Spire South Bank 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?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced, comprehensive inspection visit on 17 and 18 August 2016 and an unannounced inspection on 26 August 2016.

Overall we rated the hospital required improvement, although surgical services were good.

Are services safe at this hospital/service?

Incidents were reported and dealt with appropriately and outcomes with learning were cascaded to staff. However, the tool used for undertaking root cause analysis, was not fit for purpose. Some root cause analysis were not completed thoroughly. The ward and theatres were visibly clean and well equipped. Fluid balance charts were not always completed. Nursing and surgical staffing was suitable for patients' needs and staff had undergone appropriate training, in adult care, but not for the care of children and young people. A resident medical officer was present 24 hours a day, seven days a week, to provide medical care. Consultants were on call 24 hours a day for their patients. The lead for safeguarding was the matron, who had undergone level 3 training. However, other staff dealing with children and young people did not have the required level of safeguarding training. Some staff were aware of how to escalate safeguarding concerns outside the hospital.

Are services effective at this hospital/service?

The endoscopy suite was Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited. Policies and practice were evidence based and followed national guidance. Pain levels were assessed and managed appropriately. Patients' nutrition needs were met following surgery and the service was improving in its performance in fasting patients prior to surgery. Arrangements were in place to ensure that consultants were competent to perform surgical procedures. There were arrangements in place to obtain medications out of hours. Not all staff had a clear understanding of mental capacity and how to assess a patient's capacity to consent to treatment.

Are services caring at this hospital/service?

Patients were treated with compassion, with their dignity and respect upheld. Patients felt well cared for and would recommend the service to others. Staff respected patient confidentiality. Patients understood their care and treatment and had opportunities to ask questions. Staff had access to contact details for religious leaders, to help meet patients' spiritual needs.

Are services responsive at this hospital/service?

Flexible appointments and surgery times were available to patients. When operations had to be cancelled, they were always rescheduled within 28 days. All patients aged over 75 years were screened for dementia. Any patients identified as living with dementia followed a dementia care pathway. Staff had an awareness of dementia and had received training in this. The hospital had hearing loops and access to interpreters for patients for whom English was not their first language. Catering staff were aware of religious and cultural preferences for food and catered for these accordingly. There was evidence of changes to practice as a result of patient complaints and feedback.

Are services well led at this hospital/service?

The hospital had a clear governance structure and framework, which was driven by their corporate body, Spire Healthcare Ltd. Audit results were discussed at governance meetings, with findings cascaded to staff through team meetings and via email. There was no oversight of risk with regards to children and young people. The risk register

Summary of findings

contained mostly corporate risks and there were no dates when the risk was added or target dates for completion. A business plan had been developed, although this lacked strategic direction and was not supported by clear objectives and milestones. Leaders were visible and approachable, with the hospital director and matron visiting the ward and theatres daily. Staff felt respected and valued and described the staff within the service as 'like family'.

Our key findings were as follows:

- The hospital was clean and well equipped
- Staffing levels were appropriate; staff were registered with the appropriate professional body and were well trained.
- The lead infection prevention and control nurse did not have a specialised infection prevention and control qualification.
- There was an effective practising privileges procedure in place, supported by the Medical Advisory Committee (MAC,) which ensured that surgeons were fit to practise.
- Children under the age of 18 years were treated at the hospital. Numbers were very low and the hospital did not have the infrastructure to effectively support this service. Therefore it was withdrawn shortly after our inspection.
- Patients and relatives said that staff were kind and took time to explain things to them.
- There was excellent multidisciplinary team working, this included care to patients with cancer.
- There were processes in place to ensure that patients were safe, however, the hospital's risk register was not reflective of some of the key risks.

However, there were also areas of where the provider needs to make improvements.

Importantly, the provider should:

- Comply with Healthcare associated infection (HCAI): operational guidance and standards, (July 2012,) Health Building Note (HBN) 00-10 Part A: Flooring and HBN 00-10, in all clinical areas.
- The flooring and coving in patient bedrooms should be considered for refurbishment as part of a plan, to ensure compliance with current infection control guidelines.
- Review the requirement for clinical hand wash basins in patients' bedrooms.
- Ensure the infection prevention and control lead has a specialised infection prevention and control qualification to enhance their knowledge.
- All NEWS charts should have clear evidence of regular observations, according to the patient's condition and the type of surgery undertaken.
- Ensure there is a nursing presence in the 'Garden Suite' so that patients who may be deteriorating can be identified quickly.
- Clinical staff should have a system of formal clinical supervision.
- Review the Spire tool used for root cause analysis and ensure all root cause analysis are completed thoroughly and in a consistent manner.
- All staff should have a clear understanding of mental capacity and how to assess a patient's ability to consent to treatment.
- Ensure the risk register is updated to include the date the risk was identified, why the risk has been included, the date of review, appropriate controls to mitigate the risk.
- The hospital should continue working towards improving its performance in discharging patients before 11am as part of Spire's clinical scorecard.
- Staff should be confident in making safeguarding referrals outside of the organisation.
- A hearing loop should be available in the main outpatient area.

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	Overall, we rated the surgical services as good for effective, caring, responsive and well-led. Safety required improvement. Incidents were reported and dealt with appropriately and outcomes with learning were cascaded to staff. Some root cause analyses had not been completed thoroughly. Not all staff had been trained to the right level of safeguarding to care for young people. However, this service was withdrawn after our inspection. We observed that the day unit, although had a nurse call system, did not always have nurses in sight or earshot of patients. The person who was responsible for leading on infection and prevention control in the hospital, had no nationally recognisable, specialist qualification to undertake this role. Fluid balance charts were not always completed thoroughly. The ward and theatres were visibly clean and well equipped. Nursing and surgical staffing was suitable for patients' needs and staff had undergone appropriate training, except with regards to the care of young people Patients were assessed, operated on and cared for in line with professional guidance and corporate policies. Pain was assessed and managed well. Nutrition and hydration needs were met, although fluid balance charts were not always completed adequately. Performance on pre-operative fasting had improved. Patient outcomes were monitored through regular national and local audits and performance was fed back to staff. Staff provided compassionate care to patients and ensured they had a positive experience. Patients were treated with dignity and respect and confidentiality was maintained.

Summary of findings

Patients were offered flexible appointments and found the booking system easy to use.
Performance with regards to discharging patients within appropriate time frames had improved.
Information about the complaints procedure was available for patients and relatives.
A business plan had been developed, although this lacked strategic direction and was not supported by clear objectives and milestones.
There was a clear governance structure and framework.
Leaders were visible and approachable and staff felt valued by them.
Leaders were responsive to immediate risks, but the risk register was incomplete.
The service used new technologies to improve and innovate the way they treated patients.

Outpatients and diagnostic imaging

We rated outpatients and diagnostic imaging services as requires improvement for safety and well-led and good for caring and responsive. CQC does not have the methodology to rate the effective domain.
Not all staff were trained to the right level of safeguarding. In addition, staff who were trained to the right level, were not necessarily scheduled to work when there were children in the hospital.
Most of the staff were unclear of the procedure to report safeguarding concerns externally and told us that they would refer concerns to their line manager and/or matron.

Requires improvement 

Suitable arrangements were not in place to ensure advice could be obtained from a registered nurse (child branch) when children attended for appointments. However, we raised this with the hospital director who agreed to cease treating children with immediate effect.
Patient records maintained by the imaging department were not always legible. Records in the main outpatient department (OPD) area were not always stored securely although these were in private consulting rooms rather than in public areas
Conversations about patients between staff could be overheard by other patients.
There were no formal supervision arrangements in place.

Summary of findings

There was no hearing loop in main outpatients.
The hospital had a clear vision and this was displayed throughout the hospital, on all desktops and formed part of the annual enabling excellence programme. Despite this not all staff were aware of it.
A business plan had been developed although this lacked strategic direction and was not supported by clear objectives and milestones.
Outpatient meetings were not held regularly and there was no discussion around performance of the department.
Outpatient performance was not discussed at the Clinical Governance Committee.
The risk register was not used to identify and record local risks faced by the hospital.
Care and treatment was delivered in line with evidence-based guidance.
Patients' nutritional and hydration needs were met.
Patients' pain levels were assessed and managed according to their need.
Information about the outcomes of patient care and treatment was routinely monitored.
Staff had the right qualifications, skills and knowledge to do their job.
Multidisciplinary team (MDT) working practices were in place.
Information about patients and clinical guidance was available to staff and provided in a timely manner.
Staff had an understanding of the relevant consent and decision making requirements of legislation.
Staff understood people's needs and provided compassionate care.
Clinical staff communicated well with patients so that they understood their care and treatment options.
Staff understood the impact of treatment for patients and those close to them and took the time to listen to their concerns.
Services were planned and delivered in a way that met the needs of the local population and flexibility was reflected across each of the outpatient services.
Care and treatment was accessible at the patients' convenience.

Summary of findings

‘One-stop’ clinics for some specialities were available so patients could undergo tests and a consultation within the same appointment to minimise patient attendances.
98% of NHS patients were seen by a consultant within 18 weeks of their initial referral. Private patients were seen very rapidly.
The services had processes in place to manage patients with complex needs, including those with a learning disability.
Information on complaints or how to raise a concern was available to patients. Complaints and concerns were responded to in line with the complaints policy.
Each area of outpatients was overseen by a head of department, with exception of the breast unit, radiology staff reported to the imaging head of department and nursing staff reported to the outpatients’ head of department.
The views of staff and patient views and experiences were gathered and action plans developed to improve the service.

Summary of findings

Contents

Requires improvement

Spire South Bank Hospital

Services we looked at
Surgery, Outpatients and Diagnostic Imaging.

Summary of this inspection

Background to Spire South Bank Hospital

Spire South Bank is a private hospital in the center of Worcester. The building was originally established as a nursing home but was developed and re-opened as a hospital in 1986.

The registered manager has been in post since March 2016.

The hospital provides outpatient services and surgical procedures, to both adults and children. However, the hospital ceased offering services for children and young people in August 2016, immediately following our inspection.

The operating facilities at the hospital include two laminar flow theatres, one laparoscopic theatre and an endoscopy suite. There are two main inpatient wards and a day case suite, with 25 beds in total.

The outpatient department is comprised of 10 consultation rooms and three treatment rooms. There are also separate units for oncology and haematology, the Spire Eye Centre (SEC), a breast unit and a bone and joint clinic. The hospital provides imaging and physiotherapy, in addition to a pharmacy department providing services for both inpatients and outpatients.

There are two satellite outpatient clinics, one in Cheltenham, the other in Droitwich. They are not open every day. Each clinic has a unit manager who report to Spire South Bank's hospital director. We did not visit these clinics as part of our inspection.

The hospital is managed by Spire Healthcare and is part of a network of over 35 hospitals. The hospital provides care for private patients who are funded by their insurance companies or are self-paying. Patients funded by the NHS, mostly through the NHS referral system, can also be treated at Spire South Bank Hospital.

Our inspection team

Our inspection team was led by:

Inspection Lead: Kim Handel, Inspection Manager, Care Quality Commission

The team of 10 included CQC inspectors and a variety of specialists: outpatients nurse, surgery nurse and remotely, a chemotherapy nurse specialist.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection visit on 17 and 18 August 2016 and an unannounced inspection on 26 August 2016. We spoke with a range of staff in the hospital, including nurses, allied health professionals, support staff and consultants. During our inspection we reviewed services provided by Spire South Bank Hospital in the ward areas, operating theatres, outpatients, pharmacy and imaging departments.

During our inspection we spoke with nine patients and 48 staff, including consultants, who are not directly employed by the hospital. In addition, we spoke with two family members/carers from all areas of the hospital, including the wards, operating theatre and the outpatient department. We observed how people were being cared for and reviewed personal care or treatment records of patients.

To get to the heart of people who use services experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Summary of this inspection

Information about Spire South Bank Hospital

Spire South Bank provides inpatient and outpatient services for various specialities to both private and NHS patients. This includes, but is not limited to, orthopaedics, general surgery, ophthalmology, gynaecology and diagnostic imaging.

The hospital has 25 beds. The inpatient wards have 20 beds, some in single rooms and others in small bays. There are five further beds in the day case unit, the Garden Suite. There are three theatres: one laparoscopic theatre and two with laminar flow. The hospital also has 10 consultation rooms, an endoscopy suite and two 'pods' with reclining chairs, which are used to treat patients undergoing outpatient chemotherapy.

There were 5,633 inpatient episodes at Spire South Bank Hospital between April 2015 and March 2016. Of these, 4,533 were day cases 80%, and 1,100 stayed one or more nights in the hospital. In total, there were 5,302 visits to theatre between April 2015 and March 2016.

In the outpatients department, 39,013 people were seen between April 2015 and March 2016. Of these, 760 were children.

Between April 2015 and March 2016, around 55% of the patients having day or inpatient treatment were funded by the NHS; the remaining patients were self-funding or paid for by their insurance companies. In outpatients, around 32% of patients were funded by the NHS, with the rest being paid for by other means.

There are 184 doctors who have practising privileges at Spire South Bank and their individual activity is monitored. In addition, there is a whole time equivalent of 129 staff employed.

Spire South Bank Hospital has the following accreditations:

- Joint Advisory Group Accreditation for the endoscopy suite
- European Accreditation for the sterile services department

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day by an onsite resident medical officer. Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital.

The hospital's accountable officer for controlled drugs is the hospital director, who was appointed in May 2016.

Spire South Bank was last inspected by the Care Quality Commission in February 2014. There are no outstanding non-compliances.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Good

Surgery

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

Information about the service

Spire South Bank Hospital provides surgical services for various specialities to both private and NHS patients. Until August 2016, the hospital cared for adults and young people over 16 years of age. However, the hospital ceased operating on young people age 16-18 years in August 2016 and now operates on adults only.

There are two main inpatient wards and a day case suite, with 25 beds in total. The hospital is registered for 41 beds.

The service provides, but not limited to; orthopaedic, urology, gynaecology, urology, cosmetic and general surgery to inpatients and day patients over the age of 18 years. From April 2015 to March 2016 there were 5,302 visits to theatre. The three most commonly performed surgical procedures are phacoemulsification of lens (cataract extraction) with implant (494), multiple arthroscopic operations on knee (122) and intravitreal injection (110).

The hospital has two laminar flow theatres (where air is moved at the same speed and in the same direction, to avoid contamination), one laparoscopic (keyhole) theatre and a Joint Advisory Group (JAG) accredited endoscopy suite. The endoscopy suite has two consulting rooms, an endoscopic treatment room and a two stage recovery area.

We carried out an announced inspected on 17 and 18 August 2016 and an unannounced visit on 26 August 2016. We visited the preadmission clinic, theatres, the anaesthetic rooms, recovery, the ward and the Garden Suite, for day case patients. We also visited the endoscopy suite.

We spoke with five patients, 25 staff members and reviewed 11 medical records and four medicine charts.

Summary of findings

Overall, we rated the surgical services as good for effective, caring, responsive and well-led. Safety required improvement.

- Incidents were reported and dealt with appropriately and outcomes with learning were cascaded to staff. However, root cause analysis of serious incidents, were not always robust.
- The ward and theatres were visibly clean and well equipped.
- Nursing and surgical staffing was suitable for patients' needs and staff had undergone appropriate training, except none had the correct level of safeguarding to care for young people undergoing surgery
- Patients were assessed, operated on and cared for in line with professional guidance and corporate policies.
- Pain was assessed and managed well.
- Nutrition and hydration needs were met and performance on pre-operative fasting had improved.
- Fluid balance charts were not always completed thoroughly.
- Patient outcomes were monitored through regular national and local audits and performance was fed back to staff.
- Staff provided compassionate care to patients and ensured they had a positive experience.
- Patients were treated with dignity and respect and confidentiality was maintained.
- Patients were offered flexible appointments and found the booking system easy to use.

Good

Surgery

- Performance with regards to discharging patients within appropriate time frames had improved.
- Information about the complaints procedure was available for patients and relatives.
- A business plan had been developed, although this lacked strategic direction and was not supported by clear objectives and milestones.
- There was a clear governance structure and framework.
- Leaders were visible and approachable and staff felt valued by them.
- The service used new technologies to improve and innovate the way they treated patients.

Are surgery services safe?

Requires improvement

Overall, we rated surgical services as requires improvement for safety because:

- Not all staff caring for young people under 18 years had safeguarding level three training, which is a requirement. However, the hospital took immediate action and stopped treating and admitting patients under 18 years old.
- Root cause analyses were not always completed thoroughly.
- National Early Warning Score (NEWS) charts were not always completed adequately.
- We visited the day unit (The Garden Suite) six times and did not see any nurses. A deteriorating patient may not have been identified promptly.
- The person who was responsible for leading on infection and prevention control in the hospital, had no nationally recognised qualification to undertake this role.
- There had been a review of fluid balance charts following an incident. We found though, that six out of eleven charts that we looked at had not been completed thoroughly.
- The flooring and coving in patient bedrooms was not compliant with infection control guidelines.
- There were no clinical hand wash basins within patients' bedrooms, which is not compliant with infection control guidelines.
- Patients who were healthcare workers and at a higher risk of MRSA colonisation, were not identified at preadmission.

However, we also found that:

- Staff understood their responsibilities to raise concerns and safety incidents and reported them accordingly.
- Staff followed the World Health Organisation, 5 steps to safer surgery surgical safety checklist.
- The duty of candour (to be open and honest) had been implemented and it was well embedded within the service.

