were delays. During our inspection, one patient told us they had to wait 15 minutes but were kept informed of the delay and reasons for delay by staff.
- If a clinic appointment ran behind schedule staff provided refreshments including light meals. We saw staff offered refreshment for one patient whose appointment was delayed.

Meeting people's individual needs

- Hearing loops were available in the waiting area, which helped those who used hearing aids to access services on an equal basis to others.
- We were shown details of a telephone translation service used by the hospital. The staff we spoke to showed good knowledge and awareness of the service and knew who to contact if required. Staff provided an example where they contacted the service to help with a patient whose first language was Russian. There were speaker telephones in all the consulting rooms we saw.
- We observed the waiting room and clinic areas were accessible to all people including wheelchair users. This included level access from the car park set down area and automatic entry doors at the main entry as well as entrances to the departments. Outpatient clinics were also provided on the second floor and we saw this was accessed by a lift which was also suitable for wheelchair users.
- The outpatients and imaging departments had toy boxes available to provide distraction and comfort to children. We saw three different toy boxes for different age groups that were suitable for toddlers and slightly older children.
- We saw adults and children used the same waiting areas resulting in lack of privacy and dignity for both groups as waiting areas were often left unsupervised. Separate waiting areas would provide both adults and children privacy and dignity.
- In Outpatients the waiting area for children contained a table, four chairs a large activity cube and two books. we were told that during children's clinics, and on request at any other time, the service provided additional toys and colouring sheets. Staff did not leave these items out continuously in order to keep the area clear and tidy, but routinely offered them when a child attended with their parent during an adult clinic.
- Staff we spoke with told us all seats in the waiting area were suitable for bariatric patients. Bariatricsis the branch of medicine that deals with the causes, prevention, and treatment of obesity. We saw that the seats appeared to be very sturdy. This allowed bariatric patients to sit anywhere they chose.
- The hospital is a part of the Dementia Action Alliance. This is an alliance for organisations across England to

connect, share best practice and take action on dementia. Staff were encouraged to undertake training which was offered by an external company. Staff we spoke with demonstrated a good understanding of dealing with patients living with dementia. We were provided with examples when staff used a 'butterfly sticker' system on patient medical records so patients living with dementia could be identified easily. Patients were also given priority to be seen first and were scheduled for a longer appointment time in clinic. We saw a dementia information folder in the nurses' office which staff could access.

Learning from complaints and concerns

- Complaints were discussed weekly at senior clinical team brief governance meetings and monthly at head of department meetings and departmental meetings. They were also reviewed at the quarterly clinical effectiveness meeting and clinical governance meetings. Complaints were also discussed at quarterly MAC meetings.
- The hospital received 32 complaints from July 2015 to June 2016. These were all resolved at a local level and were not escalated to the Ombudsman or Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Staff at all levels described an open and honest culture and a willingness to accept responsibility for any shortcomings.
- There was a robust system in place for capturing learning from complaints and incidents. The senior management team "signed off" every complaint, which was logged onto the incident reporting software. Anonymised complaint logs were used to help inform all staff and changes to practice were fed back through the heads of departments to frontline staff.
- All written complaints were acknowledged within two days of receipt or within five days if a full answer could be provided. If further investigation was required, this was within a 20-day timescale in accordance with Spire Healthcare policy. The hospital used a corporate "Please talk to us leaflet" that was sent with the acknowledgement to help inform the complainant of the process and their rights. We saw three written complaints related to outpatient and imaging departments and noted all responses were within the time scale set by the policy.
- Concerns raised in comment cards were acted upon. The matron discussed any concerns or complaints with the departmental manager as soon as possible. The imaging department manager provided us with an example where the hospital did not have an up-to-date next of kin contact details. The hospital wrote a letter of apology to the patient, acknowledged what had gone wrong and explained that staff were asked to check details with patient at every contact. The patient was satisfied with the outcome. This was consistent in all three complaints we looked at.
- Managers we spoke with told us where complaints involved clinical care, the consultant responsible for the patient's care was also involved in the investigation.
- All complaints were reported to the Spire Healthcare head office via the regional reporting structure. This enabled all Spire Healthcare hospitals to learn from complaints within the group.
- The hospital did not use child feedback forms in the outpatients or imaging department. However, at the follow up visit, the children lead nurse showed us work in progress to develop a child-friendly feedback form. This contained pictures as well as words for children unable to read. Children could then give feedback by ticking an appropriate box to show how they felt about the hospital. This would enable the service to receive feedback from its youngest patients who may not be able to write.
- Feedback was sought from young people who used the service, as well as the parents of younger children. We saw that the service monitored trends on a quarterly basis which allowed the service to identify any areas for improvement.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good

Leadership and culture of service

- The hospital was led by the director and the head of clinical services. The outpatient clinical service manager and manager for the allied health professionals and pharmacy reported to the head of clinical services.
- All staff we spoke with felt managers and the hospital SMT were open and approachable. At the staff focus groups, we heard that the majority of staff felt established at the hospital and had worked there for many years. They described the SMT as very visible and they felt able to discuss any issues with them on a daily basis. The SMT had an open door approach and during busy days, they visited clinical areas at least twice daily to “ensure the day was going smoothly”.
- We saw good examples of local leadership in the nursing, imaging and physiotherapy teams. For instance, a health care assistant (HCA) told us about the support she received when a consultant “demanded a trained nurse” instead of an HCA to manage a clinic. The nurse manager intervened and explained that the HCA was assessed as competent to run the clinic, the consultant apologised to the HCA.
- Staff we spoke with told us they enjoyed coming to work and were passionate about the care they gave to patients. This was consistent with the data provided by the hospital of low staff sickness and turnover rates in the outpatient and imaging departments.
- We were told that the overall hospital safeguarding lead also acted as the adult safeguarding lead. The lead was trained to level two for safeguarding adult and children training. However, staff we spoke with identified the matron as the overall hospital safeguarding lead. The training level for the hospital safeguarding lead was not in line with the national guidance from the intercollegiate document “Safeguarding Children and Young People: Role and Competencies for Health Care Staff” (March 2014) and from the NHS England guidance “A Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework” (July 2015). A hospital safeguarding lead’s role was to disseminate information and provide staff supervision and would not be able to do this without appropriate training. We raised this with the hospital management at our visit and we were told the overall hospital safeguarding lead will be enrolled to complete the appropriate safeguarding training.
- Safeguarding was discussed but not as a standard agenda item in two of the four minutes of the clinical governance meetings the hospital provided. We saw examples of discussions such as the commencement of the adult and children safeguarding lead roles and ensuring staff who were involved in caring for children to complete safeguarding children level three training.

Vision and strategy for this core service

- Staff we spoke with were clear about the values of the organisation and were committed to working towards achieving the broad vision and strategy. Examples of this included the hospital being a “world class healthcare provider”, “first choice for consultants”, “patients to recommend us” and “a great place to work”.