- The service had procedures in place to report pressure ulcers, falls, catheter acquired urinary tract infections and venous thromboembolisms (blood clots). Action was being taken to ensure harm free care.
- Staff adhered to infection prevention and control measures, equipment was cleaned regularly and endoscopes were cleaned in accordance with guidelines.
- There was sufficient equipment to ensure safe patient care, all equipment was recorded and tracked in line with guidance and details of implants and prostheses used in surgeries were recorded appropriately.
- Medications were stored appropriately on the ward. During our inspection we found that medications were not always stored securely in the anaesthetic rooms whilst surgery was being performed. Whilst this was not in breach of national guidelines, the senior staff were asked to implement a risk assessment for this practice, which was completed immediately.
- Records were completed appropriately, with a clear understanding of the surgical plan. The records were also stored securely within a locked room.
- Staff assessed risk at preoperative assessment well, completing the necessary risk assessment forms.
- Staff were able to recognise and respond to a deteriorating patient.
- Staffing levels were appropriate and shifts were filled with very limited use of bank or agency staff.
- Surgical staffing was appropriate, with a registered medical officer on duty 24 hours a day.
- Patient care was consultant led and consultants reviewed patients regularly following surgery.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally. The hospital had an adverse event and near miss reporting policy which stated that all incidents and near misses should be reported on the hospital's electronic incident reporting system.
- There was an electronic incident reporting system in place to record incidents and near misses and all staff had individual access to the system. Staff were comfortable with using the reporting system and gave examples of incidents and near misses that they had raised. Safety goals had been set and performance against them was monitored.
- The hospital used the Spire clinical scorecard key performance indicators to set goals and targets. Reports showing the service's performance against these performance indicators were reported every quarter. We reviewed the report for the first quarter of 2016 and saw that, out of 35 key performance indicators, (KPIs) the hospital met or exceeded their targets for 23 performance indicators, such as recording patients' temperatures in theatre and recovery. They did not meet their target for eight performance indicators, for example, discharging inpatients by 11am. In quarter two, we saw this had improved and 29 KPIs had been met or performance exceeded targets.
- The hospital had reported 250 clinical incidents between April 2015 to March 2016, of which 170 (68%) happened within the ward and operating theatre. There had been no never events, no inpatient deaths and no serious injuries from April 2015 to March 2016. A never event is a serious incident that is 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 type 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.
- When things went wrong, investigations were carried out. The hospital graded incidents into levels one, two or three due to the level of harm. The first two levels were investigated locally while level three events were investigated by an independent investigator. These were not always thorough and robust particularly with regards to some serious incidents that we considered during the inspection. Not all relevant staff and patients were involved in the investigation.
- Root cause analysis (RCA) reports were produced to identify the reason for the incident occurring and any learning points from the practice that led to the incident. We reviewed the four root cause analysis reports within surgery, from incidents in October 2015 and April 2016 and found that these had not been completed thoroughly. The first incident involved a deep surgical infection, where the patient required subsequent multiple surgeries, most of which took place in another hospital. Although the report stated that the microbiologist's view was that the cause was inconclusive in that the infection could have arisen from

a joint or could have tracked inwards from the skin, there was no consideration given to the theatre environment, staff members, or their scrub competencies. The only recommendation was that notes from another hospital should have been sourced earlier. In another RCA, which involved an abdominal wound infection, presenting the night after surgery, the cause appeared to be dismissed as being possibly caused from umbilical flora migrating into the abdomen or residual bile from the gall bladder. This patient had required admission to another hospital and intravenous antibiotics. However the RCA stated that there had been no effect on the patient. All these incomplete RCAs had been signed off by both the governance committee and MAC.

- The Monthly Incident Review Committee reviewed all incidents and formulated action plans to prevent reoccurrence. We reviewed the minutes from the last three meetings and saw that incidents were discussed and where appropriate action plans were formulated. Decisions were made where information should be sent to, for example the MAC or infection prevention and control meetings. However, any risks arising from incidents had not been added to the hospital's risk register.
- Lessons were shared to make sure action was taken to improve safety beyond the affected team or service. Staff were able to tell us about incidents that had happened and we saw that these were discussed during the theatre and ward departmental meetings. We saw that learning points from incidents which occurred at other Spire hospitals were also discussed at the theatre departmental meetings.
- Staff also told us of an incident involving an ophthalmic (eye) operation. We saw that the service had adapted the World Health Organisation (WHO) 'Five steps to safer surgery' checklist for ophthalmic patients as a result.
- From November 2014, all providers were required to comply with the Duty of Candour Regulation. 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 were aware of the duty of candour regulation, ensuring patients received a timely apology when there had been a defined notifiable safety incident.
- Patients were told when they were affected by something that went wrong, were given an apology and were informed of any actions taken as a result. Patients were informed of any related risks as a result of the incident. We saw evidence of this within root cause analysis reports, incident reports and complaints and through discussion with staff. The duty of candour was well implemented and staff adhered to the principles of being open and honest.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The safety thermometer is a tool for measuring, monitoring, and analysing patient harms and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas, for example, new pressure ulcers and falls.
- The hospital monitored the incidence of pressure ulcers, falls, and venous thromboembolism (VTE). VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients.
- From April 2015 to March 2016 two patients acquired VTEs whilst at the hospital.
- In the first three months of 2016 the service had 1.18 VTEs which was worse than their target of 0.5. This was also worse than the Spire average of 0.49. One of the contributory factors was thought to be dehydration. As a result of this an action plan was made, to redesign the fluid balance charts. In the second quarter of 2016 the service reduced their incidence of VTEs to 0.56, which was only slightly above expected, as set by Spire.
- Patients wore anti embolism stockings following surgery to reduce the risk of acquiring VTEs.
- The service assessed all patients for VTE, scoring 100% compliance with risk assessing patients for this, in accordance with National Institute for Health and Care Excellence (NICE) guidelines. This exceeded their target of 95%.
- In the first three months of 2016 the service had no inpatient falls, better than the Spire average of three falls. However, in the second quarter of 2016 this had increased to 2.38 inpatient falls, above their maximum expected, set by Spire, target, of two falls. The Spire national average had also increased to 2.61 falls. The hospital had an action plan in place to address the incidents and had introduced 'call before you fall' posters to encourage patients to seek assistance before moving.

- For the same time period the service had no pressure ulcers grade 2 or above. The service's maximum target for this was 0.1%. The service continued in the second quarter with the same performance, having no pressure ulcers grade two or above. This was better than the Spire average of 0.12 pressure ulcers.

Cleanliness, infection control and hygiene

- Effective standards of cleanliness and hygiene were maintained. The wards and theatres were visibly clean and tidy.
- Reliable systems were generally in place to prevent and protect people from a healthcare associated infection. The hospital had a prevention and control of infection manual which covered the mandatory infection prevention and control training, the World Health Organisation (WHO) five moments for hand hygiene, the 'bare below the elbow' requirement, and the use of personal protective equipment such as gloves, aprons, gowns and masks. We saw staff complying with the manual's contents and adhering to preventive infection control measures.
- The infection control lead had been in post for six years, however did not have any accredited or nationally recognised specialist training in infection control and prevention, which meant they were not fully qualified to undertake this role. This may have posed a risk to infection control and prevention management within the hospital.
- We observed equipment being cleaned by housekeeping staff and saw items had dated 'I am clean' stickers so that staff knew how recently an item had been cleaned.
- We saw that hazardous cleaning chemicals were stored securely in a locked cupboard within a locked room, in accordance with Control of Substances Hazardous to Health (COSHH) guidelines.

- We observed a lack of clinical handwashing facilities in ward areas. Clinical hand basins were provided in utility areas, but not in patient rooms. This meant that at the point of care, staff were washing their hands in the sinks in patients' bathrooms. Although the sinks in patient bathrooms had wrist operated taps, best practice would be to have dedicated clinical sinks within ensuite rooms. Department of Health Guidelines 2013 HBN009 state that: 'Ensuite single bedrooms should have a general wash hand basin for personal hygiene in the ensuite facility in addition to the clinical wash basin in the patient's room'. Therefore the hospital was not compliant with infection control guidelines. There was no risk assessment in place and this was not on the hospital's risk register.
- The flooring in patient rooms and bathrooms was not compliant with Department of Health (DH) 2013 HBN0010 part A. The coving from the floor did not rise far enough up to the wall and was not smooth. This meant that cracks could appear where the floor met the wall and be a place for bacteria to collect. There was a no risk assessment in place, but this issue was on the hospital's risk register. However, there were no dates for review or no indication when this risk had been added.
- Some of the patient bedrooms had carpeted flooring, which meant that spillages were harder to clean than hard flooring and therefore bacteria could collect on the carpets. However, spillage kits were available, which were used by the housekeeping staff when necessary. A cleaning schedule for the carpets was in place, with an external company deep cleaning the carpets every six months, unless required sooner.

- The senior managers were aware of these concerns and told us that they were in the process of putting together a business plan to request funds from Spire's head office in order to refurbish the patient bedrooms, to be compliant with guidelines. However, this business plan had not yet been submitted at the time of our inspection and senior managers were unable to provide us with a timescale.
- The hospital screened new admissions during the preadmission process, who were at risk of MRSA. The criteria the service used to decide if patients were at risk of MRSA included previous diagnosis and if they had recently been an inpatient in another hospital or resident in a care home. However, the risk assessment form did not include a section on occupation, therefore patients who worked within the healthcare setting, and were at risk of having MRSA colonised, were not identified and therefore may not have been screened.
- We saw within medical records that patients, who were identified as at risk of being an MRSA carrier, were tested by nose swab.
- The hospital reported that they had no incidences of hospital acquired MRSA, Methicillin-sensitive Staphylococcus Aureus (MSSA), Clostridium difficile or E. Coli infections from April 2015 to March 2016. However,

one RCA we saw stated that the patient had an MSSA infection in their wound, although there was no evidence of blood bacteraemia or that this was hospital acquired. These are infections that have the capability of causing harm to patients.

- From April 2015 to March 2016 the hospital reported that there had been no surgical site infections for primary hip arthroplasty (hip replacement), breast, gastrointestinal and colorectal, urological and vascular surgeries. This was better than the service's target of less than 0.6% of patients, and better than the Spire average which was 0.18%. The hospital reported zero surgical site infection for primary knee arthroplasty (knee replacements) from April 2015 to March 2016, during which period they carried out 76 procedures. From January 2016 to May 2016 there was no surgical site infections in knee replacement surgeries. This was better than their target of less than 0.6% and better than the Spire average of 0.13%. The hospital reported two surgical infections for spinal surgery from April 2015 to March 2016, during which period they carried out 189 spinal procedures. This rate of surgical site infection was similar to the NHS hospital average. These infections were six months apart and there were no trends as the hospital had investigated this. One orthopaedic and trauma infection and one gynaecological surgical site infection had been reported during the same period, compared to 695 and 310 procedures respectively. There was no benchmarking data available to see how this compared to other services. We saw that the hospital carried out a root cause analysis on any reported infections.
- The hospital held infection prevention and control committee meetings with a consultant microbiologist every two months, where staff discussed recent audits, including hand washing audits and sharps bins audits.
- We reviewed the most recent observational hand hygiene audits for endoscopy, surgical recovery and the surgical ward. These audits showed that all staff were compliant with hand washing protocols.
- We spoke with five patients and four said that they saw staff using hand sanitiser before and after every personal interaction. The fifth patient could not remember whether this had happened or not. We also witnessed staff using hand sanitiser in between caring for patients, in compliance with the National Institute for Health and Care Excellence (NICE) guideline QS61 statement 3. Within the ward, hand sanitiser dispensers were not on the walls or by the doors of the patient bedrooms but were held at the end of the patient's bed. This means that staff were able to sanitise their hands at the point of care.
- Personal protective equipment, such as gloves and aprons, were used and were available in sufficient quantities. We saw staff using these where appropriate when caring for patients.
- Theatre staff carried out correct preoperative infection control techniques including wearing gowns, caps and theatre shoes in line with NICE guidance.
- The endoscopy suite decontaminated its endoscopes in compliance with British Society of Gastroenterology (BSG) guidelines. Scopes were washed manually with brushes and then flushed through a processor. Clean scopes were placed in drying cabinets to ensure that bacteria did not form on the scopes.
- The endoscopy suite audited its compliance with the Health Technical Memorandum 01-06 decontamination of flexible endoscopes. We reviewed the audit from May 2016 and saw that the unit achieved 100% compliance with tracking endoscopes, which ensured that all endoscopes tracked had been correctly cleaned and disinfected following usage.
- The sterile services department which sterilised all reusable medical equipment, for example, theatre instruments and devices was accredited by a company that provided quality assurance that certain services comply with national standards. This showed that they were compliant with national guidelines on sterile services.
- The service had a local plan for controlling a major outbreak of hospital infection. This informed staff of what to do in the event of suspicion and confirmation of an outbreak; plans to manage the outbreak and how to communicate it effectively to staff and patients.

Environment and equipment

- The design, maintenance and use of facilities and premises generally had patient safety in mind. All doors within the ward were fire doors and there was clear, unobstructed access to fire escapes. However, the Garden Suite; which was used for day case patients, was out of hearing and sight of the main ward area.
- Equipment was maintained and used according to manufacturer's instructions. There was sufficient equipment to maintain safe and effective care, including theatre instruments, blood pressure monitors and

bedpans. We saw that daily morning surgical meetings were held to ensure that all staff had the required equipment for the surgeries planned for that day. We saw that any new equipment that was delivered was checked by theatre staff before use.

- Resuscitation equipment, for use in an emergency in operating theatres and ward areas, was regularly checked and documented as complete and ready for use. The trolleys were secured with tags, which were removed daily in order that checks could take place. Its contents were in date. However, we did find that the serial numbers on the checklist did not match up with the serial numbers on the tags.
- The service also had a major haemorrhage trolley in the theatres, for use when patients suffered a critical bleed. Staff we spoke with were aware of the trolley and its location.
- There were systems to maintain and service equipment as required. Equipment had been tested appropriately to ensure that it was safe to use.
- The ward and theatres were tidy and well maintained.
- All equipment was recorded and tracked. An asset list was held by the engineering department and was updated regularly. The hospital had a contract with an external provider that completed the majority of the equipment maintenance in the hospital. Faulty equipment was reported and recorded. When equipment was urgently needed, the maintenance company provided a replacement within 24 hours to ensure patient safety was not affected.
- Consultants and staff were encouraged to contribute to any developments and equipment purchases throughout the hospital. The anaesthetists had trialled different anaesthetic machines before they were purchased. All three operating theatres had the same machines which were the first choice of the anaesthetists who practised at the hospital.
- The majority of anaesthetists with practising privileges at the hospital worked in the local NHS trust. As far as possible, all the equipment used in theatres was standardised with the trust. This included using the same brand of arterial lines, central venous pressure lines and patient monitors. This ensured that the anaesthetists were familiar with the equipment and ensured compatibility for patient transfers. Similarly, the cardiac output monitor and ultrasound scanner were chosen by the anaesthetists and were the same machines that were used in the local trust.
- Theatre staff had completed medical device competencies for specialist equipment used in particular procedures. This ensured that staff were able to use specialist equipment competently and ensured patient safety.
- There were arrangements for managing waste and clinical specimens. Sharps bins were used to dispose of needles and appropriate bins were used for toxic waste. Clinical waste was double bagged to reduce the risk of spillages and was destroyed off site by an external contractor. The hospital underwent an annual sharps audit in April 2016 and 44 sharps bins were audited. The hospital performed well in this audit, with none of the sharps bins were overfilled or left unlocked.
- Recording systems were in place to ensure that details of specific implants and equipment could be provided rapidly to the health care products regulator. An implant register was kept within surgery of all cosmetic implants and prosthesis and serial numbers were also noted in the patients' medical records.

Medicines

- There were arrangements for managing medicines, medical gases and contrast media. Nursing staff were able to explain the process for safe administration of medicines and were aware of policies on preparation and administration of controlled drugs as per the Nursing and Midwifery Council Standards for Medicine Management.
- The hospital used the Spire medicines management policy. This included guidance for the security and storage of medicines, environmental monitoring and prescription and administration of medicines.
- Implementation of systems, processes and practices was monitored through local audits and improved when required. We reviewed the hospital's audit on storage of medication in theatres from June 2016. This identified that there was no standard operating procedure (SOP) for medicine cabinet key security out of hours; that there was no temperature monitoring for fridges in all three anaesthetic rooms and that some temperature monitors were missing. We saw that action plans were created for the three areas of concern and two of them, relating to room and fridge temperatures, had been completed within three days of the audit. The third action plan; to write the SOP was due to be completed by the end of July 2016. A copy of the SOP was provided to us after the inspection.

- We saw that medications on the ward were kept within locked cupboards, inside a locked store room. The temperature of the room was monitored daily to ensure it kept within correct temperatures, to ensure the efficacy of the medicines. There were separate locked cupboards for intravenous fluids, medicines, topical creams and controlled drugs, to ensure that these were not mixed up. The cupboards were neat and tidy and the pharmacist rotated and topped up stock daily. Medications requiring refrigeration were kept within a locked fridge in the store room. Within the ward nurses' station there was an electronic monitor which showed all the hospital's fridge temperatures. When any fridge's temperature went outside of the acceptable boundaries the monitor's alarm went off, alerting staff to this. If the alarm was for a fridge outside of the ward, then a protocol was in place for nursing staff to call and alert the relevant department.
- We also reviewed the service's delayed or omitted dose audit from March 2016. The audit involved consideration of 50 medicine charts and found that five medicines were not given as the patient did not need them, one medicine was omitted due to the patient's clinical picture and one was not given as the patient's own medication was not available. This led to an action plan to ensure that nursing staff inform the pharmacy immediately if a patient forgot to bring one of their own medicines with them. We saw this was discussed at the medicines management meeting and the ward meeting to ensure learning for all relevant staff.
- We reviewed four medicine charts and saw that all entries were signed for and all allergies were documented. We saw one drug chart had a missed dose, without explanation. A second chart had a missed dose for a diuretic. Staff had not written a code for why the drug was not given, but instead inferred that the patient had low blood pressure, by writing a down arrow and the letters 'BP'. If a patient was unable to have a medication because of their clinical need, codes should be used, according to Spire policy, to ensure accuracy and clear interpretation.
- During our inspection we found that medications were not always stored securely in the anaesthetic rooms whilst surgery was being performed. Whilst this was not in breach of national guidelines, the senior staff were asked to implement a risk assessment for this practice, which was completed immediately.
- Allergies were clearly documented on patients' medicine charts.
- A service level agreement was in place with the local NHS trust for medicines required out of hours when the pharmacy was closed.

Records

- Patients' individual care records were accurate, complete, legible, up to date and stored securely. There was a corporate patient records policy which stated that all entries to patient notes should be timed, dated and signed.
- All notes that we saw were signed and dated.
- Records contained information on the patient and their time in the hospital, including pre-assessment, any medical investigations, results, the operation and any medications given, including medicines to take home.
- Theatre records included the five steps to safer surgery checklist. We saw that these were completed fully and appropriately.
- Patients' medical records were stored within the locked nurses' room, with nursing records kept at the patients' bedsides. Most of the beds were in single rooms, however, there were two five bedded bays.
- Preoperative assessments were recorded. Out of the 11 records reviewed, all had preoperative assessment risk forms included, which were completed appropriately. Young people, aged 16-18 years old, who were being pre-assessed for surgery had an adolescent risk assessment completed.
- Staff were able to describe an incident whereby a patient had developed a venous thromboembolism (VTE). VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients following surgery, sometimes due to dehydration. We saw that as a result of this the fluid balance chart had been redesigned and staff underwent further training in completing the charts. However, whilst senior staff told us that the new chart had been embedded, out of the 11 records we reviewed six of the fluid balance charts had not been completed fully.
- We were shown one fluid balance chart audit which had taken place in July 2016. Theatre were 92% compliant, the ward was 75% compliant with completing the fluid charts, for IV and oral fluids, and urinary output. However the audit tool stated they were only 50% compliant at recording 24 hour balance. It was stated

that this was an improvement on the previous audit, but it was unclear when this was. The ward meeting minutes did demonstrate that fluid balance had been discussed. This was not evident in the theatre meeting minutes.

- The hospital's records policy stated that a condition of consultants being granted and maintaining their practising privileges was that they ensured a copy of the operation notes and relevant medical records were accessible within the hospital, to ensure that each patient had a single chronological health record. In all the records we reviewed of patients that had been discharged, we saw records of the operation, any medication given and any prosthesis or implant inserted so that a full record of care was available for each patient.
- When changes were made to the theatre lists, the list was reprinted onto pink paper so that staff could easily see that it was a newer version.
- The hospital's policy also stated that they retained clinical records for 11 years following the conclusion of treatment, incorporating guidance by the Department of Health Records Management Code of Practice.

Safeguarding

- Arrangements were in place to safeguard adults from abuse that reflected relevant legislation and local requirements. Staff generally understood their responsibilities and adhered to safeguarding policies and procedures. There was a safeguarding vulnerable adults policy in place, which explained staff responsibilities, the categories of abuse and how to manage situations of suspected abuse. There was also a separate local safeguarding policy that included information on female genital mutilation.
- The lead nurse for safeguarding was the matron, who was trained to level 3. All staff we spoke with were aware of the safeguarding lead and said they would approach them for advice when required.
- All staff were required to complete level two training in safeguarding for both adults and children. We saw that 89% of staff had received training in level two safeguarding adults, and 87% of staff had received training in level two safeguarding children. However, it is noted that the training year ran from January to December, therefore, there was still time for staff to complete this training.
- Not all staff who were involved in caring for young people aged 16 – 18 years old had safeguarding children level three training. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level three in safeguarding. There was a general lack of awareness from the senior managers, which was reflected in the Spire South Bank safeguarding policy, dated June 2016, that safeguarding level three training was required as it had not been realised that young people under 18 years of age were classified as children. When we raised these concerns the hospital took immediate action and withdrew services for children and young people.
- There was a local safeguarding policy which contained the telephone numbers needed to contact the safeguarding lead for the county.
- Posters were up around the hospital detailing the safeguarding leads at the hospital.
- There were hospital guidelines in place with regards to chaperones, which were offered to all patients, undergoing intimate examinations or procedures of the genitalia, breast or peri-anal areas. This helped to ensure that patients felt comfortable, were safeguarded from abuse and staff were protected from potential allegations of abuse.
- Medical representatives who were visiting theatre signed in at the main hospital reception. However, their credentials were not checked and their presence in theatres during an operation was not recorded. This was reported at the time of our inspection. The theatre manager told us they would start to check the credentials of representatives entering theatres with immediate effect.

Mandatory training

- Staff received effective mandatory training to enable them to provide safe care. Some of the training was completed through e-learning which could be completed flexibly, and some was provided onsite.
- During 2015 82% of staff had completed all mandatory training. This was below the target of 95%. At the time of our inspection, 85% of staff had completed their mandatory training. Mandatory training covered a variety of topics including moving and handling, infection control, compassion in practice and fire safety.

- Staff we spoke with were able to tell us about the training they had undergone. We saw sheets on the ward for staff to sign up to onsite training at a time convenient for them.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for the vast majority of patients and risk management plans were developed in line with national guidance.
- Preoperative assessment is a clinical risk assessment where the health of a patient is considered to ensure that they are fit to undergo an anaesthetic and therefore the planned surgical operation. It also gives an opportunity to ensure that patients are fully informed about the surgical procedure and the post-operative recovery period and can arrange for post-operative care at home. We reviewed 11 preoperative assessment forms and saw that they were completed appropriately to ensure patients were ready for their surgical procedures. We also saw that young people, aged 16-18, undergoing surgery; had a separate preoperative assessment form which catered to their age.
- Not all patients due for admission attended a pre-assessment clinic. They were assessed according to their clinical needs by completing a preoperative questionnaire which they returned to the hospital. Patients were then triaged to determine who required a face-to-face consultation in clinic. Patients who listed several risk factors within the questionnaire were given appointments for a face-to-face consultation.
- All patients who were having major planned surgery, involving the insertion of a prosthesis; such as knee or hip replacement, attended the preoperative assessment clinic. Preoperative assessments were carried out in line with National Institute of Health and Care Excellence guidelines.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing or medical emergencies. The hospital used the National Early Warning Score system (NEWS). This is a national standardised approach to the detection of a deteriorating patient and has a clearly documented escalation response, in line with National Patient Safety Agency 2007 guidelines. On the NEWS chart staff recorded observations including oxygen saturations, blood pressure and temperature and collated a total score. At various score points, different types of escalation were required. Guidance was available on the back of the NEWS charts about what escalation was required for each trigger score.
- We reviewed 11 patients' NEWS charts and found that five of these had limited observations. Two charts showed that no observations had been recorded postoperatively, two had three sets of observations postoperatively, and one had four sets of observations postoperatively. However, there was no evidence that any deterioration had not been identified.
- The hospital audited its compliance with the NEWS chart and we saw that 96% of patients from the first three months of 2016 had their NEWS scores completed, above the Spire target of 95%. We also saw that during the same period 95% of patients had their temperature recorded on their NEWS chart whilst in theatre and recovery, exceeding the target of 85%.
- The Garden Suite; which was used for day case patients, was at the far end of the corridor and round a corner from the main reception area and nurses' office, therefore out of hearing and sight. Whilst there was a nurse's desk within the Garden Suite, we did not see this attended by a member of staff. We visited the Garden Suite six times during the course of our two day inspection and on every occasion there were no nursing staff present with the patients. The patients in this unit each had a buzzer they could use to summon nursing assistance if needed. Day case patients are generally lower risk than inpatients due to the lesser risks attached to their surgeries and there was no evidence that the patients required any assistance from the nursing staff. However, the staff would not have been able to see if a patient was deteriorating, if the patient could not summon assistance.
- Patients were risk assessed for venous thromboembolism (VTE), which is where blood clots form in veins, which have the potential to be fatal. The service audited its compliance with completing the VTE assessment and we saw that 95% of patients had fully completed VTE risk assessments, meeting the target of 95%.
- We saw that 100% of patients eligible for chemical VTE prophylaxis (a preventative measure for patients at risk of developing VTE) had it prescribed, exceeding the target of 95%. We also saw that 100% of patients were prescribed the prophylaxis for the correct duration; 10

days for knee and 28 days for hip replacements, better than the target of 95%. 100% of patients were given the prophylaxis within the recommended timescale, against their target of 80%.

- Risk assessments were completed using nationally recognised tools, for example the Waterlow score, to assess patients' risk of developing pressure ulcers.
- There was a safeguarding vulnerable adults policy in place, which explained staff responsibilities, the categories of abuse and how to manage situations of suspected abuse. There was also a separate local safeguarding policy that included information on female genital mutilation.
- The service had a sepsis screening tool and sepsis care pathway for staff to use if they suspected a patient had sepsis. Nursing staff were aware of the screening tool and pathway and told us they would escalate any patients displaying these symptoms to the resident medical officer (RMO).
- We also saw that allergies to materials such as latex were recorded on the board behind the patient's bed.
- Patients who had had an endoscopy under sedation were monitored for at least 30 minutes following the procedure, to ensure they were safe whilst they were drowsy.
- There was a two bedded extended recovery unit within the inpatient ward. If a patient was assessed as requiring a level of observation not able to be provided on the ward, they were booked into the unit. If a patient deteriorated during surgery, they were admitted to the unit postoperatively to be stabilised. All of the nursing staff on the ward were able to care for these patients, and would be allocated less patients to enable them to give the dependant patients the care they required. If a patient suffered further deterioration and required transfer for level two or three care, the consultant made arrangements for transfer to the local NHS trust. There was a policy to support this process and there was a service level agreement between the hospital and the local NHS trust.
- From September 2015 to August 2016 three patients were transferred to the local NHS trust. These were investigated and there were no negative themes identified.
- The practising privileges agreement required surgeons to be contactable at all times when they had patients in the hospital. They needed to be able to attend the hospital within 30 minutes, according to the level of risk to the patient. They had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover in the event that they were not available, for example when they were on holiday.
- Nursing staff confirmed that consultants were easily contactable when they were on call and that if the consultants were on leave they had details of the consultant covering.
- Patients were under the direct care of their consultant. The consultants remained on-call following the surgical procedure and saw the patient once they had been moved back to the ward. Whilst the consultants were not in the hospital at all times, they came back to the hospital if needed and the RMO was available and on-site 24 hours a day.
- The hospital had an admission policy setting out a safe and agreed criteria for admission of patients for any procedure.
- The hospital only admitted patients for elective surgery, ambulatory care, day surgery and extended recovery patients. It did not accept obstetric admissions or patients requiring admission under the Mental Health Act. It also set out a list of factors which would exclude patients from being accepted for day surgery such as poorly controlled conditions, for example, hypertension or diabetes and previous serious cardiac or respiratory problems. This ensured that patients were not admitted when skills or resources to care for them, may not be available.
- Cosmetic surgery was performed. The service ensured that the pre-admission consultation took account of the Royal College of Surgeons' recommendations; including ensuring psychologically vulnerable patients were identified and referred for assessment. There was a psychologist available for any psychological assessments.
- Cosmetic surgery patients were given a two week 'cooling off' period, prior to any surgery being undertaken. This is in line with good practice.
- The service used the World Health Organisation (WHO) Five Steps to Safer Surgery checklist. We observed staff using the checklist prior to surgery during the inspection. We reviewed 11 WHO checklists and saw that one was incomplete with no sign off for instruments and swabs being counted following surgery.
- The WHO safety checklist had been adapted, by the hospital, for cataract surgery.

- There was appropriate 24 hour emergency call hotline for patients, following discharge. Every patient was given the ward telephone number, so that they could get advice or escalate concerns to the nursing staff and RMO on duty.
- We reviewed the call log which was kept in the nurses' office, and looked at a sample of the calls that had been received. Patients had called the office as a result of pain and concerns about wound healing. These patients had appointments made for them to attend the hospital later the same day to be reviewed. One patient had called the ward regarding bleeds following discharge. The consultant was informed and the patient was advised to go to the local NHS emergency department.
- All female patients of child bearing age were required to have a pregnancy test prior to undergoing surgery. Compliance with this was measured via the clinical scorecard and was 100%.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times, in line with relevant tools and guidance.
- The service followed independent nursing guidelines for acuity; using one registered general nurse to five patients in the morning and one registered general nurse to six patients in the afternoon and night. This was derived from an adaptation of the Shelford staffing tool. We were told that staff reviewed the dependency of patients and if extra support was required then extra staff would be put on duty.
- During our inspection we saw that planned numbers of nursing staff had been met. We saw that in January, February and March 2016 there no unfilled shifts at the hospital.
- The theatres had nine full time equivalent (FTE) operating department practitioners (ODPs) and health care assistants (HCAs) and 10 FTE registered nurses. The ratio of registered nurse to ODP or healthcare assistant was one to one.
- There was one FTE theatre nursing vacancy and no vacancies for ODPs and healthcare assistants.
- There was 8% turnover for nurses and no turnover for healthcare assistants within theatre from April 2015 to March 2016. This was lower than average when compared to other independent acute hospitals.
- Between 0.05% and 0.20% of nursing bank and agency staff were used in theatres from April 2015 to March 2016. This was below the average rate of use of bank and agency staff, compared to 33 other independent services.
- When new agency staff worked within theatres the theatre manager ensured that their professional indemnity insurance and professional registration was in place.
- Nursing handovers occurred three times a day; at 7am, 12pm and 7pm. Each nurse had an individual handover sheet. Nursing staff told us that the box for writing information about the patient was small and that they sometimes did not have enough room to record everything. However, they told us that they were always told the details verbally and that they always received sufficient information. We observed a nursing handover and found it to be well structured, clear and gave the incoming staff all the information they needed to know about their patients.

Surgical staffing

- Patient care and surgery was consultant led. The hospital had a database of consultants who had been granted practising privileges that was also monitored centrally as well as locally. This included the status of each consultant with regards to their indemnity, appraisal, General Medical Council registration and Disclosure and Barring Service (DBS) checks which helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. At the time of the inspection the consultants were seen to be 95% compliant with all checks.
- There were similar rules for anaesthetists. The Worcestershire Anaesthetic Group was a consortium of 19 anaesthetists. Anaesthetists within the consortium worked together to ensure all operating lists were covered and provided a 24 hour on-call system. Not all the anaesthetists who had practising privileges at the hospital were members of the consortium. The anaesthetists that were not members had to provide the name of an anaesthetist who would cover for them in the event of an emergency.
- The hospital's compliance officer managed the database and explained an email was automatically generated to remind a consultant, if for example, their appraisal or indemnity was overdue or expired. Those

outstanding had received reminders. We saw evidence that the hospital director had previously suspended consultants from practice, who had not complied with supplying required documents.

- We saw evidence that practising privileges were reviewed every other year in accordance with the hospitals practising privileges policy.
- The hospital practising privileges agreement required the consultant to visit and review the patient daily and more frequently if necessary. Patients we spoke with confirmed that their consultants visited them daily whilst they were on the ward. Nursing staff also confirmed that consultants attended the hospital when they were asked to, and that they were easily contactable.
- There was a Spire 'Consultants Handbook' which stated that surgeons had to provide two designated deputies who could be contacted in the event of an emergency, should the admitting consultant surgeon be unavailable. We were assured that if the consultant or nominated deputy were on leave, there was another, who was contactable and within a 30 minutes journey away, so that they could attend quickly if needed.
- The hospital did not employ any resident medical officers (RMOs), but sourced these through an external agency via a Spire group contract. All RMOs completed an induction before their first shift within the service. The RMO provided medical support to wards and theatres and was in attendance 24 hours a day, seven days a week. The RMO we spoke with during our inspection had worked shifts at the hospital for many years and was very familiar with the setup of the service.
- The RMO confirmed that they were not called in to assist with surgery as this would have been outside of their scope of practice, as they were medical staff, not surgeons. The RMO confirmed that they were not asked to work outside of the competencies and that if patients required specialist medical attention that they would dial 999 for an emergency transfer to the local NHS trust.

Major incident awareness and training

- Potential risks were taken into account when planning services. Arrangements were in place to respond to emergencies and major incidents.
- The hospital had a local business continuity plan which set out the early response to an event, for example loss of power or communication systems, where the hospital's ability to accommodate patients and provide essential services were severely compromised.
- The plan set out the roles of the initial emergency response team and the local response and recovery team. It covered immediate evacuation procedures and the process for communicating the incident to all staff. As the hospital was part of Spire Healthcare Limited, there were plans in place to redirect admissions to other Spire hospitals in the area.
- There was an emergency generator that activated after 20 seconds of delay upon failure to the main electrical supply. The generator could provide up to 32 hours of electricity. Within theatres the operating lights had a three hour battery life and the anaesthetic machines had a two hour battery life.
- Signs were displayed on the ward about fire evacuation for immobile patients. The ward operated on a 'stay put' policy whereby staff and patients remained on the ward if a fire alarm rang, unless the fire was within the ward or they were told to evacuate by the fire brigade.
- Fire bells were tested weekly.

Are surgery services effective?

Good

Overall, we rated surgical services as good for effectiveness because:

- The endoscopy suite was Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited.
- Policies and practice were evidence based and followed national guidance.
- Changes to national guidance were monitored and circulated to staff.
- Pain levels were assessed and managed appropriately.
- Patients' nutrition and hydration needs were met following surgery and the service was improving in its performance in fasting patients prior to surgery. However, this was not always recorded appropriately.
- Patient outcomes and adherence to policies was audited.
- All nurses were competent and trained in intermediate life support.

- An induction programme was provided to all newly employed staff.
- Arrangements were in place to ensure that consultants were competent to perform surgical procedures.
- There was positive multidisciplinary working, both internally with physiotherapists and pharmacy, and also externally, with the local NHS trust.
- Consultants were on call 24 hours a day for their inpatients and there were arrangements in place to obtain medications out of hours.
- Staff had easy access to records and all records that were seen were comprehensive.
- Patient consent forms were completed and included all relevant risks and benefits of the procedures.

However, we also found that:

- Not all nursing staff had a clear understanding of mental capacity and how to assess a patient's capacity to consent to treatment.
- Fluid balance charts were not always completed adequately.

Evidence-based care and treatment

- Relevant and current evidence-based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered.
- Policies were current and based on professional guidelines, for example, National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- Policies were available on the intranet and in hard copy in clinical areas.
- NICE guidelines were reviewed centrally by Spire and were cascaded to the individual hospitals and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospitals for implementation.
- Patient safety alerts from the National Patient Safety Alert (NPSA) were circulated for local action by the Spire National Clinical Governance and Quality Committee. New safety alerts were also discussed during theatre departmental meetings and displayed on the staff notice board.
- The National Clinical Governance and Quality Committee monitored the release of new NICE guidance and findings of confidential enquiries and fed this learning into the service by cascading the information down through team meetings.
- The service had systems in place to provide care in line with best practice guidelines (NICE CG50: Acutely ill patients: Recognition of and response to acute illness in adults in hospital). For example, an early warning score was used to alert staff should a patient's condition deteriorate. The system used National Early Warning Score (NEWS) which incorporated escalation actions that should be taken.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. This was monitored through internal audits to ensure compliance.
- The service audited its compliance with the World Health Organisation (WHO) surgical safety checklist and we reviewed the audits for the first six months of 2016. The audits showed that for the January to March 2016 theatres had an overall compliance rate of 89%. We saw that areas of non-compliance were identified and action plans were implemented to improve performance in these areas. We also reviewed the audit for April to July 2016 and saw that compliance with the checklist had increased to 93%.
- Corporate evidence based care pathways were used which were based on clinical guidelines from established and recognised bodies. The pathways covered a range of procedures including general surgery, weight loss surgery, endoscopy and standard preoperative assessments, and were stored on the hospital's intranet so that staff could access them easily.
- Compliance with care pathway documentation was audited every quarter. We reviewed the most recent audit and saw that the service was 90% compliant with completing the care pathway documentation, which was an improvement from the previous quarter.
- A Spire policy was in place regarding equality and discrimination. Staff treated patients individually and without prejudice when interacting with them and making decisions. Therefore, discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was avoided when making care and treatment decisions.