Governance, risk management and quality measurement

- The nursing and radiology leads reported to the matron who was part of the hospital senior management team. The matron was accountable to the hospital director.
- There was a process for reporting against the governance framework for all Spire Healthcare hospitals with regional and national benchmarking against other Spire Healthcare hospitals.
- The provider had an electronic incident reporting system that fully linked complaints, incidents and risk reporting. This assisted managers in monitoring processes and identify any developing trends or patterns.
- The safety records were monitored monthly by the executive team. Lessons learned were discussed and disseminated across the organisation.
- There were clear lines of accountability and responsibility with explicit and effective information flow pathways.
- The Senior Management Team (SMT) also shared information at the monthly heads of departments meetings. Once the SMT had reviewed and considered the information, they produced an integrated governance report that was fed upwards to the provider’s central Clinical Governance and Quality Committee for review and feedback.

- The SMT explained that updates to NICE guidance or safety alerts were received monthly from corporate level and shared via the heads of department meetings. We saw examples of this in the minutes of the meetings we reviewed.
- Departmental managers we spoke with demonstrated a clear understanding of the risks within their areas. They provided an example such as flooring in the consulting rooms was not fit for purpose which was consistent with the Spire Health risk register we saw. The departments were able to identify clinical and non-clinical risks.

Public and staff engagement

- Staff of all grades we spoke with expressed pride in their team work and the services they provided. This was consistent with the feedback provided at the focus groups.
- With the appointment of a new hospital director in 2016, the hospital engaged with staff through ‘process’ meetings with all the departments. These meetings gave staff a chance to participate and be involved in re-shaping the structure and methods to achieve the hospital goals.
- The hospital had started regular staff forums which provided staff the opportunity to interact with one another. We saw this advertised in both staff and consultant newsletters which were produced to inform and engage staff.

Innovation, improvement and sustainability

- There were opportunities for internal promotion and further learning and development. Examples of staff undertaking courses being funded by the hospital included a master’s degree in tissue viability for nursing staff and an MRI post-graduate certificate for imaging staff. At the focus group, staff also told us that consultants provided weekly on the job training for physiotherapists.
- The SMT told us that the hospital’s equipment availability had increased 40% in the last 12 months. Staff we spoke with said that the availability of equipment has improved and did not have an issue with lack of equipment.
- The hospital had an "Inspiring People" programme where staff were encouraged to identify innovative ideas to enhance services for patients and their colleagues and regular awards were given for the best ideas. The scheme was also used to recognise staff that had gone "above and beyond" for a patient, visitor or colleague. Exceptional ideas or performance were nominated for the Spire group national annual awards ceremony.

Requires improvement

Termination of pregnancy

Safe	Requires improvement
Effective	Requires improvement
Caring	Not sufficient evidence to rate
Responsive	Requires improvement
Well-led	Inadequate

Are termination of pregnancy services safe?

Requires improvement

Incidents and safety monitoring

- Staff we spoke with described the processes for reporting incidents and for shared learning. Staff used an electronic reporting system to record and monitor safety incidents. Staff completed a mandatory online training module for incident reporting.
- All incidents and adverse events in the hospital were discussed at the quarterly Medical Advisory Committee (MAC), Clinical Governance Committee (CGC), weekly Senior Management Team (SMT), monthly Heads of Department (HOD) and departmental meetings. Minutes of these meetings confirmed this happened across the hospital within the reporting period. However, there was no record of any discussion of any incidents or adverse events related to the Termination of Pregnancy services in any of the minutes we reviewed.
- Mortality and morbidity cases were discussed at the hospital's clinical governance meetings, which were held quarterly. We looked at the most recent meeting minutes dated September 2016 and saw there were no reported deaths within the service between July 2015 and June 2016.
- There had been no reported never events relating to Termination of Pregnancy services. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- From 1 April 2015 all independent healthcare providers are required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff we spoke with correctly described the Duty of Candour (DoC) regulation and what this meant in their practice. We saw that staff had received training on duty of candour as part of the hospital's mandatory training programme. We saw a poster displayed on the staff notice board describing the process to follow should DoC apply.

Mandatory training

- Details of the mandatory training can be found in the surgery core service report.

Safeguarding

- There was no evidence the consultant was trained in female genital mutilation (FGM).
- We asked the consultant and staff involved in the termination of pregnancy service about the arrangements for consultations with patients in accordance with NICE Guidance PH 50, 2014 and Quality

Statement 116 Domestic Violence and Abuse, 2016. The guidance states that providers should ensure that health and social care practitioners provide facilities which enable people to speak about their experiences in a private discussion. Staff we spoke with told us they did not routinely see patients on their own as part of the consultation or assessment process and the consultant told us a private discussion would not be offered.

- There were no safeguarding alerts within the Termination of Pregnancy service at the time of our inspection.
- We saw documentary evidence in the register of patients who had used the service that all the patients were aged 18 years or above.
- Staff we spoke with correctly identified the safeguarding processes they would follow and the named leads for vulnerable adults and children .Staff did not solely cover termination of pregnancy services, therefore details about the arrangements in place for staff to safeguard adults and children from abuse are reported in greater detail elsewhere in this report.

Cleanliness, infection control and hygiene

- Spire Healthcare had systems in place to prevent and protect people from a healthcare-associated infection in the 'Prevention and Control of Infection Manual' policy dated November 2015. This included guidance on hand hygiene, use of personal protective equipment such as gloves and aprons, spillage of body fluids, and guidance on infection control within the operating theatre department. We saw personal protective equipment such as apron and gloves were readily available in all clinical areas.
- NICE QS61 statement 3: recommends that people receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. During our inspection we were unable to observe staff adherence to hand washing and other infection and prevention control (IPC) processes in the termination of pregnancy service as there were no patients using the service on the days of our visits. Audits to monitor IPC, including hand washing, were carried out in the operating theatre department, inpatient and outpatient areas. These did not solely relate to termination of pregnancy services, and are therefore reported in greater detail in the surgery and outpatient and imaging core service reports.
- The Department of Health code of practice on the prevention and control of infections and related guidance (2015) requires that there is clear segregation of clean and dirty equipment and waste in hospitals. Arrangements were in place for this. However, we saw clean equipment used in termination of pregnancy procedures stored in an unmarked utility room located within the operating theatre department. It was unclear to us whether the unmarked area utility room was designated as a clean or dirty area as there was no signage. Staff confirmed this was a dirty utility area.
- We also saw an x ray machine stored within the waste disposal storage area outside the operating theatre department. Staff confirmed this was also a dirty utility area.
- We brought our concerns about the lack of segregation of clean and dirty equipment to the immediate attention of the manager who took corrective action by transferring the clean equipment at the time to a clean utility area. As this did not solely relate to the Termination of Pregnancy service we have reported about this in more detail in the surgery core service part of this report.
- Surgical instruments, equipment and consumables used in the surgical termination of pregnancy were supplied and decontaminated by the hospital on site central sterile supply department (CSSD).
- The ultrasound scanner used within the termination of pregnancy service to ascertain gestational age, was located in consulting room 19 in the outpatient department and had visible finger prints on the console; we were told by the surgeon that it was cleaned with sanitiser wipes. This was not in accordance with the manufacturer's instructions. We asked to see records of the cleaning and maintenance of this equipment and none were available. We brought this to the attention of the management team.
- At our unannounced follow up visit the manager told us that the ultrasound equipment seen during the announced inspection had since been decommissioned. We saw this stored in a locked room

with other decommissioned devices. A new ultrasound scanner was in place which had passed acceptance testing and was labelled as safety checked. We also saw a daily cleaning schedule for the new scanner in place.