- Technology and equipment was used to enhance the delivery of effective care and treatment. Recent acquisitions included patient controlled analgesia and epidural pump infusion portable machines, which meant that patients could walk around the ward with their machine, so that they could maintain their independence and be more mobile.
- Patients who were assessed as being at risk of venous thromboembolism (VTE), which are blood clots, were prescribed VTE prophylaxis, in accordance with NICE guidelines.
- Guidance was followed regarding the recording and managing of medical device implants. A central register of this information was not kept; however, all implants were recorded in the prosthesis registers in each theatre. All implant serial numbers were also noted in the patient's physical records.
- Adherence to local policies and procedures was monitored with a schedule of local audits, for example; safe and secure medicine storage audits, missed doses audits, fluid balance audits, and five steps to safer surgery audits. The audits showed that the service was generally compliant with local policies. The service underperformed in completion of the fluid balance charts, notably at completing daily totals, where this was only completed in 50% of the charts audited.
- The service also contributed to national and local audits including Patient Reported Outcome Measures (PROMS), the National Joint Registry (NJR) audit, Theatre Quality Assessment Document (QuAD) audit, Commissioning for Quality and Innovation (CQUIN), the National Blood Comparative audit and Patient-led Assessment of the Care Environment (PLACE).
- We reviewed the service's CQUIN audit from July 2016 on the prevention of malnutrition and dehydration and saw that overall compliance was 88%, below the target of 95%, which was to be achieved by March 2017. An action plan was in place to improve the score, including feeding back to staff and continuing with spot checks.
- The audits were featured in the clinical audit plan and discussed at the service's clinical audit and effective group. This ensured that the service was implementing and using NICE guidance correctly.
- The service ensured that following surgery patients were supported to be mobile through minimal use of intravenous infusions or catheters.
- Patents were supported to be as fit as possible for surgery. Staff gave patient's lifestyle advice on how to eat well, or how to mobilise joints if the patient was undergoing a joint replacement.
- Patients having cosmetic surgery received appropriate preoperative assessment. This included relevant psychiatric history and discussions about body image. Staff confirmed that this was undertaken at the preadmission consultation stage, with input from a psychologist if necessary. We also saw evidence of this in the medical notes we reviewed.
- Patients undergoing cosmetic surgery were provided with right information to help them make the best decision. All relevant risks and benefits were discussed with the patient before the decision to go ahead with the treatment was made. All patients undergoing cosmetic surgery waited for two weeks in between the initial consultation and the operation, to ensure that they were happy with their decision to proceed.

Pain relief

- Patients' pain was assessed and managed. A numerical pain score whereby zero was when a patient reported no pain, two for moderate pain and four for worst unimaginable pain was in use. A pain 'trigger to action' audit had been conducted.
- A monthly sample of patients' notes who had a pain score of over two were audited to find out what trigger prompted action and how long after the pain score was recorded did action taken place. The most recent audit from July 2016 showed that half of the patients audited (5/10) continued to have a pain score of two or more after they received pain relief and therefore needed more. Out of these five patients, two patients did not receive further pain relief within one hour. Following the audit, an action plan was put in place for all patients with a pain score of two or more to have their pain reassessed within an hour of administration of pain relief, to check if they required any more.
- Following surgery patients were given effective pain relief as their pain was assessed routinely following surgery. If patients in recovery were in pain following their surgery, they were kept in recovery until the pain relief had taken effect, so that they were not transferred to the ward whilst they were uncomfortable.
- The service's clinical scorecard from the first three months of 2016 showed that 100% of patients had pain scores recorded with every set of observations.

- We reviewed 11 patient records and saw that pain scores had been recorded in nine of the records and pain relief had been given where appropriate. The remaining two records did not have evidence of pain being assessed; however, the patients were in for day-case surgery and had undergone a local anaesthetic.
- The service's patient satisfaction survey results from May 2016 showed that 100% of patients found that staff controlled their pain either a 'great deal' or a 'fair amount'.
- Patients we spoke with said that their pain was well managed during their treatment.

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed and generally met.
- Staff completed an assessment of patients' nutritional status and their needs as part of their initial nursing assessment and updated this, if their condition changed, during the patient's stay.
- We reviewed 11 patient records and found that Malnutrition Universal Screening Tool (MUST) scores were recorded as appropriate. The MUST score is a five step screening tool to identify adults who are at risk of malnutrition.
- Intravenous fluids were prescribed, administered and recorded appropriately.
- Pre-operative fasting guidelines were aligned to the recommendations of the Royal College of Anaesthetists (RCOA). These stated that food could be consumed up to six hours before admission and water up to two hours before admission. However, we saw, from the clinical scorecard, that in the first quarter of 2016, 25% of patients were fasted within these guidelines, against a Spire target of 50%; this meant that 75% of patients were not being fasted correctly, with all of these patients being fasted for longer than necessary before their surgery. The service improved in the second quarter of 2016, with 60% of patients fasted within guidelines, exceeding their target of 50% and the same as the Spire average. Nausea and vomiting was formally assessed and prescribed treatment given as required.
- Patients had access to dietician services, postoperatively, particularly if they had undergone bowel or bariatric surgery.

Patient outcomes

- Information about the outcomes of patients' care and treatment was collected and monitored.
- The service's endoscopy suite was Joint Advisory Group on gastrointestinal endoscopy (JAG) accredited. This meant that the endoscopy suite met the required standards of competency and quality, as set by JAG.
- Patient Reported Outcome Measures (PROMS) data was collected for total hip and knee replacements using the Oxford Hip and Knee score. Data for the Oxford Knee Score showed that out of 51 patients, 90% reported an improvement. Data for the Oxford Hip Score showed that out of 38 patients, 95% reported an improvement.
- Female patients of child bearing age were tested for pregnancy prior to surgery. This was audited, as part of Spire's clinical score card and compliance was 100%. This was better than the target of 95% and the Spire average which was 99%.
- The National Joint Registry (NJR) data was routinely entered with patient consent at point of surgery. We reviewed the February 2016 annual NJR clinical report and saw that all indicators, such as consent rate and revision rates (where surgery needs to be redone) were green, indicating that they met or exceeded the benchmark target.
- Between September 2015 to August 2016 there were three unplanned returns to theatre. These returns to theatres all involved different procedures; total hip replacement, tonsillectomy and upper and lower blepharoplasty (eyelid lift). There were no themes identified as a common cause for the return to surgery.
- Between September 2015 to August 2016 there were three unplanned transfers to other hospitals from the ward and theatres. This is not high compared to other independent acute hospitals. These were investigated and no themes were identified.
- From April 2015 to March 2016 there were 12 unplanned readmissions within 28 days of discharge.
- The cosmetic surgery revision rate, where patients have their cosmetic surgery revised as they are dissatisfied with some aspect of the result, was just under 5%. This is in line with the rate of 5%.
- Care bundles (a set of interventions that, when used together, improve patient outcomes) were used to improve outcomes for peripheral lines, central venous catheter lines and urinary catheters.

- There was a clinical audit and effectiveness group to learn from audit results. This group was made up of front line staff who reviewed audit outcomes and fed lessons back to staff.
- South Bank Hospital was one of the first of Spire's hospitals to adopt the Private Healthcare Information Network (PHIN) system. This was a new requirement where private providers had to commence submitting data by 1 September 2016 to the Competition and Markets Authority. In order to ensure compliance with the new regulations the service used patient satisfaction surveys and an adverse event database had been completed.

Competent staff

- Staff had the right qualifications, skills, knowledge and experience to do their job. All nursing staff were trained in intermediate life support (ILS). In addition, there were nine other hospital staff who held a current advanced life support (ALS) certificate.
- An external agency was used to recruit RMOs. The agency was responsible for their training. The RMO we spoke with was trained in ALS, European paediatric advanced life support (EPALS) and advanced trauma life support (ATLS). All RMOs who worked at the hospital were trained in ALS as a minimum.
- The hospital provided an induction programme for new staff. We saw induction training signup sheets available on the ward for new staff.
- We reviewed two staff competency booklets including one for a scrub nurse and a recovery nurse and saw that these had been completed appropriately.
- Staff were encouraged and given opportunities to develop. We spoke with staff who had worked within the service for some time, and who had worked their way up through the organisation to management positions. Healthcare assistants were being trained in acute illness management strategies (AIMS) to ensure their continuing learning and development.
- A continuing professional development optometrist education programme was in place.
- There were arrangements in place for supporting and managing staff. Workshops were held for nurses undergoing revalidation with their professional regulator. We were given examples of extra support put in place for newly qualified staff, to ensure that they felt comfortable and confident in undertaking their duties.
- The hospital's appraisal year ran from January to December. Evidence submitted in June 2016 prior to our inspection demonstrated that 40% of registered theatre nurses and 64% of theatre staff and healthcare assistants had undergone their appraisal. There were plans in place to ensure the remaining staff had their appraisal before the end of the year.
- The hospital had clinical supervision guidelines which stated that supervision sessions should be held at a minimum of every eight weeks. We heard that clinical supervision generally took place about three times a year. However, staff of all levels told us that they would ask their line manager for supervision if they felt that they needed it.
- There was a clear process for the granting of practising privileges for new consultants. This required consultants to send in a CV, a formal application, have an interview and have an endorsement from a medical advisory committee (MAC) representative.
- The role of the medical advisory committee (MAC) included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document. The MAC checked registration with the General Medical Council the consultants' registration on the relevant specialist register, Disability and Barring Service (DBS) check and indemnity insurance.
- Practising privileges for consultants were reviewed every other year. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of practice, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to check when privileges were due for review.
- The service ensured that consultant surgeons only carried out surgery that they were skilled, competent and experienced to perform. When each consultant applied for practising privileges they provided a scope of practice. There was a procedure in place to prevent surgeons from operating outside their scope pf practice. Surgeons at the hospital only carried out surgery that they also did in their NHS trust, to ensure that they maintained their skill in these areas. If there were

concerns regarding surgeons' competencies to carry out particular operations then the hospital director would speak to the NHS trust that they were employed with and request evidence of certification in that area.
- Poor or variable staff performance was identified and managed. Managers gave us examples of staff who had been identified as underperforming and the action taken to help improve their performance. This included them working on a supernumerary basis; where they were not allocated any patients, to allow them to shadow and learn from more experienced colleagues.
- Within endoscopy, the manager kept track of the number of procedures each consultant carried out. If this number was less than 100 for a year, they contacted the consultant's NHS practice to check that they had carried out an adequate number of procedures there, to ensure their competency was current and up to date.
- Surgical first assistants were qualified and competent. Two of the first assistants were qualified as level one advanced scrub practitioners and one assistant was qualified as level two.
- From April 2015 to March 2016, 21 consultants had their practising privileges removed. A further seven consultants had been suspended from practising. This included consultants who had relinquished their practising privileges, had retired or were suspended as a result of not maintaining their GMC registration or failing to provide evidence of mandatory documentation.

Multidisciplinary working (in relation to this core service only)

- All necessary staff were involved in assessing, planning and delivering patients' care and treatment.
- Physiotherapists were employed, some of whom were based in the ward. We saw physiotherapists helping patients recovering from joint operations, assisting and teaching them to walk with mobility aids. The physiotherapists worked closely with the nursing staff to, for example, help a patient get washed and dressed as part of their therapy.
- The pharmacist attended the ward daily to rotate medication stock and top up any medications which had been used during the previous day. The pharmacist was involved in decisions about medication, along with the RMO.
- Patients were discharged from a service at an appropriate time of day and all relevant teams and services were informed if necessary. If care assistance was required from social services, discharge only occurred once any ongoing care had been organised and was in place.
- There was evidence of team working between theatre staff and ward staff with both sets of teams aware of changes in practice in the different areas.
- Arrangements for discharge were considered prior to elective surgery taking place. Discharge arrangements were discussed at pre-admission and confirmed following admission to ensure that any involvement from external organisations which were needed was finalised.
- Relevant information was shared between the provider and GP. For example details of the surgery and any implant used were detailed in the patient's notes and in the discharge letter.
- A service level agreement for the transfer of critically ill patients to the local NHS trust, if patients deteriorated whilst in the hospital.

Seven-day services

- Consultants were on call seven days a week for inpatients in their care.
- An RMO was on the ward 24 hours a day, seven days a week, to provide medical care to patients. The RMO could access a locked medication trolley that was kept on the ward, out of hours, when the pharmacy was closed. The trolley contained painkillers and antibiotics that were most frequently required by patients. This was reconciled by the pharmacist.
- The pharmacy was open Monday to Friday, during office hours. If patients required medications outside of this time, which were not held in the medication trolley, then an on-call service was provided by the local NHS trust.
- There was an on-call system for theatre staff who would be called if a patient needed to return to theatre out of hours.
- There was a radiographer available 24 hours a day on an on call basis.

Access to information

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.

Good

Surgery

- There were pathways for different types of procedures. These pathways ensured that the progress was made and any deviation from the prescribed pathway could be identified and an appropriate intervention made swiftly.
- From March to June 2016 all patients who were seen had all of their relevant medical records available.
- Computers were available in the wards and theatre areas. All staff had secure, personal log in details and had access to e-mail and all hospital systems.
- Care summaries were sent to GPs on discharge to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Not all staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 (MCA) and the Children's Acts 1989 and 2004.
- There was a consent policy in place which set out the importance of consent, the test for capacity as per the Mental Capacity Act 2005 and the roles of advanced decisions and lasting powers of attorney. Staff were aware of the policy but were not familiar with it.
- Nursing staff we spoke with were unable to tell us the legal test for mental capacity, as set out in the MCA 2005. Nursing staff were unsure of how to assess mental capacity and told us they would ask a set of questions including, the name of the current prime minister, and what year it was. These questions are part of a test to identify whether a patient may be living with dementia; not the test for mental capacity. Nursing staff told us that they never took consent from patients, as this was done by the consultant for the surgical procedure.
- Not all nursing staff were aware of how young people aged 16 – 18 would consent for procedures. Two nurses told us that they would seek consent from the young person's parent in this instance, which is contrary to the MCA, where young people over the age of 16 can consent for themselves. However, following the inspection the hospital withdrew its services for young people and therefore, this risk has been mitigated.
- Nursing staff were aware that a written consent should be obtained and that patients could not go to the operating theatre without a written consent form completed and signed, however, were unaware of the wider issues surrounding consent.
- The service audited their compliance with the completion of consent forms. We reviewed the most recent audit from July 2016 and saw that 100% of the 10 records reviewed were completed in full, with the risks and benefits filled in and both the consultant and patient signing and dating the form.
- We reviewed 11 consent forms and found that these had been completed.
- There were processes to aid translation during the consent process. If English was not the patient's first language, there was access to a translation service.
- The service observed the two week cooling off period in between consultation and surgery, for patients undergoing cosmetic procedure, as recommended by the Royal College of Surgeons.

Are surgery services caring?

Good

Overall, we rated surgical services as good for caring because:

- Patients were treated with compassion, with their dignity and respect upheld.
- Catering staff were aware of religious and cultural preferences for food and catered for these accordingly.
- Patients felt well cared for and would recommend the service to others.
- Staff respected patient confidentiality.
- Patients understood their care and treatment and had opportunities to ask questions.
- We observed staff introducing themselves and interacting well with patients.
- Staff had access to contact details for religious leaders, to help meet patients' spiritual needs.

However, we also found that:

- The service's score for patient-led assessment of the care environment (PLACE) was 80% for privacy, dignity and wellbeing.

Compassionate care

- Staff understood and respected people's personal, cultural, social and religious needs, and took these into account.

- There was a local policy for patients requiring religious and cultural consideration. The policy covered various religious and cultural groups, and explained differences in preferences in relation to prayer, blood transfusion, same sex physicians, food and after death rituals.
- Catering staff were aware of different religious and cultural preferences regarding food and provided meals that complied with these accordingly.
- We reviewed the patient satisfaction survey results from May 2016. This was a Spire document, which was collated by an external company. This showed that 97% of patients would recommend the hospital. The results also showed that 99% of patients felt that the care and attention from nursing staff was either excellent or very good.
- Staff took the time to interact with patients and those close to them in a respectful and considerate way. We observed compassionate care towards patients from nursing staff, theatre staff health care assistants and physiotherapists. Staff put patients at ease and were approachable to patients.
- Staff showed an encouraging, sensitive and supportive attitude to patients and those close to them.
- We observed staff introducing themselves to patients before starting care, and the patients we spoke to confirmed that staff always did this.
- The Patient-led Assessment of the Care Environment (PLACE) score for 2016 showed that the service scored 80% for privacy, dignity and well-being. This was a slight decrease from the 2015 score which was 81%. The independent acute hospital average was 84%.
- However, patients we spoke to during the inspection told us that they had been treated with dignity and respect during their admission.
- Out of the 183 patients surveyed in May 2016 via the Spire patient survey, 99% agreed that they were given privacy during discussions about their condition and treatment and 99% of patients felt that they were always treated with respect and dignity.
- Staff made sure that patients' privacy and dignity was respected, including during physical or intimate care. Staff ensured that curtains were pulled around patients who were nursed in bays, and that bedroom doors were closed for patients within private rooms. During surgery theatre staff behaved sensitively and ensured patients were not unnecessarily exposed.
- Staff respected patient confidentiality at all times. Patients who were nursed in bays were brought into private rooms for sensitive conversations, although there was no specific room for this. We were told by nursing staff that they would find an unoccupied bedroom to have these conversations in.
- The friends and family survey results between October 2015 and February 2016 were similar to the England average for NHS patients, with between 96% and 100% of patients recommending the service. However, in March 2016 this score dropped to 89%. Response rates were above the England average for October and November 2015; at 84% and 65% respectively, however, remained under the England average for the rest of the reporting period; December 2015 to March 2016, with response rates ranging from 9% to 35%.
- Patient feedback from comment cards was overwhelmingly positive.
- Staff made the hospital feel as normal as possible for patients. There was flexible visiting hours for all patients. Patients nursed within private bedrooms had their own television and toiletries were provided within the ensuite bathroom.
- Staff supported patients to be mobile and independent postoperatively. Physiotherapists encouraged patients to get mobile soon after surgery and promoted independence.

Understanding and involvement of patients and those close to them

- Staff communicated with patients so that they understand their care, treatment and condition.
- Patients we spoke to confirmed that staff explained their care and treatment in easy to understand terminology and that all relevant risks and benefits of the operation had been discussed prior to the patient consenting.
- Consultants visited patients following their operation and answered any questions that patients had.
- The service's patient satisfaction survey results from May 2016 showed that 95% of patients agreed that they were involved with decisions about their care and treatment. Out of 135 patients 91% said that they 'definitely' found staff to talk to about their worries, with the remaining 9% agreeing with this 'to some extent'.
- The survey also showed that 94% of patients said that staff told them about medication side effects to look out once they were back home.
- Staff recognised when patients and those close to them needed additional support to help them understand

and be involved in their care and treatment. There was access to a service which provided translators for patients for whom English was not their first language. The service also had access to sign language interpreters for deaf patients.
- Patients and those close to them were routinely involved in planning and making decisions about their care and treatment. Patients we spoke to confirmed that they were involved throughout the process and given choices where appropriate.
- Staff advised patients about all possible costs that would be incurred. We saw in the medical notes we reviewed, that all self-funding patients received a written quotation for proposed treatment before they decided to go ahead and before any deposit was paid. Discussions regarding costs were held by the service's sales team, as opposed to the clinicians.

Emotional support

- Staff understood the impact that a patient's care, treatment or condition would have on their wellbeing. We saw staff take the time to sit with patients and interact with them.
- The service's policy on patients requiring religious and cultural consideration included details of varying religious organisations, who could be contacted if patients had spiritual needs.
- Nursing staff provided examples of extra steps that they would take if a patient living with dementia was admitted to the ward. They explained that as these patients often find hospitalisation distressing, that they would allow family members to remain with the patient for longer than usual, in order to help orientate them and calm their fears.
- There was free Wi-Fi throughout the hospital, to help patients contact those close to them and to retain links to their social networks and communities.

Are surgery services responsive?

Good

Overall, we rated surgical services as good for responsiveness because:

- Patients told us they received appointments quickly.
- When operations had to be cancelled, they were always rescheduled within 28 days.
- The service had improved its performance in discharging day case patients within six hours of admission.
- All patients aged over 75 were screened for dementia. Any patients identified as living with dementia followed a dementia care pathway. Staff had an awareness of dementia and had received training in this.
- The service had hearing loops and access to sign language interpreters for patients with hearing impairment. The service had access to translation services for patients for whom English was not their first language.
- Patients knew how to complain and felt confident in doing so and staff were able to explain actions they would take if they received a complaint from a patient.
- The hospital was planning commencing a new spinal service which would be the first in the county.

However, we also found that:

- The service was performing under organisational targets in relation to discharging patients before 11am.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to inform how services were planned and delivered. The hospital was in the process of starting a spinal service which would be the first of its kind in the county. This would mean that patients requiring spinal surgery would no longer need to travel to Birmingham for some types of surgery.
- The services provided reflected the needs of the population they served and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available, including cosmetic surgery, general surgery and endoscopy.
- The hospital had two laminar flow theatres (where air is moved at the same speed and in the same direction, to avoid contamination), and one laparoscopic (keyhole surgery) theatre. The laminar flow theatres operated Monday to Saturday 8am to 6pm and the laparoscopic theatre operated Monday to Friday 8am to 6pm. Both of the laminar flow theatres had provision for emergency procedures for general surgery and orthopaedics if a patient had an unplanned emergency return to theatre.

Good

Surgery

- Although the theatres mainly operated Monday to Saturday 8am to 6pm, further sessions could be offered until 8pm to provide patients and consultants flexibility.
- We were also told that the service offered evening and weekend clinics to provide flexible access to appointments. Patients we spoke with confirmed that they were given a choice of appointments and that they were able to schedule their procedures at a time convenient for them.
- The service offered patients access to consultants of their choice, who had practising privileges at the hospital.
- The service carried out work that the local NHS trust was unable to perform in time, in order to reduce the number of patients breaching their 18 week referral to treatment time.
- The facilities and premises were appropriate for the services that were planned and delivered. The service had two laminar flow theatres, (where air is moved at the same speed and in the same direction, to avoid contamination), that were used for ophthalmic surgery, urology surgery, cosmetic surgery, ear, nose and throat surgery and orthopaedic surgery. The service also had a laparoscopic theatre which was used for laparoscopic (keyhole) surgery, bariatric surgery and minor vascular surgery.
- Senior ward staff held weekly bed management meetings, to assess the number of expected patients and ensure sufficient bed space for them. We observed one of these meetings and saw that two patients had been booked into the same bed space for the same day. As this was reviewed in advance, staff managed to find another suitable bed for the patient, ensuring that there were no issues or delay on admission.

Access and flow

- Patients had timely access to initial assessment and treatment.
- The referral time to treatment (RTT) was used for tracking waiting times for treatment for NHS patients. This target is that 90% of patients should begin treatment within 18 weeks of their original referral. The target was abolished in June 2015. From April 2015 to November 2015 the target had been exceeded, ranging between 94% to 99% of patients being treated within 18 weeks. However, from December 2015 to March 2016 the service's performance fell to between 80% to 87%.
- Waits for appointments and treatment were minimal for private patients. Patients we spoke with told us that from their initial referral or appointment, they were seen quickly and without delay. All the patients we spoke with were happy with the length of time between initial consultation and the operation date.
- Patients accessed care and treatment at a time to suit them. Patients we spoke with told us they were given a choice of dates for their procedure.
- Action was taken to minimise the time patients had to wait for treatment or care. Extra theatre lists were added when necessary, to ensure patients were treated without delay.
- Care and treatment for patients with the most urgent needs were prioritised. Patients who had co-morbidities to be considered, for example those with diabetes, were placed at the beginning of the theatre lists so that they got operated on as quickly as possible, regardless of whether they were private or NHS patients. Once any urgent patients had been treated, privately funded patients were prioritised over any non-urgent NHS patients.
- The appointments system was easy to use and supported patients to access appointments. Staff told us that the system was accessible and patients reported that from their perspective, making an appointment had been an easy process.
- Care and treatment was only cancelled or delayed when necessary. The service cancelled 14 procedures for non-clinical reasons from April 2015 to March 2016. Cancellations were explained to patients, and they were supported to access care and treatment again as soon as possible. All 14 of the cancelled patients were offered another appointment within 28 days of the cancelled appointment.
- There was a target in place to discharge 55% of inpatients before 11am on their day of discharge. For the first quarter of 2016 the service failed to meet this target, discharging 41% of patients before 11am. The Spire average for the quarter was 52%. For the second quarter of 2016 the service had improved to discharging 47% of patients by 11am, however, this was still below the target.
- 67% of day case patients were discharged within six hours of admission in the second quarter of 2016. This was an improvement from the first quarter where they

discharged 58% of day case patients within six hours of admission. Whilst the service did not have a target for this performance indicator, this was in line with the Spire average.

Meeting people's individual needs

- Services were planned and delivered to take account of the needs of different people.
- Patients at risk of living with dementia were identified during the pre-assessment stage. All patients aged over 75 years old had dementia screening. Any patients who screened positive for living with dementia were risk assessed and followed a dementia care pathway. All staff were aware of dementia and had attended training on caring for patients living with dementia.
- Reasonable adjustments were made so that disabled patients could access and use services on an equal basis to others. All areas of the ward were wheelchair accessible.
- The hospital used a hearing impairment service to ensure that patients with hearing difficulties could still access and use services. We also saw that hearing loops were available for patients or relatives with hearing aids.
- The hospital engaged with patients who were living in vulnerable circumstances and actions were taken to remove barriers when people find it they found it hard to access or use services.
- There was a translation service available for patients for whom English was not their first language. Staff were aware of the service and how to access it. We were told that any interpreting requirements were usually identified at pre-admission and that arrangements were then made to ensure a translator was present when the patient was admitted.
- Relatives could stay with patients in the anaesthetic room if the patient desired.
- Arrangements were in place to take account of needs of patients being discharged that had complex health and social care needs. Staff explained the process for getting assistance from social services to help patients following discharge.
- The service had a dementia lead and staff had completed dementia awareness training.
- A psychologist was available if patients required mental well-being assessment. If a patient was assessed as requiring this, arrangements were made for their transfer to the local NHS hospital.
- We spoke with the catering staff who explained that they provided a wide ranging menu including vegetarian, vegan, halal, kosher and gluten free. They explained that patients could order food not on the menu if they wished, and that the hospital chef would make it accordingly.
- Patients we spoke to confirmed that the food was good quality and tasty.

Learning from complaints and concerns

- Complaints were handled effectively and confidentially, with a regular update for the complainant and a formal record was kept.
- Patients knew how to make a complaint or raise concerns and were confident in doing so.
- There was a Spire leaflet entitled: 'Please talk to us'. These leaflets explained to patients how to raise concerns or complaints. There were also posters on display which asked for feedback. Patient discharge surveys were available where patients could raise concerns.
- Patients we spoke with told us that they had been provided with details of who to contact if they were unhappy with anything. All of the patients we spoke to told us that there was nothing they wanted to complain about, and provided only positive feedback.
- The service had received 68 complaints from April 2015 to March 2016. This was an increase on the previous two years, where they had received 19 (April 2013 to March 2014) and 38 (April 2014 to March 2015).
- There was a Spire corporate complaints policy. The hospital director had overall responsibility for the management of complaints. All complaints were entered into the hospital's electronic incident reporting system and investigations were carried out by the head of department. All individuals involved in the complaint were sent a copy and were asked to provide a statement, if appropriate.
- Complaints were acknowledged within 48 hours of receipt of the complaint, in writing. The complaints process and what the complainant could expect was explained within the acknowledgment. The service then had 20 working days to investigate the complaint. If the complaint was complex and would not be completed within 20 working days a holding letter was sent to the complainant so that they were kept informed.

Good

Surgery

- In the first three months of 2016 the service 70% of complaints had a response letter within 20 days, below the service's target of 75%.
- There was a three stage complaints process, which is an industry standard. If the complainant was not satisfied with the outcome of the investigation, they were invited into the hospital to meet with senior staff. Second stage clinical complaints were escalated to the Spire Medical Director.
- Third stage complaints were escalated to the Health Service Ombudsman or the Independent Adjudication service, whichever was appropriate. However, no complaints had been escalated to level three during the previous year.
- During the first three months of 2016, 1.7% of level 1 complaints were escalated to level 2, against a maximum target of 1.5%. This showed that whilst the hospital was mainly on track with resolving complaints, there were some which were unable to be resolved at the local level.
- Lessons were learned from concerns and complaints and action was taken as a result to improve the quality of care.
- 'You said…we did' posters were displayed around the hospital which showed actions taken as a response to complaints. Some of the posters we saw showed that patients had complained about difficulties in putting on anti-embolism stockings. As a result stocking aids were purchased to help patients. There had been several complaints regarding difficulties in car parking at the hospital. As a result of this staff parked off site on a rotational basis to ensure that there were sufficient car parking spaces for patients and their visitors.
- Complaints were reviewed by the medical advisory committee (MAC), the clinical governance committee and the incident review committee. These reviews identified that there was a trend of complaints regarding billing and charging. Therefore, the service displayed new posters in the waiting areas explaining the charging system. As a result of this there had been a decrease in complaints about charging. It had also been identified as a result of a complaint that further training was required for staff on postoperative lymphedema (a chronic condition involving the build-up of fat cells) following a complaint regarding care. Training was then scheduled for the appropriate staff.
- Any lessons learnt were reported on the service's electronic incident reporting system for audit purposes.

Are surgery services well-led?

Good

Overall, we rated surgical services as good for well-led because:

- The hospital had a clear governance structure and framework.
- Audit results were discussed at governance meetings, with findings cascaded to staff through team meetings and via email.
- The senior managers responded promptly to concerns about children's services.
- Service level agreements were reviewed regularly to ensure they were still fit for purpose.
- Leaders were visible and approachable, with the hospital director and matron visiting the ward and theatres daily.
- Staff felt respected and valued and described the staff within the service as 'like family'.
- Patient feedback was obtained through surveys and management ward rounds. Information gathered informed changes to practice.
- Staff engagement with the service had increased significantly since October 2015.
- The hospital was in the process of introducing a new spinal service, to meet the need of the local population.
- The service used new advances in surgical procedures to ensure that patients received the best care possible.

However, we also found:

- The risk register contained mostly corporate risks. There were no dates when the risk had been added or target dates for completion.
- Not all root cause analysis were completed, but had been signed off by both the governance and medical advisory committee as complete.
- There was no strategy or oversight around the safeguarding requirement for young people aged 16-18 years old. There was no understanding of this risk from the senior managers.
- A business plan had been developed, although this lacked strategic direction and was not supported by clear objectives and milestones.

Vision and strategy for this this core service

- There was a clear vision and a set of values, with quality and safety the top priority.
- The hospital's vision was to be recognised as a world-class healthcare business, with a focus on developing excellent clinical environments and delivering the highest quality patient care.
- There was a strategy and business plan for achieving the priorities and delivering good quality care. Progress against delivering the strategy had been monitored and reviewed at the senior management team strategy day. The business plan was also reviewed when the new senior management team came into post in late 2015. However, although this contained objectives, there were no dates for delivery and no milestones in place with regards to progress.
- The business plan was created by the senior management team and distributed through heads of department to all staff, including the use of staff forums.
- Staff knew and understood what the vision and values were. Staff were able to tell us the values such as 'caring is our passion' and 'driving excellence'.

Governance, risk management and quality measurement for this core service

- There was a governance framework to support the delivery of the strategy and good quality care.
- There was a governance structure throughout the hospital. The hospital had a number of subcommittees, which then reported trough to the Spire board. All these committees had terms of reference which accurately reflected their role in the hospital, their structure and purpose.
- Clinical effectiveness and audit meetings monitored and discussed safety alerts, shared learning from incidents, policy updates and reported to the clinical governance committee (CG).
- The hospital had a schedule of annual audits with associated timescales. Audit reports were reviewed locally at clinical governance meetings and medical advisory committee (MAC) and the results were shared with staff through the heads of department. We saw evidence of this in the theatre and ward meeting minutes and staff we spoke with confirmed this. All consultants received copies of the MAC minutes electronically.
- The hospital reviewed and managed risks through use of committees such as the MAC, the clinical governance committee and the incident review committee.
- The hospital had a corporate driven risk register, which had been issued in March 2016. The corporate register was difficult to navigate and lacked defined action plans and deadlines. Although there were columns to add key information, for example, dates when risks had been added and key actions, none of these had been completed. Some of the risks stated, for example, lack of hard flooring in clinical areas, was the cause, not the risk. During our feedback to the hospital we discussed this with the hospital director and two senior members of the Spire management team, who agreed the risk register, required a review.
- Senior managers were unaware of the requirements surrounding the care of young people, for example, that all those caring for children and young people were required to undergo level three safeguarding training. This lack of understanding was reflected in the hospital's care of children and young people's policy.
- There was a Spire corporate clinical governance and quality assurance policy. The policy underpinned the service's governance and quality programme and covered clinical risk, research, education and the governance structure.
- Staff were clear about their roles and understood what they were accountable for. Staff were aware of the limits of their practice and escalated issues that arose which were beyond their professional competencies.
- Working arrangements with partners and third party providers were managed well. Each service level agreement had a process for reviews. A new hospital director had been employed from November 2015. Upon their employment they had reviewed all existing service level agreements and contracts with external organisations to ensure that they were fit for purpose.
- There was a holistic understanding of performance, which integrated the views of people with safety, quality, activity and financial information. Staff we spoke with, from junior level to senior managers, all described that although the hospital was a business, and needed to be commercially profitable, that patient experience and their safety came first. Almost all nursing staff we spoke to explained that they viewed patient safety as the highest performance indicator, and that they did not think about the commercial side of the business. Staff told us that this balance towards patient focus had increased with the recruitment of the new senior management team.

Good

Surgery

- There were comprehensive assurance systems and service performance measures, such as the clinical scorecard, which were reported and monitored. Action was taken to improve areas of poor performance that were identified, such as compliance with fasting guidelines. As a result of this we saw that compliance increased in the next scorecard.
- There was an alignment between the recorded risks and what staff said was 'on their worry list'. Staff told us that their main worries were infections (surgical site and general infections) and safe staffing levels. Both of these were on the risk register.
- Consultants working under practising privileges had indemnity insurance. This was checked as part of the process for granting and reviewing practising privileges.
- There was a sepsis lead in place and sepsis training was covered within mandatory training. Guidance was available on assessing and treating sepsis.
- The service had not conducted any sepsis audits at the time of our inspection. However, the service planned to incorporate this into their audit plan for quarter four (last three months of the year).
- There was a strategy for continuous improvement in infection prevention and control. We reviewed the 2016 annual plan and saw that action plans were in place as part of their ongoing strategy. Each action had an assigned lead, a due date and updates where relevant.

Leadership / culture of service related to this core service

- The hospital was led by a senior management team, the majority of whom were newly appointed comprising of a hospital director, a matron, an operations manager, a finance and commercial manager and a business development manager. The ward and theatre each had their own manager, both of whom had worked at the hospital for a substantial length of time, and worked their way up to management positions.
- Leaders understood the challenges to good quality care and identified the actions needed to address them. They were aware of their areas which needed improvement, such as the need for refurbishment within the ward and bedrooms, and were in the process of putting together a business plan to request the funds to action this.
- The hospital director was responsive to the concerns we raised during the inspection regarding the care and treatment of young people. As a result of us raising concerns the hospital director stopped treating young people under the age of 18 with immediate effect.
- Leaders were visible and approachable. All staff we spoke with confirmed that the hospital director and matron visited the theatres and ward daily and that they knew each staff member's name. Staff said that it was noticeable how visible the senior management team and noted this as very positive. The ward and theatre managers were also visible and approachable. Staff told us that they could raise concerns or share ideas with their managers and that this was supported and encouraged.
- Leaders encouraged appreciative, supportive relationships among staff. Staff members told us that colleagues and managers had provided excellent support during personal difficulties.
- All staff felt respected and valued. Staff said that the service was 'like a family' and that everyone was supported and respected. Staff were encouraged to develop and maximise their potential.
- There was a whistleblowing policy in place and a corporate whistleblowing officer who maintained a confidential central register of whistleblowing concerns. Staff we spoke with felt confident in raising whistleblowing concerns if needed.
- The culture was centred on the needs and experiences of patients. Staff confirmed that this was their top priority. Many of the staff we spoke with had worked in the hospital for a substantial length of time. Many of these cited the culture and working environment, with the ability to focus on individual patients, as a reason for their length of stay.
- The culture encouraged candour, openness and honesty. Staff were trained in duty of candour and were aware of their roles and responsibilities under this.
- There was an emphasis on promoting the safety and wellbeing of staff. Confidential counselling was available if required for any staff member.