- Cleaning within the operating theatre department was carried out by housekeeping staff (out of hours) and operating theatre department staff and has been reported in further detail in the surgery core service part of the report.

Environment and equipment

- All surgical termination of Pregnancy were undertaken in the operating theatre department. This met the requirements of Department of Health guidance HBN26 Facilities for surgical procedures, 2004.
- Recommended Standards of Practice (RSOP) 22 Maintenance of equipment requires that providers of Termination of Pregnancy services should minimise risks and emergencies through a programme of regular checking and servicing of equipment. This is particularly the case with anaesthetic and patient monitoring equipment. We have reported on the maintenance and use of equipment in the surgical report as well as the outpatients and imaging report.
- All equipment owned by the hospital had been serviced and safety checked in line with the provider's policy.
- Within the Termination of Pregnancy service we saw an ultrasound scanner used to determine the patient's gestational date which belonged to the surgeon. Local standard operating procedures required the surgeon to show and provide a copy of the service history to the hospital. We saw the service history related to this scanner which showed it was last serviced/maintained in September 2015.
- Resuscitation equipment was available in the outpatient department, operating theatre department and inpatient areas should it be required for patients accessing Termination of Pregnancy services. We saw this was checked and maintained by the relevant teams from each area, was in date, suitably stored, and ready for use. All staff we spoke with correctly described its use and had completed regular mandatory training at an appropriate level to their job role so that they were able to use the equipment if required.
- All areas where consultations and treatments were carried out were private and did not allow patients to be seen or overheard whilst receiving termination of pregnancy services.
- Oxygen cylinders were available in treatment rooms and on each resuscitation trolley. The oxygen cylinders we saw were all correctly stored and in-date.
- Managers showed us there were systems in place to receive and act on safety alerts for medical equipment and medicines, and provided recent examples of where these had been communicated to all staff. All staff we spoke with correctly described the process and were able to recall examples up until November 2016.

Medicines

- The hospital had an on-site pharmacy. Pharmacists and suitably trained pharmacy support staff provided a daily service between 8.30am and 5pm, Monday to Friday, and on Saturday mornings. Clinical staff reported that the pharmacy team were readily available to offer support and advice to both staff and patients, maintained adequate stock levels, and dispensed prescriptions in a safe and timely manner.
- Out of hours there was restricted access to the hospital pharmacy. We saw appropriate security procedures in place to ensure only approved staff could access medicines, and that the out of hours arrangements were clearly communicated to relevant staff.
- Medication administration records were contained within all patient records we looked at, and were completed in accordance with local policies. We saw that the allergy status of each patient was clearly documented and, where relevant, was acted upon. This correlated with any documented allergies in the patient's medical and nursing records.
- All medicines were dispensed by qualified pharmacists in the hospital pharmacy. This was located near to the outpatient department where consultations took place. A range of patient information was available to help patients understand their medicines. For example, this was available in larger print for people with visual impairment.

- Medicines were supplied and administered against a written prescription by a doctor. This included medicines for pain relief and preventive antibiotics to reduce the risk of post –procedure infection.
- Medicines to be used in case of medical emergencies were easily accessible and were checked on a regular basis by clinicians and by pharmacy staff so that they were ready for use.
- Outpatients, and some inpatients that were being discharged, were issued with a private prescription. We looked at the storage of private prescription stationery within the pharmacy department. In accordance with good practice the stationery was securely stored in a locked cabinet. Each prescription had a unique identifier number and was issued on an individual basis to a named prescriber.
- We saw a register of all the private prescriptions issued was maintained in the pharmacy department in accordance with local policy.
- A copy of the current British National Formulary (BNF) was available in clinical areas and the hospital pharmacy for relevant staff to refer to. The BNF is the national authority on the selection and use of medicines.
- We saw that in all clinical areas and the hospital pharmacy medicines were safely stored in accordance with the manufacturers' recommendations. This included medicines used for anaesthesia and medical gases. Medicines that had temperature storage requirements were kept refrigerated. The minimum and maximum temperatures of fridges and other medicines storage areas were monitored daily to ensure that medicines were stored correctly. We reviewed records of temperature recordings and found them to be up to date and within range.
- There were systems in place to check for expired medicines and to rotate medicines with a shorter expiry date. All the medicines we looked at were within the expiry date.
- Pharmacists carried out a range of audits in relation to administration and safety of medicines. These were not specific to termination of pregnancy services and have therefore been reported in the surgery and the outpatients and imaging service reports.
- NICE QS 61 recommends that people are prescribed antibiotics in accordance with local antibiotic formularies. Records we looked at confirmed that there were local protocols in place and that prescribers were using them.

Records

- Arrangements for the management of patient records were set out in Spire Healthcare: Information lifecycle management and patient record policy dated 2013. The policy review date had expired. However, staff we spoke with confirmed this was the version they currently referred to.
- The Spire Healthcare policy stated that as with other records, all records of termination of pregnancy, which include patient-identifiable information, must be stored securely and kept strictly confidential within the establishment.
- We reviewed ten sets of patient records of women who had used the Termination of Pregnancy service between June 2015 and October 2016. All of the records we looked at were filed in individual patient folders and maintained in accordance with national standards from the relevant professional regulators including the general medical council and nursing and midwifery council.
- We saw that records were largely paper held and were generally well maintained and stored securely in lockable cabinets and trolleys. However, we also saw around five sets of patient records stored on the floor in a consulting room used solely by the Termination of pregnancy service. We brought this to the immediate attention of a manager and saw that corrective action was taken by transferring the records to a secure cabinet.
- Staff we spoke with told us that prior to the termination of pregnancy all patients had an ultrasound scan to confirm the gestational date, which is the term used to describe how many weeks pregnant the woman is. In all of the patient records we looked at we saw that a record of the ultrasound scan and the reported gestational date took place. We asked to see the reports of each patient's ultrasound scan and the images that were produced as these were not stored in any of the patient records we looked at. These were unavailable to us at

the time of our visit. Staff we spoke with were unable to locate them or account for their whereabouts. We raised this as an immediate concern with managers during our inspection.

- Managers we spoke with told us that the consultant kept the reports of the ultrasound scans and the images and they would be reviewing this practice in light of our findings so that the images and reports were accessible to all relevant staff.

Assessing and responding to patient risk

- There was an admission policy for patients using the Termination of Pregnancy service, based on Royal College of Obstetricians and Gynaecologists (RCOG) guidelines. The policy set out the patient pathway from admission to after discharge, and included the written information to be provided to patients considering having a Termination of Pregnancy. This included potential risks, and what to be aware of after the procedure. The hospital telephone number was given as a contact number (24 hours a day 7 days a week) for reporting any concerns after discharge.
- All patients were asked about their medical history to assess their suitability for treatment; this included assessment of potential risk factors. If a patient was unsuitable for treatment at Spire Alexandra, for example due to an existing health condition they would be referred to another provider. We did not see evidence of any patients needing to be referred elsewhere because they were unsuitable, and staff told us they could not recall examples of when this had happened.
- Prior to termination of pregnancy patients should have a blood test to identify their rhesus status. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications, should the patient have future pregnancies, and is in line with department of health RSOPs. The records that we reviewed demonstrated that all patients underwent a blood test prior to the termination procedure and those who had a rhesus negative blood group had received an anti-D injection.
- All patients had a venous thromboembolism (VTE) assessment to determine their risk of developing a blood clot or bleeding. This is recommended by the Royal College of Obstetricians and Gynaecologists (RCOG) to reduce avoidable harm and death from VTE. Within the reporting period (July 2015 to June 2016) VTE screening rates in the hospital were equal to or above 95%.We saw completed VTE assessments in 100% of the patients' medical notes we reviewed.
- Spire Alexandra Hospital had adopted the national 'five steps to safer surgery' checklist, which was designed to prevent avoidable mistakes. All surgical termination records we reviewed contained completed checklists with the risk outcome documented.
- The hospital had clear policies in place in to manage a deteriorating patient using The Royal College of Physicians national early warning score (NEWS). NEWS is a nationally adopted system to alert clinicians of any medical deterioration and trigger a timely clinical response.
- All of the patient records we looked at showed that patients were risk assessed at the point of admission and that staff used the NEWS(to record observations, such as blood pressure, temperature, respiratory and heart rate following the termination of pregnancy procedure
- We saw that there was an on call system for anaesthetists and that any emergency situation would also be managed by the RMO and hospital resuscitation team. Due to the small size of the Termination of Pregnancy service the consultant would attend the hospital out of hours if a problem occurred with a patient.
- If a patient lived a long distance from the hospital, and their journey would be more than a couple of hours then they would be advised to stay overnight following a surgical termination. We were told this rarely happened, and if it did then the resident medical officer would be provided with the consultant details, to call if the clinical condition of the patient indicated a need to do so.
- There had been no emergency transfers to NHS services following a termination of pregnancy in the previous 18 months. The hospital had a generic policy and procedure in place for any emergency transfers and is therefore covered in more detail in the surgery core service of this report.

Nursing staffing

Requires improvement

Termination of pregnancy

- RSOP 18 : Staffing and emergency medical cover requires that providers of a Termination of Pregnancy service should ensure there is a sufficient number of staff with the right competencies, knowledge, qualifications, skills and experience to safeguard the health, safety and welfare of all who use the service and meet their routine and non-routine needs.
- Support was provided to patients, the surgeon, and anaesthetists by the executive management team, RMO, nursing staff and operating theatre department staff, allied health professionals and administrators. There were no staff appointed to solely cover termination of pregnancy services. Staffing is therefore reported in greater detail elsewhere in this report.

Medical staffing

- Patient care was consultant led. There was one specialist consultant surgeon who carried out assessments, consultations and surgical Termination of Pregnancy.
- The consultant attended the hospital on set days at set times. This meant that the department managers knew in advance when the surgeon was attending and were able to arrange sufficient staffing, including anaesthetists
- Records we looked at showed that between December 2015 and December 2016 nine anaesthetists had been involved in the administration of general anaesthesia for the termination of pregnancy services. All anaesthetists were engaged by the hospital under practising privileges.
- There was a planned rota, to ensure that the hospital had one of three resident medical officers (RMOs) available 24 hours a day. The RMOs provided advice and reviewed patients for example, for pain management. RMOs also provided urgent care if a patient required it.
- The rota meant that RMOs normally got the required amount of rest, both during the day and for an uninterrupted period during the night. This was monitored by an external agency.
- RMOs were easily contactable by staff for advice or to review a patient, for example, for pain management.

Major incident awareness and training

- We saw the Spire Healthcare Business Continuity plan which had been adapted for Spire Alexandra Hospital. The plan was in date and detailed action to take in event of a major incident such as a bomb explosion, widespread fire or flood, prolonged loss of power, heating, communications or water. Staff were aware of the plan although they told us they had not received any specific training or carried out scenarios, or had to apply it in practice.
- The plan outlined processes across the hospital and has therefore been reported in greater detail in the surgery report.

Are termination of pregnancy services effective?

Requires improvement

Evidence-based treatment and outcomes

- Termination of Pregnancy at Spire Alexandra Hospital was offered between 6 and 12 weeks, and was undertaken by vacuum aspiration; a practice which is reported by the RCOG as effective, and preferable to sharp curettage for surgical abortion under those circumstances. We saw that termination of pregnancy was by surgical methods only and there were no arrangements for medical abortion.
- The guidelines for the termination of pregnancies are published by the Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Nursing (RCN), and National Institute of Nursing. Providers must meet the requirements of The Abortion Act 1967 (as amended) and The Abortion Regulations 1991 and are required to follow all of the Department's of Health Required Operating Procedures (ROP's) for independent sector places.
- RSOP 13: Contraception and sexually transmitted infections (STI) screening states that women should be offered testing for Chlamydia (C. trachomatis) and undergo a risk assessment for other sexually transmitted infections. A system for partner notification and follow-up for referral to a sexual health service should also be in place. In all of the records we looked

at there was no documentary evidence that an offer of any STI screening by the service or elsewhere. Staff confirmed that screening for sexually transmitted infections was not offered.