Public and staff engagement

- Patients' views and experiences were gathered and acted on to shape and improve the services and culture.
- The service used the friends and family survey and patient-led assessment of the care environment (PLACE)

audits to gain feedback on patients' experiences. The friends and family test is a survey designed for NHS patients to gauge feedback from patients about the quality of service and whether patients would recommend the service to their friends and family. The service had monthly customer experience group meetings which discussed the patient satisfaction survey and planned any actions arising as a result of this.

- The senior management team undertook ward rounds to engage with patients.
- There had been an attempt to hold patient forums but patients had not engaged with this.
- Staff felt engaged and that their views were reflected in the planning and delivery of services and in shaping the culture. The hospital conducted a staff engagement survey in August 2016. This found that 89% of staff felt fully engaged at work, an increase on the previous survey from October 2015, where 84% had felt engaged. Similarly, 87% of staff felt that their manager consulted them on decisions that impacted on them or their role. This was an increase of 17% from the previous survey and 7% higher than the Spire average. Similarly, 91% of staff agreed that managers valued their ideas, an increase of 21% from the previous survey.
- There was close cooperation and involvement of the surgeons and anaesthetists during the planning and construction of the laparoscopic theatre.
- Both leaders and staff understood the value of staff raising any concerns. Front line staff understood that they had the most direct contact with patients and therefore, would be the most likely person to hear of concerns. Senior staff were aware of this and therefore, encouraged front line staff to report this accordingly so that any issues could be fed back.

Innovation, improvement and sustainability

- When considering developments to services, the impact on quality and sustainability was assessed and monitored. The service was in the process of developing a new spinal service, which would be the first of its kind in the county. The theatre manager told us that in order to ensure that this new service would be sustainable; they would have to review staffing levels and consider recruitment of new staff.
- The senior staff were adamant that there had never been an occasion where financial pressures had compromised patient care.
- Leaders and staff strived for continuous learning, improvement and innovation. Many of the staff we spoke with had started working at the hospital in junior positions, and had worked their way up to management roles. One staff member we spoke to had started working as a healthcare assistant and had been supported to obtain a nursing degree and was then employed at the hospital as a registered nurse.
- The hospital had started doing intraoperative radiotherapy. This is where during surgery, once a tumour had been removed, a concentrated dose of radiation therapy was delivered to the tumour site. This is used instead of traditional radiotherapy following surgery, where patients would have to attend daily trips, for a number of weeks to the hospital.
- The hospital had also introduced the use of Toric intraocular lenses for cataract surgery patients. Toric lenses correct astigmatisms (an eye defect which impacts on long distance vision); therefore, patients who received toric lenses during cataract surgery were treated for both cataracts and astigmatisms. This meant that patient no longer needed glasses for long distance vision.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Spire South Bank Hospital provides an outpatient service for various specialties to both private and NHS patients. These include, although not limited to, general surgery, orthopaedic, ophthalmology, dermatology and urology. There is also an outpatient service for private oncology patients.

There were 39,013 outpatient total attendances in the reporting period (April 2015 to March 2016); of these 32% were NHS funded and 68% were private. This included 300 children and young people from birth to 18 years, who were all private patients.

There are 10 consultation rooms and three treatment rooms within outpatients. There are also separate units for oncology and haematology, Spire Eye Centre (SEC), breast unit, bone and joint clinic and the imaging department. There are dedicated receptions for each outpatient area.

Oncology and haematology services provide treatment in two chairs, for breast, urology, upper and lower gastrointestinal, and both malignant and non-malignant haematology disorders. This service was for private patients only.

The imaging department offers plain film radiography, computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound, fluoroscopy as well as digital mammography. There are separate waiting areas and dedicated changing facilities within the department.

We spoke with 16 staff members, including consultants, nursing staff, care assistants, allied health professionals, senior management and support staff. We spoke with four patients and reviewed 14 sets of notes.

Summary of findings

We rated outpatients and diagnostic imaging services as requires improvement for safety and well-led and good for caring and responsive. CQC do not have the methodology to rate the effective domain.

- Patient records maintained by the imaging department were not always legible. Records in the main outpatient department (OPD) area were not always stored securely although these were in private consulting rooms rather than in public areas.
- Most of the staff were unclear of the procedure to report safeguarding concerns and told us that they would refer concerns to their line manager and/or matron.
- Suitable arrangements were not in place to ensure advice could be obtained from a Registered Nurse (child branch) when children attended for appointments.
- Not all staff, who dealt with children were trained to the right level in safeguarding.
- Adult nurses had not received additional training and skills through completing competencies to enable them to care for children and young people. However, we raised this and our safeguarding concerns with the hospital director who agreed to cease treating children and young people, with immediate effect.
- Some of the consulting rooms did not comply with best practice with regards to infection prevention and control.
- Conversations about patients between staff could be overheard by other patients.

Requires improvement

Outpatients and diagnostic imaging

- There were no formal supervision arrangements in place.
- There was no mechanism in place to monitor referral to treatment times of private patients.
- There was no hearing loop in the main outpatients.
- The hospital had a clear vision and this was displayed throughout the hospital, on all desktops and formed part of the annual enabling excellence programme. Despite this not all staff were aware of it.
- A business plan had been developed although this lacked strategic direction and was not supported by clear objectives and milestones.
- Outpatient meetings were not held regularly and there was no discussion around performance of the department.
- Outpatient performance was not discussed at the Clinical Governance Committee.
- The risk register was not used to identify and record local risks faced by the hospital.

However, we also found:

- Care and treatment was delivered in line with evidence-based guidance.
- Patients' nutritional and hydration needs were met.
- Patients' pain levels were assessed and managed according to their need.
- Staff had the right qualifications, skills and knowledge to do their job.
- Multidisciplinary team (MDT) working practices were in place.
- Information about patients and clinical guidance was available to staff and provided in a timely manner.
- Staff had an understanding of the relevant consent and decision making requirements of legislation.
- Staff understood people's needs and provided compassionate care.
- Clinical staff communicated well with patients so that they understood their care and treatment options.
- Staff understood the impact of treatment for patients and those close to them and took the time to listen to their concerns.
- Services were planned and delivered in a way that met the needs of the local population and flexibility was reflected across each of the outpatient services.
- Care and treatment was accessible at the patients' convenience.
- 'One-stop' clinics for some specialities were available so patients could undergo tests and a consultation within the same appointment to minimise patient attendances.
- 98% of NHS patients were seen by a consultant within 18 weeks of their initial referral. Private patients were seen very rapidly.
- The services had processes in place to manage patients with complex needs, including those with a learning disability.
- Information on complaints or how to raise a concern was available to patients. Complaints and concerns were responded to in line with the complaints policy.
- Each area of outpatients was overseen by a head of department, with exception of the breast unit, radiology staff reported to the imaging head of department and nursing staff reported to the outpatients' head of department.
- The views of staff and patient views and experiences were gathered and action plans developed to improve the service.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We found outpatients and diagnostic imaging services required improvement for safety because:

- Most of the staff were unclear of the procedure to report safeguarding concerns and told us that they would refer concerns to their line manager and/or matron.
- Not all staff were trained to the required level of safeguarding children. Those who were trained to the right level, were not always scheduled to be on duty when a child attended a clinic.
- Suitable arrangements were not in place to ensure advice could be obtained from a Registered Nurse (child branch) when children attended for appointments. We raised this and the levels of safeguarding training with the hospital director who made arrangements to cease treating children with immediate effect. However, there was a risk that this service could recommence, without measures in place to support the specific needs of children and young people.
- Patient records maintained by the imaging department were not always legible. Records in the main outpatient department (OPD) area were not stored securely although these were in private consulting rooms rather than in public areas.

However, we also found:

- Staff understood their responsibilities to report incidents, incidents were investigated and patients and / or their relatives were informed when things went wrong.
- Good standards of cleanliness and hygiene were maintained within the main OPD and the additional outpatient units.
- Maintenance and use of equipment was carried out according to manufacturer's guidelines. We identified some risks with automatic doors.
- Arrangements were in place to ensure medicines and contrast media were prescribed, recorded, administered and stored appropriately for most outpatient areas.
- There were systems in place to report safeguarding concerns, there had been no safeguarding referrals made within the previous 12 months.
- Risks were managed in accordance with guidance and documented as appropriate in most cases.
- Staffing levels and skill mix were reviewed in advance and each area was staffed safely.
- Arrangements were in place to ensure business continuity.

Incidents

- Staff understood their responsibilities to report incidents, incidents were investigated and patients and/or their relatives were informed when things went wrong.
- There were eight non-clinical and 44 clinical incidents in the period April 2015 to March 2016 with none categorised as serious.
- The hospital had not reported any never events. 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 type 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).
- The hospital used an electronic incident reporting tool to report incidents. The staff we spoke with were confident in the use of the electronic system and told us that they always reported incidents where it was appropriate to do so.
- We were told by staff that shared learning took place at team meetings. We reviewed team meeting minutes and saw incidents were included as an agenda item, this included incidents from within their department as well as the wider hospital and incidents of note from other Spire hospitals.
- We reviewed the root cause analysis for one incident that had happened in outpatients; this included a clear description and chronology of the incident as well as recommendations and an action plan. Agreed actions had been completed promptly.
- We asked staff about their understanding of duty of candour. 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. The majority of staff we spoke with understood what this meant and told us that they would share information with patients and their parents or carers as soon as practicable following an incident.
- There had been no Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incidents.

Cleanliness, infection control and hygiene

- Good standards of cleanliness and hygiene were maintained within the main OPD and the additional outpatient units, we observed the main OPD and individual outpatient units to be visibly clean during the inspection.
- The hospital had an infection prevention and control lead that coordinated infection prevention and control within the hospital. However, this lead, despite being in post for more than six years, did not hold any accredited training in infection control and prevention.
- The hospital held infection prevention and control committee meetings with a consultant microbiologist every two months, where staff discussed recent audits, including hand washing audits and sharps bins audits.
- Sharps, including those that held chemotherapy waste were disposed of correctly.
- We observed that some consulting rooms within outpatients had carpeted floors and some of the flooring where patients received treatments did not join the wall as required by Healthcare associated infection (HCAI): operational guidance and standards, (July 2012,) Health Building Note (HBN) 00-10 Part A: Flooring and HBN 00-10. The hospital had identified this as an infection control risk.
- There was a policy and procedure in place for the management of cytotoxic spillages and there was suitable equipment available and the nursing staff we spoke with were able to tell us how to use the equipment if needed.
- All staff were required to complete infection control training. We were provided with data compliance rates for infection control training and this was variable across each of the outpatient areas; 90% compliance had been achieved by the eye centre, 66% for the main OPD, 54% compliance for imaging and 44% for oncology against a target of 95%. We were provided with a statement from Spire South Bank that training compliance for infection control was 100% for all outpatient areas.
- There was a sticker system in place which indicated equipment had been cleaned and the date that this had been done. We saw that stickers had been placed on equipment; the equipment we saw was visibly clean.
- We observed that staff were bare below the elbows to enable effective hand washing and reduce the risk of infection. We saw that staff wore personal protective clothing as required and this was available throughout the ward areas. Hand gel was available in each area of outpatients.
- We were provided with hand hygiene audits for the Spire Eye Centre, Oncology and OPD for quarter two (April, May June 2016), no areas of non-compliance were found. Some non-compliance had been identified with hand hygiene in OPD in April 2016, this was re-audited in June 2016 and 100% compliance was achieved.
- We saw cleaning schedules for all areas within outpatients and diagnostics as well as each of the additional units which held outpatient appointments. Cleaning schedules for each of the units had been completed on a daily basis; however, we noted that within the main OPD the cleaning schedules were signed weekly to confirm daily cleaning had taken place rather than being signed daily as per other areas. This meant that staff may not be prompted to undertake cleaning daily. We brought this to the attention of the senior managers and the process was revised and implemented during the inspection
- There had been no reported cases of MRSA, MSSA or Clostridium difficile in the preceding 12 months.

Environment and equipment

- The hospital was equipped appropriately and equipment was maintained according to manufacturer's instructions, although we identified some risks with automatic doors.
- We observed that the automatic doors in the eye centre and imaging department presented a potential risk to staff, patients and the public because the doors had frosted glass and opened outwards. This meant that it was not always easy to observe whether someone was standing within range of the door opening out on them, which could present a risk to injuring someone. The

imaging department had identified this as a risk and we were informed that this had been recorded on their local risk register; it had not been transferred to the hospital wide risk register.

- There were clear signs in place where ionising radiation was used, this included lights and warning notices. Access to the magnetic resonance imaging (MRI) room was controlled by keypad.
- All staff had access to personal protective equipment (PPE), including gloves and aprons. In addition to this, the imaging department had lead aprons available.
- A range of equipment items were used within outpatients and each of the separate units. We reviewed the servicing records for a sample of these and found that all items had been serviced in line with requirements and repairs undertaken by the servicing contractors promptly. Specific procedures were followed for imaging equipment to be formally signed over to the engineer and back to the hospital staff to ensure accountability for works undertaken.
- All equipment items which omit radiation must have a set of local rules which are required to be followed in order to comply with the Ionising Radiations Regulations 1999 (IRR99). The local rules are written by the Radiation Protection Advisor (RPA) and must be complied with. Local rules must be reviewed and revised (as necessary) by the RPA every two years. Local rules are to ensure the correct guidance is followed for each specific type of equipment and to minimise the risk of unnecessary exposure.
- Equipment safety testing stickers were in place, with appropriate dates. Equipment safety testing is an annual examination of electrical appliances and equipment to ensure they are safe to use.
- Each area had access to a resuscitation trolley for use in an emergency, with exception of the breast unit. We reviewed the equipment and found that items of equipment were all within date and daily checks were undertaken by staff. The breast unit did not have a complete resuscitation trolley and instead had a bag of airways. We were told that in the event of a cardiac arrest, a team would be called from the main hospital who would attend with the resuscitation trolley. We reviewed an emergency practice scenario that had been undertaken and saw that the system worked well.
- Clinical waste was stored appropriately in designated bins or sharps bins with the correct coloured bag used for each type of waste.
- Radiation risk assessments had been completed for each of the imaging devices as well as occupational safety. For example, risk assessments had been completed for the CT scanner, fluoroscopy, X-ray room, mammography room, mobile x-ray unit as well as risk assessments for patient's carers and nurses supporting patients during imaging. Non-lumened endoscopes, for example nasal endoscopes and laryngoscopes were used in outpatients. Three-part decontamination wipes were used to clean the scopes in outpatients. A new policy was in place for scopes although not all staff were aware of this. However relevant staff had received training and had competencies in place to ensure that the correct protocol was always followed.

Medicines

- Arrangements were in place to ensure medicines and contrast media were prescribed, recorded, administered and stored appropriately.
- There was an onsite pharmacy that was open between 8am to 5pm Monday to Saturday. Staff told us that the pharmacists and assistants were responsive to both patients and the department's needs and patients received their medication promptly.
- Medicines were stored in locked cupboards or fridges and the nurse in charge of the area was responsible for holding the keys during opening hours; keys were then stored in a key safe which was locked by use of a keypad. One area of outpatients, the bone and joint clinic did not follow the same system. Keys were kept in an unlocked drawer during opening hours and after the department was closed; this increased the risk of medicines being accessed inappropriately. This was brought to the attention of the manager who put in place a secure key press immediately
- Chemotherapy was manufactured off site and supplied in a named patient basis and delivered straight to the chemotherapy unit to be administered. No intrathecal chemotherapy was administered.
- Room temperature checks were recorded, a new digital system was in place to monitor the temperature of the fridges, this was directly linked to the pharmacy department who would be alerted if the temperature of a fridge went out of range.
- Review of a sample of patient records confirmed that medication was administered as prescribed.

- There was a patient group directive in place for contrast media. We saw that radiographers had been trained to administer this without an individual prescription from a prescriber.
- Prescription pads were all stored securely.

Records

- Follow-up appointments were recorded for most patients; we noted that for one patient it was not recorded in their notes whether a follow-up was required. We also saw that the records for two patients were difficult to read and had not been recorded clearly. Some records had not been signed and dated.
- In imaging, we found one request had the required protocol recorded on a 'sticky note' attached to the patient's notes which meant that this information could have been lost.
- Records in the main OPD were not always stored securely although these were in private consulting rooms rather than in more public areas.
- Patient records were stored at an off-site location and requested 24 hours prior to the patient's appointment. The hospital supplied us with data and staff confirmed that records were mostly available for outpatient appointments and that for only 1% of appointments the patient records had not been available. We were informed that in most cases the patient could still be seen but would be rearranged if clinically appropriate.
- Records were held with the medical secretaries or behind the reception desk in each of the units, however, we noted that shortly prior to outpatient clinics the records were held in the consulting rooms and these were at times, left unattended. The door to the consulting rooms were closed but not locked.
- The imaging department used a digital system which meant that images were available promptly.
- A checklist was also used to ensure the right procedure was being undertaken on the right patient and we saw this checklist had been used in each of the records we reviewed.

Safeguarding

- There were systems in place to report safeguarding concerns. The hospital had safeguarding policies and procedures in place which were available to staff on the intranet, including how to manage suspected abuse and out of hours contact details.
- There had been no safeguarding referrals made within the previous 12 months. The staff we spoke with were confident in what sort of issues would concern them, but most of the staff were unclear of the procedure to report safeguarding concerns and told us that they would refer concerns to their line manager and/or matron.
- Not all staff had been trained to the required level of safeguarding children. Staff that were trained to the right level were not routinely scheduled to be on duty when a child attended the imaging or outpatient departments. However, the hospital director immediately arranged to cease treating patients under 18 years old in the hospital in order to mitigate this shortfall.
- Staff were aware of female genital mutilation (FGM), which involves genital cutting and female circumcision and removal of some or all of the external female genitalia. Any patients under the age of 18 would have been referred to the police. However, physical examination of this nature was not required for the types of paediatric outpatient attending the Spire South Bank and would therefore only become apparent if a child disclosed this.
- In 2016 safeguarding training levels were as follows:
  - Levels 1 & 2 children's safeguarding training 100% of oncology, imaging and outpatient booking staff, as well as 86% outpatient nursing staff and 89% eye centre staff had completed and
  - Level 3: 36% imaging staff, 25% oncology, 62% outpatient nursing and 50% of eye centre staff. This was all against a target of 100%.