- The Royal College of Obstetricians and Gynaecologists (RCOG) recommend that where possible services should provide surgical termination without resorting to general anaesthesia. General anaesthesia was the only option for patients undergoing surgical termination of pregnancy at Spire Alexandra Hospital. Staff we spoke with said that patients were made aware of this prior to admission and chose this option in all cases. This was a decision they had reached following discussion with the consultant. If the patient required surgical treatment without a general anaesthetic or medical termination of pregnancy they were referred elsewhere.
- RSOP 13: contraception recommends that Termination of Pregnancy services should be able to provide all reversible methods of contraception, including long-acting methods (LARC), immediately after abortion. Staff we spoke with told us that patients were routinely advised of the available options. Records we reviewed confirmed that this happened at the initial assessment and before the patient was discharged from hospital, and that contraception was supplied.
- Data on complications and patients returning to theatre has been reported within the surgery core service report. There were no reported complications or return to theatre in the termination of pregnancy services.
- We requested evidence of any benchmarking against department of health (DOH) statistics or reports regarding any including waiting times for treatment (RCOG recommended audits include pathways of care, information provision, pre-abortion assessment, abortion procedures and care after the abortion)and were told that these measures were not in place.
- The RCOG recommend in RSOP 14 that all women requesting an abortion should be offered the opportunity to discuss their options and choices and receive therapeutic support from a trained pregnancy counsellor. This should be offered at every stage of the pathway and patients should have access to a 24 hour trained pregnancy counsellor Patients were asked to discuss their options and choices with the consultant in the first instance and could request a referral to a trained pregnancy counsellor in an external organisation. Patients were provided with the telephone number of the external organisations.
- RSOP 16 Performance standards and audit recommends audit of outcomes. We requested data about patient outcomes. We were told that the service did not audit outcomes in relation to the termination of pregnancy service.
- There was a lack of monitoring of the quality and compliance with national policies and procedures for termination of pregnancy and a lack of management oversight of this service

Nutrition and hydration

- All of the records we looked at showed that patients had a nutritional assessment prior to admission and that a record of their nutritional and hydration risks needs and care plan was maintained.

Pain relief

- RCOG guidelines: Care of women requesting induced abortion (2011) recommend that women should be offered pain relief such as non-steroidal anti-inflammatory drugs (NSAIDs) during surgical abortion. We saw in all of the records we looked at that pre and post-procedure pain relief was prescribed and administered with good effect. However, we also saw patients were routinely provided with non-steroidal anti-inflammatory medicines, along with paracetamol and codeine where required. Staff we spoke with were unaware that prophylactic paracetamol has been reported as ineffective in reducing pain after surgical abortion and is not recommended by RCOG Guidelines ‘ Care of Women Requesting Induced Abortion (2011) .

Competent staff

- RSOP 18: Staffing and Emergency Medical Cover: states that providers should ensure there is a sufficient number of staff with the right competencies, knowledge, qualifications, skills and experience to safeguard the health, safety and welfare of all who use the service and meet their routine and non-routine needs.
- RCOG guidelines ‘Care of women requesting induced abortion guideline 6 recommends a regular audit of the

number of staff competent to provide methods of contraception and the availability of staff. We asked to see this audit report and were told that it had not taken place.

- The termination of pregnancy service was provided by a specialist surgeon who was a member of the RCOG. The consultant did not hold an NHS post and told us they did not provide a termination of pregnancy service in any other organisation. We were told the consultant had completed the revalidation process in accordance with Spire policies in the previous 12 months and had undertaken an appraisal carried out by another surgeon on a Medical Appraisal Guide Form rather than the Spire revalidation system. The appraisal documentation did not make any reference to termination of pregnancy.
- Records we looked at showed that nine anaesthetists had provided the anaesthetic service for the termination of pregnancy service between December 2015 and December 2016. All anaesthetists were engaged by the hospital by a practising privilege agreement, and were not engaged solely for the termination of pregnancy service. We have therefore reported about this aspect of medical staffing in more detail in the surgical core service section of this report. One anaesthetist we spoke with told us there was no expectation that they provided an anaesthetic service for termination of pregnancy in other organisations, or any requirement for them to demonstrate specific competencies in relation to termination of pregnancy.
- All assessments, ultrasounds and treatments in relation to termination of pregnancy service were carried out directly by the consultant who was supported by nursing staff and operating department staff.
- The Royal College of Nursing (RCN) framework for termination of pregnancy, 2013 describes training and role development requirements in relation to termination of pregnancy. This includes robust competency assessment in performing practical skills, understanding and implementation of the principles of risk management, and a thorough working knowledge of the law on termination of pregnancy.
- We asked to see evidence that this was in place for nursing staff, and none was available. We saw that assessment of competence frameworks were provided for staff to demonstrate their skill, and knowledge in other areas within the hospital, and had been successfully completed by staff. However staff told us there were none that related to gynaecological or termination of pregnancy services and that there were no systems in place to assess staff competence in this area.
- RCN guidance on the disposal of pregnancy remains, 2015 states that all those involved in caring for women should have a detailed understanding of the local operational processes that apply. Nursing staff we spoke with were unable to identify the standard operating procedures in place and told us they relied on the instruction of the consultant. Staff had not recognised the lack of adherence to the managing the disposal of pregnancy remains guidance until we brought it to their attention.
- RCN guidance on the disposal of pregnancy remains, 2015, states that there should be opportunities for all trained and qualified nursing staff engaged in disposal procedures to receive education and training that facilitates their understanding of the diversity of emotional and practical needs of women. We asked for evidence that such education and training had been provided and none was available. Managers and staff consistently told us that they learned by experience and where required, they would ask the consultant or matron for any specialist advice, however they were unable to provide examples of when this had happened.
- All staff we spoke with had successfully completed mandatory life support training appropriate to their level of responsibility. For example, we saw the RMO and five members of the operating theatre department had completed advanced life support training, all clinical staff had completed intermediate life support training and non-clinical staff basic life support training.
- Nursing and operating department staff who were responsible for supporting the consultant in the delivery of termination of pregnancy services, and staff responsible for the governance of the service told us they could not recall any initial training or continuing professional development specifically related to termination of pregnancy or The Abortion Act had been provided, or completed by any staff.

Multidisciplinary working

Termination of pregnancy

- We saw that communication with the patient's GP happened with the patient's consent.
- The RCOG recommend in RSOP 14 that all women requesting an abortion should be offered the opportunity to discuss their options and choices and receive therapeutic support from a trained pregnancy counsellor. This should be offered at every stage of the pathway and patients should have access to a 24 hour trained pregnancy counsellor. Patients were asked to discuss their options and choices with the consultant in the first instance and could request a referral to a trained pregnancy counsellor in an external organisation. Patients were provided with the telephone number of the external organisations. There was also a general hospital helpline that could be accessed 24 hours a day. Out of hours, patients could phone the ward staff for general advice and the consultant could be contacted if required.

Seven-day services

- RSOP 11: Access to timely abortion services requires that arrangements should be in place to minimise delays in women accessing services.
- The consultant who delivered the service told us that the service was flexible to meet individual patient requests, six days a week; Monday to Saturday.
- If the consultant was not available, patients were signposted to alternative locations that provided dedicated termination of pregnancy services.

Access to information

- Hospital policies were provided to enable staff to follow national guidelines. They were stored on the hospital intranet which could be accessed by all staff. The policies we viewed were all in date, with the exception of record keeping, and staff showed us how they accessed them.
- Each clinical area had a computer where staff could access examination results and view x-ray images.
- Required Standard Operating Procedure (RSOP) 3 states that, on discharge, women should be given a letter that includes sufficient information about the Termination of Pregnancy procedure to allow another practitioner to deal with any complications and on going care. In all of the records we reviewed, we saw a copy of the discharge letter was filed and that sufficient information was included.
- The hospital had its own on site pathology laboratory. This meant that results from blood tests were readily available. We saw that staff accessed these results through the hospital's electronic results system and ensured that a printed copy was added to patient records.
- Records we reviewed included discharge letters that were addressed to GPs unless patients requested otherwise. A copy of the GP's letter was given to all patients on discharge.

Consent, Mental Capacity Act and Deprivation of Liberty

- RSOP 14 Counselling and RCOG guidelines highlights that women attending an abortion service will require a discussion to determine the degree of certainty of their decision and their understanding of its implications as part of the process of gaining consent.
- All care records we reviewed contained signed consent for Termination of Pregnancy from patients. Possible side effects and complications for Termination of Pregnancy procedures were documented and the records showed that these had been fully explained.
- We saw in patient records when patients expressed any doubts about treatment, that staff discussed their concerns with them. Patients were offered a second consultation if they were not entirely sure about their decision to terminate the pregnancy, this meant there was no pressure on patients to decide to have an abortion. We saw that two patients in the last year had decided not to proceed with the Termination of Pregnancy procedure following discussion with the surgeon as part of their pre-operative consultation.
- Staff we spoke with were aware of the Mental Capacity Act and could describe the process of assessing patient's capacity. The consultant we spoke with told us they had training in relation to the Mental Capacity Act.

Are termination of pregnancy services caring?

Requires improvement

Termination of pregnancy

Not sufficient evidence to rate

There was insufficient evidence to rate caring

Compassionate care

- On the days of our inspections, there were no patients using the termination of pregnancy service at the hospital. This meant we were unable to observe care and treatment or speak with any patients or carers or partners. We have therefore been unable to rate caring.
- We requested written feedback from patients and other people, for example their partners or carers, who had used the service. We were told by managers and staff that there was no information specifically gathered or reported on for patients undergoing termination of pregnancy. Feedback is therefore reported in the surgical core service report.
- We saw information requesting feedback in waiting areas, set out in 'Please talk to us leaflets'. Managers told us that feedback was reviewed by the customer satisfaction group who produced the document "You said, we did". This reported on information gathered collectively for the whole hospital and has therefore been reported in the surgical core service report.
- Staff we spoke with told us that the hospital promoted the six C's person –centred approach to care.
- There were arrangements in place for staff to decline to participate in a termination of pregnancy on the grounds of conscientious objection, as set out in The Abortion Act 1967. We saw that a register was kept of those staff that had declined on these grounds.

Understanding and involvement of patients and those close to them

- RSOP 12: information for women states that women must be given impartial, accurate and evidence based information delivered neutrally. Staff we spoke with told us that this was the approach the provider encouraged and was applied by staff.Staff spoke respectfully of the women using the service.
- Staff provided written information to patients to make them aware that the contents of the HSA4 form is used to inform the Chief Medical Officer of termination of pregnancy and is used for statistical purposes by the Department of Health.
- We were told that, patients were accompanied by those close to them if preferred.
- NICE QS 15 statement 4 states that patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care. Staff told us this was part of the patient pathway. In the records we looked at we saw this was the case.
- NICE QS 15 statement 5 recommends that patients are supported by healthcare professionals to understand relevant treatment options, including benefits risks and potential consequences. We saw that the options, benefits and risks formed part of the consent process, and were documented in patient records.

Emotional support

- RCOG guidelines set out that clinicians caring for women requesting abortion should be able to identify those who require more support than can be provided in the routine abortion setting, for example women with a pre-existing mental health condition.
- Staff and managers we spoke with told us that emotional support would be provided by the consultant surgeon. However, in all of the records we looked at we saw no documentary evidence of any assessment of the patients' emotional needs or referral to services providing such support. This was consistent with an audit of 15 sets of patient notes undertaken in November 2016. It was reported that in seven out of 15 notes there was no documentation that the patient was offered counselling. There was no evidence that any corrective action had been put in place to address this.

Are termination of pregnancy services responsive?

Requires improvement

Meeting the needs of local people and individuals

Termination of pregnancy

- The service was available to self-funding patients over the age of 18 years old. Patients requiring termination of pregnancy of a later gestation or by medication, or by local anaesthetic or conscious sedation would be referred to another provider. Patients below 18years of age would also be referred to another provider. One consultant doctor (specialist in obstetrics and gynaecology) held practising privileges for this service which was normally offered Monday to Saturday.
- Referrals were received via the hospital's self – funding hotline from patients seeking a personal service up to 12 week's gestation. If a patient presented with a gestation of later than 12 weeks, they were signposted to alternative local providers.
- Staff told us that all surgical terminations of pregnancy treatments were provided as planned day cases unless a patient chose to remain overnight.
- RSOP 15: disposal of pregnancy remains states that all providers should have policies on disposal of pregnancy remains, and that information about disposal should be available for women setting out their choices. In all of the patient notes we reviewed the surgeon had documented that information on available options of disposal of pregnancy remains was discussed as part of the consent process. However, the HTA national guidance is that whatever the woman decides, including whether she declined the offer of information and chose not to be involved in the decision, this should be recorded in the woman's medical notes. There was no record of what had been discussed, and did not provide a record of the patient's expressed wishes.
- Spire standard operating procedures required that it should be recorded in the medical notes whether information about the options for disposal of pregnancy remains was given and what the woman's decision was.
- We spoke with operating department staff, nurses from the inpatient service and pathology laboratory staff who cared for patients undergoing Termination of Pregnancy. None of the staff we spoke with, other than managers, knew where to locate the standards for termination of pregnancy and disposal of pregnancy remains. They told us they relied on the verbal instructions of the consultant in all aspects of service delivery.
- The disposal of pregnancy remains was not consistent with the hospital's policy or national guidance.

• Managers told us that minimum standards for the correct disposal of pregnancy remains were set out in standard operating procedures issued by Spire. We saw the guidance was last reviewed in July 2016 and included arrangements for the appropriate respectful disposal of the pregnancy loss, and related quality control procedures. None of the nursing or operating department staff we spoke with knew where to locate the policy, or had a correct understanding of their responsibilities. They told us that due to the size of the service they did not need to refer to the policy and followed the verbal instructions of the surgeon.