Mandatory training

- We saw from data that the hospital provided us with, that not all staff had completed their mandatory training.
- There were nine mandatory training topics which all staff were required to complete; some of the topics covered included, infection control, information governance and health and safety. The staff we spoke with informed us they had completed all mandatory training and e-learning. Review of training data provided to us demonstrated that 89% of staff who worked in the eye centre, 88% of outpatient booking staff, 78% of other staff working within outpatients, 70% of oncology staff and 67% of imaging staff had completed their mandatory training against a target of 95%. This

excluded safeguarding. We were provided with a statement from Spire South Bank, following our inspection that, not all staff had completed their mandatory training at the time of inspection although staff had until the end of 2016 to complete this. Compliance ranged from 88% to 100% for each module against a year-end target of 95%.

- There was both a hospital and local induction programme for all new staff. Those we spoke with who had completed the induction training, in recent months, told us it was helpful.

Assessing and responding to patient risk

- Risks were managed in accordance with guidance and documented as appropriate in most cases.
- We reviewed a sample of patient records and found that appropriate risk assessments had been completed.
- The staff we spoke with talked confidently about actions they would take if a patient deteriorated in the outpatient department. This included calling the crash team in the case of a cardiac arrest.
- Mock emergency scenarios were carried out and staff told us they found these helpful.
- The hospital had an agreement in place to transfer patients who deteriorated to the local NHS trust if they required critical care.
- There was a process in place for patients undergoing chemotherapy, should they feel unwell, so that they had access to advice and treatment 24 hours a day. The specialist nurses operated a one week in three on-call rota so that telephone advice could be provided at any time. Patients who felt unwell and who may have had sepsis were advised to go immediately to the emergency department, at their nearest NHS Hospital. Spire South Bank then sent the patient's details electronically using a secure web address to the NHS site, so that treatment could commence immediately, if that was required.
- Patients who underwent imaging were asked if they had had any recent previous images which could be used and we saw evidence of this on the patient file. Female patients of child bearing age were also asked whether they could be pregnant and there were protocols for days of the month they could have certain scans. We saw evidence on file that these relevant checks had been made.
- Radiation Protection Advisor (RPA) support was in place and we were told that the RPA could be contacted for advice at any time.
- The hospital also had a Radiation Protection Supervisor (RPS) whose main role was to ensure that staff complied with requirements of Ionising Radiation (Medical Exposure) Regulations (IRMER) and the local rules. The RPS assisted with risk assessments and audits. (IRMER) is the main legal requirements for the use and control of ionising radiation in the United Kingdom.
- The imaging department had clear processes in place to ensure that the right patient received the right radiological scan. Staff used a checklist which was read to the patient who verbally confirmed their details. From review of a sample of files, we saw that the checklists were completed.
- We saw signs displayed which warned people of the dangers of radiation and when an image was being taken, a light was displayed outside the room as a warning.

Nursing staffing

- Staffing levels and skill mix were reviewed in advance and each area was staffed safely. However, suitable arrangements were not in place to ensure advice could be obtained from a Registered Nurse (child branch) when children attended for appointments.
- There was no baseline acuity tool for nurse staffing in outpatients. Rotas were planned between two and six weeks in advance and were reviewed daily to accommodate any changes to clinics. We were told that staff had recently been recruited for the eye clinic and imaging department to fill vacancies. There was limited flexibility during periods of annual leave, but nursing and support staff aimed to take their leave where possible to coincide with consultants leave when the clinics would be quieter.
- We were told that, and data that the hospital supplied to us confirmed, that agency staff were rarely used and between the period April 2015 to March 2016.
- There were low sickness rates for nurses working in outpatients during the period April 2015 to March 2016.
- The hospital did not have a Registered Nurse (child branch) on site. A children's nurse was available at other Spire locations for advice, if required. However, there were no arrangements in place to ensure in advance that a Registered Nurse (child branch) was available for

on call advice on days when children attended outpatient appointments. Following our visit and as volumes were low, the hospital director provided evidence that they had ceased children's services.

Medical staffing

- Consultants and radiologists attended the OPD, imaging department or other units on set days at set times. A timetable of clinics was maintained for each area this meant that managers knew in advance which consultants were attending and were able to allocate staff appropriately to the clinics.
- The role of the resident medical officer, (RMO) was maintained through an external provider. The outpatients' service did not routinely use the RMO, as they worked predominantly in the inpatient area. However, the RMO could be called if required.
- The senior management team and medical advisory committee (MAC) monitored the competence of the consultants. This ensured that consultants were able to perform the procedures they were proposing to complete, by way of a scope of practice, within the hospital.

Major incident awareness and training

- There was a business continuity policy in place relating to all services within the hospital. We saw that there were action cards for their specific areas in the event of a business failure. Staff were aware where these were situated in their departments.

Are outpatients and diagnostic imaging services effective?

We inspected but did not rate 'effective', as we do not currently collate sufficient evidence to rate this. We found:

- Care and treatment was delivered in line with evidence-based guidance.
- Patients' nutritional and hydration needs were met.
- Patients' pain levels were assessed and managed according to their need.
- Staff had the right qualifications, skills and knowledge to do their job.
- Multidisciplinary team (MDT) working practices were in place.
- Information about patients and clinical guidance was available to staff.
- Staff had an understanding of the relevant consent and decision making requirements of legislation.

However, we also found:

- A recent audit demonstrated national cancer multidisciplinary standards were not met.
- There were no formal supervision arrangements in place.

Evidence-based care and treatment

- Care and treatment was delivered in line with evidence-based guidance.
- Policies were up to date, accessible and followed guidance from the National Institute for Health and Care Excellence (NICE). For example, the hospital's infection control policy.
- Provision of care was monitored with the use of local and national audits. During our visit we saw an audit schedule for 2016.
- Patients undergoing cosmetic surgery were given a two-week cooling off period between their initial consultation and committing to the procedure. This meant that patients had time to reflect and make informed decisions regarding their treatment. A consultant we spoke with said this could be extended if agreed with the patient's consultant.
- Consent for surgery commenced during the consultation appointment, in line with evidence based guidelines.
- The hospital complied with the NICE quality standard for breast care recommendation that a clinical nurse specialist was present during appointments.
- The imaging department used diagnostic reference levels (DRLs) as an audit to optimisation in medical exposure. DRLs were cross-referenced to national audit levels and if they were found to be high, a report would be made to the radiation protection advisor.
- Patients who were to undergo treatment for cancer, whether it be medical or surgical, were discussed as part of the local NHS Trust's multi-disciplinary meeting (MDT.) Relevant records could be sent securely to the trust. We saw that minutes of the MDT discussion were included in the patient's notes. The hospital had reached the national cancer standard for patients undergoing MDT in quarter 1 in 2016 at a 100%, against a target of 80%. In quarter two this target had been missed and only 75% had evidence of being the subject

of MDT. However, the hospital confirmed that all patients had been the subject of an MDT discussion, but the lower compliance was based on a clerical error rather than a breach of care processes.

Nutrition and Hydration

- Patients' nutritional and hydration needs were met.
- Complimentary vouchers for the hospital cafe were given to patients when their appointments were delayed for longer than 30 minutes.
- Patients who were undergoing chemotherapy treatment had access to advice from a dietician, who had practising privileges, so that their particular needs were met.

Pain relief

- Patients' pain levels were assessed and managed according to their need.
- Staff told us they were rarely required to provide pain relief to patients however, they were able to provide basic analgesia if required.
- The hospital did not have a pain management clinic.
- Pain relief for patients with cancer was managed individually by the consultants and oncology nurses with advice from the pharmacist. There were links with a local hospice for any pain assessments hat were required, as part of palliative care. Patients could also be referred into the local NHS trust's pain management service via consultant to consultant referral.
- Pain was assessed using the pain scale within the national early warning score (NEWS) charts and we saw through review of a sample of patient records that this had been completed as applicable.
- We reviewed a sample of patient records and found that most patients did not require pain relief as their visit to the department was short.
- We saw the records of two patients who were undergoing chemotherapy. Pain assessments had been completed and pain relief prescribed as required. However, pain audits were not carried out.

Patient outcomes

- Information about the outcomes of patient care and treatment was routinely monitored.
- The hospital had an audit schedule in place for January to December 2016 which outlined which departmental audits would be undertaken in which months.
- Staff participated in both local and national audits. For example, cataract care pathway, imaging dose reference audit and mammography turnaround. We requested the most recent of these audits as well as the, CT dose reference audit, imaging dose reference audit and central venous access device (CVAD) audit along with meeting minutes as evidence of presentation and discussion of findings.
- The cataract care pathway audit identified that 20% of patients did not have their lens size recorded on their operation booking form and it had been recommended as an action that re-audits take place at least annually.
- We saw that there was 100% compliance each of the imaging audits.
- There was a neutropenic sepsis audit in place, this reported on one case of sepsis within quarter one and that the correct pathway had been followed.
- The central venous access device (CVAD) audit was completed quarterly and showed the infection rate and insertion failures identified with CVAD were 0% between April and June 2016.
- The mammography turnaround time audit for May and June concluded that the first report was completed within two days, and as mammograms are double reported the final report turnaround average was 5.7 days. Following the introduction of a third radiologist the final turnaround time has been reduced by three days. We noted the audit did not specify which year this related to.
- Outpatient staff participated in the patient reported outcome measures (PROMS) audit as part of the preadmission assessment process. The PROMS captures details of patients' health and quality of life pre and post operatively through a questionnaire. The information was shared through a database to assist in the improvement of quality of procedures within the NHS.
- The service did not participate in the imaging services accreditation scheme (ISAS) or improving quality in physiological services (IQIPS). However, there is no national mandate to take part in these audits

Competent staff

- Not all staff had the right qualifications, skills and knowledge to do their job, particularly with regards to the care of children and young people.

- Arrangements were in place for staff to have an annual appraisal. All health care assistants and 100% nursing staff had received an appraisal between January and August 2016.
- Formal supervision arrangements were not in place. Competency assessments had been partially completed; although a definitive list of competency assessments required for each role had not been produced.
- Some of the staff had an internal paediatric competency certificate. These all appeared to have been signed the day before our inspection, some of which had been signed off by a person who did not appear to have a paediatric qualification. It was unclear whether these competencies had been gained from face to face, practical, observational or on line training and over what period of time they covered.
- All professional clinical staff were required to have an up to date registration. Nursing staff were required to register with the Nursing and Midwifery Council and update this annually. Radiographers were required to update their registration with the Health and Care Professions Council every two years. We saw that 100% of staff had an up to date registration.
- Medical revalidation was completed by consultants' substantive trust and shared with Spire South Bank.
- There were processes in place for checking registration with the General Medical Council and nursing and midwifery council. The management team maintained this.
- The management team reviewed competency of the consultants and checks were in place with the consultant's trust to ensure practice was current. There was 100% compliance with this at the time of inspection.
- All doctors who had practising privileges were at consultant level and registered with the General Medical Council. There was a process, for which the hospital director was responsible, to ensure registration was kept up to date. The medical advisory committee supported this process.
- Core basic competencies were assessed annually for clinical staff. We reviewed competency assessments for a sample of staff from each of the outpatient units and found they had been completed. However, there was no clear structure or list of all competencies and equipment requiring competency assessment required for their role.
- Each member of staff was required to maintain their professional skills. In addition to mandatory training, other training sessions were available to staff, these varied from on-line training to training provided by suppliers; for equipment familiarisation and face to face training sessions.

Multidisciplinary working (related to this core service)

- Multidisciplinary team (MDT) working practices were in place, although a recent audit demonstrated national cancer standards were not met.
- An audit carried out by the hospital showed evidence that 100% of patients diagnosed with cancer were discussed at an MDT meeting between January and March 2016. This reduced to 75% between April and June 2016. This did not meet the national cancer standard of 80%. However, this was due to timing and method in which data was collected. Actions taken have since resulted in audit results meeting 100%.
- There was an informal agreement with a local NHS trust whereby all patients diagnosed with cancer at South Bank Hospital were discussed at the relevant MDT meetings. The MDT coordinators at the local trust ensured that South Bank Hospital patients MDT proformas were securely forwarded to the oncology department. Relevant records could be sent securely to the trust. We saw that minutes of the MDT discussion were included in the patient's notes.
- The hospital had reached the national cancer standard for patients undergoing MDT in quarter 1 in 2016 at a 100%, against a target of 80%. In quarter two this target had been missed and only 75% had evidence of being the subject of MDT. However, the hospital confirmed that all patients had had an MDT discussion, but the lower compliance was based on a clerical error rather than a breach of care processes.
- There was a pre-chemotherapy checklist in place. Part of this checklist included evidence being required that discussion about treatment options had taken place at an MDT, prior to patients undergoing their chemotherapy. We saw evidence that this had taken place.
- The one-stop breast clinic was consultant led and if patients required a mammography, ultrasound, fine needle aspiration and/or core biopsy during the clinic, this could be arranged with the consultant radiologists on site.

Requires improvement

Outpatients and diagnostic imaging

- There were specialist nurses at the hospital for breast care, plastic surgery and oncology. Staff and patients could access them for support and information.

Seven-day services

- The outpatient department was open Monday to Friday 8am to 8pm and Saturdays 8am to 1pm. Additional clinics were held at different times if requested by one of the consultants. This would have been staffed by nurses accordingly.
- The imaging department was available to outpatients and the times mirrored that of outpatient opening times. There was an on-call service out of hours.
- There was an on call pharmacy, radiology and physiotherapy service.
- Patients were able to contact outpatient staff for advice during working hours and ward staff could be reached out of hours.

Access to information

- Staff were aware of how to access policies and procedures on the hospital's intranet. We observed staff using the intranet to locate policies during our visit. It was clear that this was routine to them.
- Patient records were stored in an off-site secure centre. These were requested and transported in to the hospital 24 to 48 hours prior to patient appointments.
- The hospital used a patient record tracking system. This meant that all staff were aware of the exact location and hospital department of a patient's medical record.
- Each consultation room had a computer where staff could access results and view diagnostic images. Some clinic rooms had a computer monitor specifically designed for viewing diagnostic images as part of the hospital's digital service.
- Discharge summaries of the care and treatment received were sent to the patient's GP by the consultants' secretary.
- A consultant we spoke with explained that they would usually telephone a patient's GP if they had received unexpected or complex results.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had an understanding of the relevant consent and decision making requirements in accordance with legislation.
- Staff we spoke with were able to describe the relevant consent and decision-making requirements pertaining to the Mental Capacity Act (MCA) and had some understanding of Deprivation of Liberty Safeguards (DoLS). Staff told us that this was included in their annual safeguarding update. A new ten step process had been introduced to assess a patient's ability to consent to treatment; this was specifically for patients who had a diagnosis of dementia. There was no other formal assessment of a patient's capacity.
- There was a consent to care and treatment policy dated January 2016. Consent for care and treatment was managed by individual consultants. Written consent was required for some procedures, although most were very minor and required verbal consent only. We reviewed 14 patient records and found that most of these did not require written consent. Consent was required for patients who were undergoing chemotherapy. We saw that written consent had been obtained in two records that we looked at of patients undergoing chemotherapy.
- The staff we spoke with had an understanding of consent arrangements for children, which included Gillick competencies. We had planned to review a sample of children's records as part of the unannounced inspection. However, prior to this, we raised concerns with the hospital regarding the management of paediatric patients' care and they took the decision to cease treating children.

Are outpatients and diagnostic imaging services caring?

Good

Overall we rated the service as good for caring because:

- Staff understood people's needs and provided compassionate care.
- Clinical staff communicated well with patients so that they understood their care and treatment options.
- Staff understood the impact of treatment for patients and those close to them and took the time to listen to their concerns.

However we also found:

Requires improvement

Outpatients and diagnostic imaging

- Conversations about patients between staff could be overheard by other patients.

Compassionate care

- Staff understood people's needs and provided compassionate care, although some patients informed us that they were dissatisfied with some aspects of the service, for example overhearing discussions around other patients.
- The patients we spoke with were mostly very satisfied with the care provided, patients told us that clinical staff were very caring and helpful. However, one patient told us that the reception staff were not always helpful and that it had been difficult to arrange an appointment. Another patient told us that privacy and dignity was not always respected because they heard clinical staff talking about other patients, although patient's initials were used rather than their names.
- There were dressing rooms available within the imaging department, to ensure patients privacy and dignity was protected.
- The Friends and Family survey results which included the NHS and private patients showed that between 92% and 98% of patients would recommend the hospital to family and friends. The response rate for NHS patients varied but was mostly similar to the England average. In May 2016 the response rate was 36% which was comparable with other hospitals.

Understanding and involvement of patients and those close to them

- Clinical staff communicated well with patients so that they understood their care and treatment options.
- Patients were all given the opportunity to be accompanied by a friend or relative during consultations and some treatments. For example, we saw a patient who was receiving chemotherapy accompanied by their partner for the duration of their treatment.
- We saw that staff took time to interact with patients and those supporting them; one patient told us that their husband had been fully involved in the discussion around their treatment, which had been helpful in the understanding their illness and subsequent management.
- Information regarding fees for self-pay patients was provided in advance of treatment. The patients we spoke with told us they were involved in making decisions about their treatment, one patient told us that staff communicated well and another that their husband had been involved in discussions which helped them understand and better manage their treatment.
- Patients including those who were undergoing chemotherapy, told us that they were kept informed of their next appointment and appointment letters were sent to them in the post.

Emotional support

- Staff understood the impact of treatment for patients and those close to them and took the time to listen to their concerns.
- There were specialist nurses at the hospital, this included, chemotherapy, breast care and ophthalmology.
- Staff were caring and compassionate. A patient we spoke with in the oncology clinic told us that staff were flexible in order to meet their needs, for example; amending their appointment time at short notice and staying later to fit in with the patients treatment.
- Nursing staff supported patients and their families emotionally through their treatment. We were told about one patient who was receiving treatment and had recently suffered a bereavement. Staff members took time to talk to them and listen and ensure that they had a family member to support them through their treatment and help them understand as they had been affected by their loss.
- Consultants and nursing staff were able to refer patients, including those undergoing chemotherapy, to the hospital psychologist if they required additional support.