• We saw appropriate facilities for the storage of pregnancy remains in the pathology laboratory. Staff told us that when specimens were sent to the pathology laboratory the specimens would be kept for six weeks as per guidance and policy and that the remains would then be sent to the crematorium for appropriate disposal. We asked to see records of these transactions and saw that the last record of pregnancy remains received in pathology, stored for six weeks and sent to the crematorium was in 2011. When asked what had happened to pregnancy remains since that date we were told that the pathology laboratory had not received any. Staff we spoke with told us that pregnancy remains were not stored or labelled in accordance with the policy, and that the remains were not sent to the pathology laboratory unless there was a need to identify any unusual pathology and aid diagnosis. This meant that there was no cooling off period for the patient to change their mind about the arrangements for cremation. This is in direct contradiction to guidance and requirements.

The HTA recommends that disposal of the pregnancy remains takes place as soon as is practicable after the woman has communicated her decision but also makes clear that women who need more time to make a decision are given this opportunity, and that service providers communicate clearly to the woman the time frames in which a decision has to be made, after which the provider will dispose of the pregnancy remains by a specified method. The service did not meet with this guidance as they disposed of the remains with general clinical waste in theatres.

Requires improvement

Termination of pregnancy

- Arrangements for patients living with a learning disability, poor social support or complex needs were not specifically set out for the termination of pregnancy service but were hospital wide and have therefore been reported elsewhere in this report.
- Information was displayed in reception areas detailing availability of chaperones, potential additional charges, availability of translation and services for patients with a hearing impairment, providing feedback about the patient experience, information on insurance policies and what to do if you had been waiting more than 15 minutes for your appointment.
- Patients seeking abortion for foetal abnormality would be referred to a specialist service.
- **Access and flow**
- Services included pregnancy testing, surgical termination of pregnancy for patients who have a general anaesthetic and who have a gestational date of between six and 12 weeks, after care, contraceptive advice and contraception supply. Twenty surgical termination of pregnancy procedures were carried out between July 2015 and November 2016.
- Patients accessed the service by self-referral or by referral from their general practitioner.
- Department of health guidance states that women should be offered an appointment within five days of referral or self-referral. We saw that all patients had been able to access an appointment within five working days of referral or self-referral.
- We saw in the records we looked at that all patients were discharged from the service in a timely manner with no evidence of any delays.

Learning from concerns and complaints

- The Spire Healthcare corporate complaints policy set out the process of complaints and time scales for responses We saw the process for raising concerns and complaints was displayed throughout the hospital and that Please Talk to Us leaflets setting out the concerns and complaints processes were readily available.
- The hospital matron was responsible for overseeing all complaints responses and escalating unresolved or complex complaints to the corporate complaints management team where required. Complaints would be managed locally wherever possible.
- All complaints were reviewed by the clinical governance committee and medical advisory committee (MAC).
- An annual report of complaints was published as part of the hospital annual governance report. None of the complaints during that period related to the termination of pregnancy service. However, staff we spoke with told us they were aware of the complaints process, and correctly described how they would be expected to respond to complaints.

Are termination of pregnancy services well-led?

Inadequate

Leadership / culture of service

- We saw the licence for termination of pregnancy issued by the Department of Health displayed in a prominent position in the main hospital reception.
- Managers told us that the arrangements for the nursing leadership and governance of the service had changed in February 2016. The operational nursing service was overseen daily by the matron and head of clinical and non-clinical services who reported directly to the hospital director.
- Staff told us that there was generally a good culture within the hospital and staff were all supportive of each other within their daily roles. Staff told us they felt it was important to provide safe and effective care to patients at all times.
- Staff told us there was no facility for the separate storage of pregnancy remains in the operating department.
- On investigation we found that, in theatres since that date pregnancy remains had been disposed of with clinical waste. We brought this to the immediate attention of the executive management team.

- The Termination of Pregnancy service was suspended by the executive team subject to an internal investigation.

Vision and strategy

- Spire Alexandra had a clear vision and strategy in place. The hospitals values were shared across all services and have been reported elsewhere in this report. However, there was no specific strategy in place for the termination of pregnancy services. Staff we spoke with could not recall being asked to contribute to any discussion about developing a strategy.
- Staff we spoke with were aware of the organisation's values and strategy, and were committed to providing a quality service. RSOP 26 states that it is the responsibility of providers to develop good clinical practice within their local setting, reflecting evidence-based guidelines from relevant professional bodies However; the termination of pregnancy service did not always reflect evidence based practice.

Governance, risk management and quality measurement for this core service

- The hospital clinical governance committee met quarterly. This committee had an overview of governance risk and quality issues for all departments. Senior department leads attended. Information discussed included safety alerts, learning from incidents, policy updates and audits. However, we looked at minutes of clinical governance meetings within the reporting period and the subsequent six months and could not see any evidence that items relating to termination of pregnancy services had been discussed. Staff we spoke with confirmed there had been no such discussion and told us doctors and nurses delivering the termination of pregnancy service did not attend the clinical governance meeting. We were not assured that there were effective governance systems in place for the Termination of pregnancy service.
- There was a lack of monitoring of the quality and compliance with national policies and procedures, lack of management oversight of this service and lack of oversight of ensuring staff are competent to deliver this service.
- The operational nursing service was overseen daily by the matron / head of clinical and non-clinical services who reported directly to the hospital director. Monitoring of patient outcomes was carried out by the clinical governance manager who was not directly involved in the service delivery. We found no evidence that outcomes for the TOP service were adequately monitored. An audit of 15 sets of patient notes was undertaken in November 2016. It was reported that in seven out of 15 notes there was no documentation that the patient was offered counselling. There was no evidence that any corrective action had been put in place to address this.
- The service had arrangements in place to ensure that conscientious objection (set out as a clause in the Abortion Act) was managed appropriately and in line with professional guidelines. A list of practitioners who has stated their conscientious objection was centrally held, and staff knew where to locate this.
- The disposal of pregnancy remains was not consistent with the hospital's policy or national guidance.
- Minimum standards for the correct disposal of pregnancy remains were set out in standard operating procedures issued by Spire. We saw the guidance was last reviewed in July 2016 and included arrangements for the appropriate respectful disposal of the pregnancy loss, and related quality control procedures. The nursing and theatre operating department staff we spoke with did not know where to locate the policy, or demonstrated a correct understanding of their responsibilities. They told us that due to the size of the service they did not need to refer to the policy and followed the verbal instructions of the surgeon.
- There were appropriate facilities for the storage of pregnancy remains in the pathology laboratory. Staff told us they received remains of a pregnancy these were kept for six weeks in accordance with the hospital's guidance and policy and the remains were then be sent to the crematorium for appropriate disposal. We asked to see records of these transactions and saw that the last record of pregnancy remains received in pathology, stored for six weeks and sent to the crematorium was in 2011. Pathology staff told us that they had not received any pregnancy remains since that date. Staff we spoke with told us that pregnancy remains were not stored or labelled in accordance with the policy, and that the remains were not sent to the pathology laboratory unless there was a need to identify any

unusual pathology and aid diagnosis. This is a direct contradiction to the guidance and requirements. We found no evidence that this had been identified as a breach of requirements and hospital policy.

- The Spire standard operating procedures stated that the responsibility for maintaining a record of the disposal of pregnancy remains rests with the hospital and that the record should be retained for a minimum of 30 years. We asked to see this as part of our inspection and it was not available.

  • Spire standard operating procedures stated that the provider should self-assess and monitor compliance with the guidance for the disposal of pregnancy remains through regular audit of relevant policies, procedures and women's medical records. We asked to see evidence that this had taken place and none was available.

- Staff and managers we spoke with told us there was no system in place to monitor compliance with the guidance. The provider had not identified that they were not following the guidance in relation to the disposal of pregnancy remains until this was bought to their attention by the CQC inspectors.
- For every termination of pregnancy procedure the Department of Health requires all providers to submit details of the termination of pregnancy using an HSA4 form, within 14 days. This process had recently been audited by the hospital and we saw three out of 15 patient notes had been reported as no HSA4 form being completed and sent between July 2015 and June 2016. We looked at ten patient notes and saw that one file did not contain evidence that the HSA4 form had been completed and sent to the Department of Health. This is not compliant with the Abortion Regulations 1991 which states that the Chief Medical Officer must be sent the HSA4 within 14 days of the abortion taking place.
- Managers told us that the arrangements for the governance of the Termination of Pregnancy service had changed in February 2016 and were implemented in September 2016.Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met for the termination to be lawful'.
- All HSA1 forms we reviewed contained two signatures. One from the consultant surgeon and one from another doctor (a second consultant obstetrician and gynaecologist or the patient's GP). The signatures were evident in all of the records we looked at. A copy of the HSA1 form was filed in the patient's medical record, which is considered best practice by the Department of Health Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy (Abortion) required standard operating procedures (RSOP).
- The Care Quality Commission (Registration) Regulations 2009 state that the registered person must maintain a register of patients undergoing termination of pregnancy. This register must be: completed in respect of each patient at the time the termination is undertaken; and retained for a period of not less than three years. A requirement of the Abortion Regulations 1991 also states that the HSA1 be retained in the patients' records for three years. We saw the register was kept securely in the operating theatre department and was completed and retained correctly.
- Staff told us that a clinical audit plan for the termination of pregnancy service was introduced in February 2016 and implemented in November 2016. Audits carried out by the service included completion of HSA1 and HSA4 forms.
- The organisation had a corporate risk register which included various areas of risk identified, such as health and safety, clinical incidents and infection control. We could not see any risks relating specifically to termination of pregnancy services. Staff confirmed that none had been reported and that there was no separate risk register for the termination of pregnancy services.
- National guidance produced by the Human Tissue Authority (HTA) 2015 makes provision for three options of disposal – burial, cremation or incineration, with an emphasis on the woman's choice. RCN guidance on the disposal of pregnancy remains states that in the case of disposal by incineration the HTA (2015) identifies the need for pregnancy remains to be subject to a different

disposal process from general clinical waste. The HTA recommend that prior to disposal the remains should be packaged and stored separately from other clinical waste, before being incinerated separately from other clinical waste We found evidence that the hospital was not compliant with this guidance.

Public and staff engagement

- All approved Termination of Pregnancy providers should have systems in place to undertake post-care patient satisfaction surveys and feedback aimed at identifying the patient's experience of the service.
- We asked for evidence that this had been carried out and monitored, and were told that the hospital survey showed that 99.6% of patients said their care was good, very good, or excellent. Staff were unable to confirm how many of the respondents to the survey had used the termination of pregnancy services.
- There were a number of methods of communicating with staff, including a newsletter emails and team meetings as well as information on computer screen savers and the hospital intranet.
- There was a hospital wide staff forum which met quarterly. Staff told us this helped keep them motivated and well informed of changes and news across the hospital.
- Public and staff engagement was part of the hospital wide system and has therefore been reported elsewhere in this report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must act in accordance with local and national guidance on the management of disposal of pregnancy remains. This includes consent, record keeping and governance.
- The provider must ensure that all HSA4 forms are completed and sent to the Department of Health within 14 days of the abortion taking place.
- The provider must ensure that patient records including ultrasound images and reports are accessible to all relevant staff.
- The provider must provide systems for robust competency assessment of staff in performing practical skills, understanding and implementation of the principles of risk management, and a thorough working knowledge of the law on termination of pregnancy
- The provider must monitor progress against plans to improve the quality and safety of services, and take appropriate action immediately where progress is not achieved as expected. In particular, continued staff non-compliance to policies and procedures, action plans following audit and ongoing review of the hospital's risk register.
- The provider must ensure staff follow policies and procedures about managing medicines, including controlled drugs.

Action the provider SHOULD take to improve

- The provider should have systems in place to undertake post-care patient satisfaction surveys and feedback aimed at identifying the patient's experience of the TOP service.
- The provider should ensure clear segregation of clean and dirty equipment and waste and equipment.
- The provider should ensure that national guidance for sexually transmitted screening processes and risk assessments for women undergoing TOP is adhered to.
- The provider should ensure national guidance for domestic abuse is followed.
- The provider should ensure there is documentation that patients using the termination of pregnancy service are offered counselling.
- The provider should ensure that patient outcomes are monitored and reported upon in accordance with national TOP guidance.
- The provider should ensure availability of dedicated hand hygiene sinks in patient bedrooms and the removal of carpets from clinical areas are included when carrying out refurbishment in accordance with the Department of Health's Health Building Note 00-09.
- The provider should consider to continue progress towards Joint Advisory Group (JAG) accreditation for endoscopy services.
- The provider should consider additional training for all staff to ensure understanding of safeguarding vulnerable adults and female genital mutation.
- The provider should ensure staff follow manufacturer's guidance on cleaning of medical devices and all medical devices are safety tested, maintained and calibrated regularly.
- The provider should ensure staff complete and record the anaesthetic equipment safety check before each theatre list.
- The provider should ensure the contents in patient information leaflets are standardised.
- The provider should ensure all agency staff receive corporate and local inductions and records are fully completed.
- The provider should ensure sufficient signage within theatres to indicate clean and dirty areas.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The must be systems for robust competency assessment of staff in performing practical skills, and understanding and implementation of the principles of risk management, The proper and safe management of medicines. Staff must follow policies and procedures about managing medicines, including controlled drugs. Regulation 12 (1)(2)(g)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. The provider must monitor progress against plans to improve the quality and safety of services, and take appropriate action immediately where progress is not achieved as expected. Regulation 17(1)(2)(a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Termination of pregnancies	Regulation 17 HSCA (RA) Regulations 2014 Good governance Good Governance1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to— a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;d. maintain securely such other records as are necessary to be kept in relation to— i. persons employed in the carrying on of the regulated activity, andii. the management of the regulated activity;e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).