Are outpatients and diagnostic imaging services responsive?

Good

Overall, we rated the service as good for responsive because:

- Services were planned and delivered in a way that met the needs of the local population and flexibility was reflected across each of the outpatient services.
- Care and treatment was accessible at the patients' convenience.

- 'One-stop' clinics for some specialities were available so patients could undergo tests and a consultation within the same appointment to minimise attendances.
- 98% of NHS patients were seen by a consultant within 18 weeks of their initial referral. Private patients could usually be seen within 72 hours.
- The services had processes in place to manage patients with complex needs, including those with a learning disability.
- Information on complaints or how to raise a concern was available to patients. Complaints and concerns were responded to in line with the complaints policy.

However we found:

- There was no hearing loop in the main outpatients area.

Service planning and delivery to meet the needs of local people

- Services were planned to meet the needs of patients.
- Clinics were held at weekends and evenings in certain specialities to provide flexibility for patients.
- Some consultation rooms were grouped in specific areas according to their speciality, for example; the bone and joint clinic, the Spire eye centre and breast unit had dedicated medical and IT equipment. In addition the Worcester Bowel clinic was situated in a dedicated area. This meant that consultants were able to work in an appropriate room, with specific equipment and staff according to their speciality.
- A 'one stop' clinic had been established for breast patients. This meant that patients could have their clinical examination, imaging and any required biopsy undertaken on the same day.
- There was free parking available on-site, however, this was limited. Staff parking was provided at a nearby location so that patients had priority. This was done in response to patient feedback.

Access and flow

- Services were planned to take into account the needs of patients who used the service, although there was no system in place to monitor referral to treatment times for private patients. However, it was felt this was not necessary as private patients were seen very quickly.
- Referral to treatment time (RTT) is the term used to describe the period between when an appropriate referral for treatment is made and the date of the initial consultation or treatment. The Department of Health stated for NHS patients, 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral; this was withdrawn in June 2015.
- The hospital met the target of 95% of NHS patients beginning treatment within 18 weeks of referral for each month between April 2015 and June 2015, when the target was abolished. Above 95% of patients began treatment within 18 weeks of referral between June 2015 and March 2016.
- The patients we spoke with said the booking system was straight forward. One patient told us they had been referred to the breast clinic by their GP, attended the 'one stop' breast service the following evening and had received treatment within three working days.
- NHS patients were able to use the NHS Referrals Scheme system to arrange their appointment for a suitable date and time that was convenient to them.
- The percentage of NHS patients who did not attend (DNA) their appointments April to July 2016 was 2.1% compared to the England average of 7%. If a patient does not attend their appointment, it would be rearranged by the hospital. However, if a patient did not attend their appointment for a second time, they would be discharged from the care of the hospital back to their GP.
- Imaging results and reports were available promptly with a target turnaround of 48 hours. Computerised tomography (CT) scans and mammograms were all double reported. We saw that audits had been undertaken on the timeliness of reports with exception of plain x-ray. Audit findings indicated the first reports were available promptly with some delays in the second report; this was between seven and eight days for quarter one (January, February and March); improvements were made and this had reduced to less than five days for quarter two (April, May and June).
- Staff told us they always informed patients verbally of delays in clinics. We observed a nurse and a receptionist in the bone and joint clinic informing patients of a ten minute delay to their appointment time. Patients were offered hot and cold drinks whilst they waited. We did not observe any excessive waiting times during our visit.
- The outpatient department and clinics were clearly sign-posted. There was a separate reception area for

each unit within outpatients. We also observed staff who worked on the hospital reception desk at the main entrance provide comprehensive directions to patients upon arrival.

Meeting people's individual needs

- Services were planned to take into account people's individual needs, although we noted there was no hearing loop in the main waiting area of outpatients.
- The staff we spoke with in the outpatients clinic told us appointment times could be extended should a patient require a longer appointment. For example, patients with complex needs were sometimes given two appointment slots; this meant that appointment lengths were tailored to meet patients' needs and delays on the day were being minimised for other patients.
- A patient told us that they were able to contact the specialist breast care nurses if they had concerns. The breast care nurses were able to provide advice and support over the phone and were able to book the patient in and see them within 24 hours.
- There was seating available in some clinic waiting areas for larger patients.
- The hospital had raised seating for patients who suffered from mobility problems.
- The hospital was able to accommodate patients in wheelchairs. There was sufficient space to manoeuvre and position a wheelchair safely. Consulting room doors were wide enough for wheelchair access and there was a lift in place for patients to attend the outpatient clinics on the first floor.
- Patients with dementia or other additional mental or physical needs were given longer appointment times and where possible were booked at the beginning of a clinic, to ensure waits were not too long. We were told about an example of a patient who had a neurological disorder and required a computerised tomography (CT) scan. A risk assessment was undertaken and the patient was given an extended time slot. Additional staff were scheduled to be on duty, to ensure the patient was treated safely.
- There was an interpretation service available where staff could arrange a translator face-to-face or over the phone for patient appointments. The staff we spoke with told us that this service was rarely needed but worked well when it was used.
- The hospital used a deaf-led registered charity to support patients that were hard of hearing with the use of a sign language interpreter at their appointments. A hearing loop was available in most areas of outpatients, with exception of the main outpatient waiting area.
- There was a clinical psychologist on-site who mainly supported patients who had been diagnosed with cancer. However, staff told us all patients could access the service if required.
- Imaging also offered patients who were claustrophobic, the opportunity to look around the scanning room prior to the appointment. Extra time was allocated and a member of staff stayed with the patient if necessary. Patients could choose music to listen to during their scan.
- A chaperone service was available to patients who required this. There were signs in outpatient clinics to indicate that chaperones could be requested.
- There were no toys, books or magazines for children in waiting areas. The hospital withdrew its services to children as a result of concerns raised during the inspection. However, children may still be present in the waiting area if they accompanied an adult attending an appointment.
- Staff and patients told us that patients were offered hot and cold drinks whilst they waited for their appointment.
- The hospital cafe offered a range of hot and cold food and drinks that could be purchased for patients and visitors.
- Information leaflets were available in the waiting areas of all outpatient clinics. Leaflets included information on medical conditions and fees associated with appointments.
- Patient information leaflets could be translated into other languages on request and signs were displayed across the hospital in other languages to alert patients and visitors to this service
- Patients we spoke with told us that they had been informed about any associated consultation fees before their appointment. This meant patients received appropriate information in relation to costs to enable them to make an informed decision about their appointment.

Learning from complaints and concerns

Requires improvement

Outpatients and diagnostic imaging

- People were made aware of how they could complain, complaints were responded to promptly and actions were taken to address concerns raised.
- Spire Healthcare Limited's corporate complaints policy directed the management of complaints and time scales for responses. This was in line with industry standards. All complaints were reviewed by the relevant head of department and clinical services manager. Clinical complaints were reviewed by the governance and medical advisory committee (MAC). Actions and lessons learnt as a result of the complaint were shared with individual departments via team meetings.
- Complaint acknowledgement letters were sent within 48 hours of a complaint being received. Complaints were responded to within 20 working days with the exception of complex complaints. In these cases, when the complaint was likely to take longer than 20 working days to respond to, a holding letters, at appropriate intervals, was sent to complainants. This complied with industry standards.
- There had been 22 complaints in outpatients and diagnostics between January and June 2016. The complaints mainly related to patients being unaware of charges and staff attitude. The actions taken included posters in all waiting areas to make patients aware of treatment costs and their responsibilities associated with fees. We also saw evidence that formal apologies had been given to patients following complaints about staff attitude, staff involved had been spoken with and supported to improve. Many of the complainants had been invited to meet with the senior team to discuss their complaint in detail.
- All the complaint acknowledgements and responses that we saw had been sent within the policy timescale
- Staff we spoke with were able to locate the complaints policy, were knowledgeable about the complaints process and explained how they would try to resolve a patients concern at the time of the complaint.
- Patients we spoke with were aware of how to make a complaint, but told us that they were satisfied with the service. One patient told us she had planned to make a complaint about the attitude of a member of staff however she was contacted by telephone and offered an apology.
- Financial information was not recorded in clinical records; verbal discussions were held with the patients and financial information stored by the self-pay team. In the past, there had been some number of complaints regarding additional fees not being included in the original price plan, for example, blood tests. In response to this, posters were displayed in the waiting area informing patients of these additional costs. We were told that this had reduced the number of complaints about unexpected payments.
- We saw posters in the hospital corridors responding to comments from patients using; "You said" and "We did". For example; "You said:" "The reception area is not confidential when discussing personal information" and "We did:" "Created a private room to discuss information with patients away from reception".

Are outpatients and diagnostic imaging services well-led?

Requires improvement

Spire South Bank Hospital required improvement for well-led because:

- There was a lack of managerial oversight with regards to children and young people's services, although this was withdrawn after our inspection.
- There was no recognition from senior managers that those caring from children and young people under the age of 18 required level three safeguarding training.
- There was no Registered Nurse (child branch) available to oversee the children's and young person's service.
- The risk register was not used to identify and record risks faced by the hospital. Risks were not dated and there was no record of progress.
- The hospital had a clear vision and this was displayed throughout the hospital, on all desktops and formed part of the annual enabling excellence programme. Despite this not all staff were aware of it.
- Outpatient meetings were not held regularly and there was no discussion around performance of the department.
- A hospital business plan had been developed, although this lacked strategic direction and was not supported by clear objectives and milestones.
- Outpatient performance was not discussed at the clinical governance committee.

However, we also found:

Requires improvement

Outpatients and diagnostic imaging

- There was a governance framework in place and relevant information was discussed at some committees or group meetings.
- Each area of outpatients was managed by a head of department, with exception of the breast unit. Radiology staff reported to the imaging head of department and nursing staff reported to the outpatients' head of department.
- The views of staff and patient views and experiences were gathered and action plans developed to improve the service.

Vision and strategy for this service

- The hospital's vision was: 'to be recognised as a world-class healthcare business through the mission statement of bringing together the best people who are dedicated to developing excellent clinical environment and delivering the highest quality patient care.' This was displayed throughout the hospital, on all desktops and formed part of the annual enabling excellence programme. Despite this, not all staff were aware of this
- We were told that a business plan was created through engagement with senior management and using data, knowledge of the health care environment and the hospital's position in it. The information was disseminated through heads of department to all staff as well as through staff forums. Some heads of department were more knowledgeable than others about their level of involvement in developing the plan.
- We requested a copy of the business plan for outpatient services and were provided with the 'Annual Clinical Governance Report 2015'. The report listed services developed in 2015 and new services planned for 2016. For outpatients, this was to develop oncology services. The report included details of:
  - lessons learned from incidents
  - infection prevention and control statistics
  - performance achieved against key targets
  - consultant appraisal compliance
  - patient and staff feedback scores
  - consultant and GP feedback
  - compliance with mandatory training.
- However, clear objectives for outpatients had not been set. We were not provided with evidence of strategic direction, objectives or milestones to drive the service forward.

Governance, risk management and quality measurement

- There was a governance framework in place and relevant information was discussed at some committee or group meetings. However, information discussed at the outpatient meetings lacked focus and there was minimal discussion around information relevant to the department. Information from the heads of department meetings was not always shared with staff who worked within outpatients.
- There was a governance structure within the hospital. Each area held team meetings which varied in frequency. Team meetings were held for the outpatient department (including the bone and joint clinic), the Spire Eye Centre, oncology, breast and the imaging department. The head of each department also attended the Clinical Audit and Effectiveness Group, reporting to the clinical governance committee (CGC) who in turn reported to the medical advisory committee (MAC).
- Team meetings were open to all staff who worked within each area of outpatients. Meetings varied in frequency with most areas holding meetings each month or every other month. We noted that meetings for the main outpatients, including the bone and joint clinic had not been held frequently with the most recent meetings held in February, April and July 2016. We were informed that there was a plan in place to ensure team meetings took place monthly.
- Items discussed at the outpatient team meetings included infection control, mandatory training and incidents and complaints related to surgery and performance. We noted that performance for outpatients had not been discussed, for example, attendances, sending GP letters, availability of records, cancelled clinics and did not arrive (DNA) rates had not been recorded as an agenda item or discussed. We were informed by Spire South Bank that these were instead discussed at the OPD Bookings and Administration meetings. Review of the CGC minutes confirmed discussions included performance around surgery but there was no evidence of discussion regarding outpatient or diagnostic performance. Other items included in the agenda and minutes were; infection control issues, complaints trends (if identified), progress

with audits, patient experience, management of risk, consultant compliance with professional registration, medical indemnity and appraisals as well as regulatory updates.

- The MAC considered information received from the CGC and discussed performance reported on the clinical scorecard.
- From reviewing meeting minutes we confirmed that information was escalated upward and could be traced through to the relevant committee minutes
- The hospital had a schedule of annual audits. Audit reports were discussed at the clinical audit and effectiveness group with highlights and areas of relevance presented at other departmental meetings. We requested a sample of audits and the corresponding minutes where audits had been presented. Some of the audits, which related to outpatient activities, were not due for presentation until after the inspection, others did not have an agreed date for presentation, for example the cataract care pathway audit was undertaken in quarter 1 (April, May and June 2016) a mammography audit had been undertaken in May and June; audits had not been presented or discussed at the relevant departmental meetings.
- There was a hospital wide risk register for South Bank hospital, which included a number of generic risks and mitigating controls. The managers we spoke with were aware of the top risks for their area.
- Review of the risk register confirmed that the risks identified lacked detail, a risk identification and review date had not been recorded and it was not always clear from the information why the risk had been included on the register, i.e. whether the risk had been identified following an incident for example or was a potential inherent risk. One risk was recorded as, 'theft by staff, patient or the public', the cause, 'cash payment' and the mitigating control, was to have notice of patients paying cash, and having additional staff on duty to count the cash. The controls around storage of monies and how long for had not been considered; there was no assessment on the likelihood and consequence based on the potential cash sum which may be received or the frequency with which they were received. Including risks such as this on a hospital wide register without rational may detract from other more significant risks. Staff had failed to identify treating children as a risk without a Registered Nurse (child branch) onsite when children were attending clinics. However, since the inspection, this risk had been mitigated as the provider had ceased children's' services at the hospital.

Leadership / culture of service

- The hospital was led by the hospital director and matron. Each area of outpatients was managed by a head of department, with exception of the breast unit. Radiology staff reported to the imaging head of department and nursing staff reported to the outpatients head of department.
- Each head of department was responsible for the day-to-day management of their service including ensuring consultant clinics ran and were supported by appropriate numbers of nursing staff.
- There was a lead nurse for oncology who reported directly to the matron.
- The staff we spoke with told us that there were very good working relationships and that they felt supported by their line manager.
- There had been information sessions about duty of candour and there were information leaflets available to staff. Most of the staff we spoke with had a good understanding of what this meant and provided examples of how, when something had gone wrong, they had communicated with the patient and/or their family.

Public and staff engagement

- The views of staff and patient views and experiences were gathered and action plans developed to improve the service. A patient satisfaction survey (private and NHS patients) was collated monthly for the whole hospital. This was also split by departments where relevant. The hospital completed additional surveys for patients attending for imaging, oncology and endoscopy services to better understand the patient experience and take action to improve where necessary. Hospital surveys were split by department where relevant to allow action to be taken. Additional audits were regularly undertaken to assess satisfaction of more specific patient groups in order to drive improvement.
- There was close cooperation and involvement of the surgeons and anaesthetists during the planning and construction of the newly opened laparoscopic theatre.
- Feedback was largely positive to how people felt they were treated and communicated with. Most patients

rated outpatient nursing staff and imaging staff as very good or excellent. Self-pay patients were slightly less satisfied with the service provided by nursing and imaging staff than NHS or insured patients. An action plan was in place.

- The staff satisfaction survey for the whole hospital in 2015 showed a response rate of 79% with an overall satisfaction rate of 71% which was 11% lower than the previous year and 6% below the average for all Spire hospitals. Staff rated the hospital above 80% for engagement, team work and the individual staff member's work. Staff rated the hospital 45% for senior leadership, 51% for working together and 65% for service quality. The action plan stated, 'The newly appointed hospital director, has re-introduced regular staff forums and the senior management team undertake regular floor walks in all departments so that if issues arise, where feasible, these can be dealt with immediately'. All staff confirmed that visibility of the senior team had improved.

Innovation, improvement and sustainability

- Staff we spoke with reported that financial pressures did not compromise care and that patients always received the dedicated amount of time for their appointment or procedure.
- Leaders and staff strived for continuous learning, improvement and innovation. By way of example, one member of staff had developed a new eye drop regime that had been introduced for patients undergoing certain treatment at the eye centre; this was to make the process more manageable and less painful for patients. A workshop had taken place for oncology patients, 'live your life after cancer' which involved sharing information with other patients. However, this project was in its infancy

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- All NEWS charts should have clear evidence of regular observations, according to the patient's condition and the type of surgery undertaken.
- Ensure there is a nursing presence in the 'Garden Suite' so that patients who may be deteriorating can be identified quickly.
- Review the Spire tool used for root cause analysis and ensure all root cause analysis are completed thoroughly and in a consistent manner prior to final sign off.
- The flooring and coving in patient bedrooms should be considered for refurbishment as part of a plan, to ensure compliance with current infection control guidelines. Healthcare associated infection (HCAI): operational guidance and standards, (July 2012,) Health Building Note (HBN) 00-10 Part A: Flooring and HBN 00-10.
- Review the requirement for clinical hand wash basins in patient's bedrooms.
- Ensure the infection prevention and control lead has a recognised, specialised infection prevention and control qualification to enhance their knowledge.
- Clinical staff should have a system of clinical supervision.
- All staff should have a clear understanding of mental capacity and how to assess a patient's ability to consent to treatment.
- Ensure the risk register is updated to include the date the risk was identified, why the risk has been included, the date of review, appropriate controls to mitigate the risk.
- The hospital should consider working towards improving its performance in discharging patients before 11am as part of Spire's clinical scorecard.
- Staff should be confident in making safeguarding referrals outside of the organisation.
- A hearing loop should be available in the main outpatient area.