Spire Healthcare Limited
Spire Sussex Hospital

Quality Report

The Ridge
St. Leonards-on-sea
TN37 7RE
Tel: 01424 757400
Website: www.spirehealthcare.com/sussex

Date of inspection visit: 19 to 20 December 2016 and 5 January 2017
Date of publication: 09/05/2017

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

Spire Sussex Hospital is operated by Spire Healthcare Limited. The hospital has 29 beds. Facilities include two operating theatres X-ray, outpatient and physiotherapy departments.

The hospital provides surgery and outpatients and diagnostic imaging. We inspected both of these core services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 and 20 December 2016 along with an unannounced visit to the hospital on 5 January 2017.

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

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

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

Services we rate

We rated this hospital as outstanding overall, and we rated caring, responsive and well–led as outstanding. This was because:

- People were truly respected as individuals and supported to be involved in their care. There was a strong focus on maintaining the privacy and dignity of patients. Patients' feedback about the quality of care and their experience was overwhelmingly positive.
- Patients received a service that was tailored to meet their needs. There were systems that ensured patients with special needs, such as those living with dementia, received appropriate care although these accounted for a small proportion of patients seen.
- Patients could access care and treatment promptly at a time that suited them.
- Complaints were taken seriously and were investigated and responded to within agreed timescales. Changes to the service were made as a result of complaints
- The hospital management team worked collaboratively with commissioners and a co-located NHS hospital to ensure the needs of the local population were met. The management team were proactive in developing services, such as the installation of an MRI scanner to meet local needs.
- The vision and values were understood and well embedded in staff's daily work. Staff felt supported by a leadership team that inspired them and who were credible and visible. Staff were proud to work at the hospital and there were high levels of satisfaction across all staff groups. Staff felt involved in the running of the hospital on a day to day level and in major projects.
- A safe and high quality service was assured through robust governance structures that proactively reviewed performance, identified areas of risk or emerging concern and made arrangements to mitigate these risks and drive improvement .
- There were innovative approaches to gather feedback from patients and actions to improve services were made as a result of such information.

We rated safe and effective as good. This was because:

Summary of findings

- Data demonstrated a good track record in safety. There were clearly defined systems to report, investigate and learn from incidents and when things went wrong, and the duty of candour was enacted.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. There was a programme of mandatory training in key safety areas which all staff completed and systems for checking staff competencies and for identifying and meeting staff's training needs.
- There were systems and processes for recognising and reporting potential abuse, for preventing and controlling infection and for managing medicines which were consistently applied by staff.
- Care was planned and delivered in line with current standards and best practice. There were audit arrangements to provide assurance of this and systems to review new guidance and oversee its implementation.
- Patients had access to a full range of health care professionals who worked together as an integrated team to meet patients' needs. Staff could access patients' records and other clinical information when it was required. There were systems to follow up patients after discharge and to liaise with their GPs.
- Patients consented to their treatment in line with relevant legislation, including those who may lack capacity to make decisions for themselves.

Following this inspection, we told the provider it should make some improvements, even though a regulation had not been breached, to help improve the service.

Professor Edward Baker

Deputy Chief Inspector of Hospitals (South)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Outstanding ☆	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as outstanding because patients were protected from abuse and avoidable harm and received care and treatment that reflected best practice guidance from competent staff. Patients were treated as partners in their care, and valued as individuals which protected their dignity and privacy. Patients' feedback was overwhelmingly positive. Services were tailored to individual needs and there was flexibility to ensure patients choices and preferences were respected. The management team were focused on the delivery of safe and effective care, and there were robust governance arrangements used to drive service improvement. All staff showed an appreciation of the hospital's values and this was demonstrated in their daily work.
Outpatients and diagnostic imaging	Outstanding ☆	We rated this service as outstanding because people were protected from avoidable harm and abuse and there were systems for reporting and learning from safety incidents. Patients received care and treatment that was based on current national guidelines from staff who were competent to do their jobs. Patients were valued as individuals and their dignity was truly respected. Feedback from patients was unfailingly positive. Patients could access care and treatment in a timely way and there was flexibility around timing of appointments. The individual needs of patients were recognised and arrangements made to meet them. The leadership was robust and visible, with a focus on providing a safe service that met the needs of the patients. There were robust governance arrangements that gave adequate assurance and which drove improvement. Staff demonstrated the organisation's values through their work.

Summary of findings

Contents

Outstanding ☆

Sussex Spire Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Spire Healthcare Limited Spire Sussex Hospital

The Spire Sussex Hospital is a purpose built building co-located with the Conquest Hospital, part of East Sussex Healthcare NHS Trust. It is operated by a parent company, Spire Healthcare Limited. It opened originally as part of the BUPA group in 1997 and was named Spire Sussex Hospital when the group was rebranded in 2007 as Spire Healthcare.

The hospital primarily serves the communities of the Hastings and East Sussex and West Kent area. It also accepts patient referrals from outside this area. The hospital is situated on the outskirts of Hastings and serves a mixed urban and rural area which includes some areas of social deprivation. Services are provided to NHS patients, and private patients who maybe insured or who self-pay to cover the costs of their treatment.

The hospital currently provides services to adults only. It stopped providing children's services in July 2016, and stopped services for young people from September 2016. It offers outpatient and inpatient services for a range of specialities including Orthopaedics, Ophthalmology, Gynaecology, Urology, Ear, Cosmetic and general surgery. Additional services offered on an outpatient basis include Rheumatology, Dermatology and Cardiology. These services are supported by on-site physiotherapy and diagnostic imaging departments.

The hospital has been registered with the CQC to carry out the following regulated activities since November 2010:

- Family Planning
- Diagnostic and screening procedures
- Surgical procedures
- Treatment of disease, disorder and injury

The hospital has had a registered manager, also the matron, in post since August 2015. The current designated controlled drugs accountable officer (CDAO) has been in post since July 2015 and who is also the hospital director. Spire Healthcare Limited has a nominated individual.

The hospital has been inspected once before in October 2013 which found that the hospital was meeting all standards of quality and safety it was inspected against. We have not yet inspected or rated this service using our new methodology. There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Our inspection team

The team that inspected the service was led by Shaun Marten, CQC inspection manager.

It comprised of two CQC inspectors, and three specialist advisors with expertise in surgery, surgical nursing and radiography. The inspection team was overseen by Alan Thorne, Head of Hospital Inspection.

Information about Spire Healthcare Limited Spire Sussex Hospital

The main service provided is inpatient and day surgery, and outpatient services. The hospital has one ward with 29 beds. Patients are cared for in single, en-suite rooms which means there is no mixed sex accommodation. There are two operating theatres.

There is a separate outpatient department which includes physiotherapy services. An imaging department which provides ultrasound, digital plain film imaging and image intensification in the theatres. The hospital is currently installing an MRI scanner which became operational in January 2017.

Summary of this inspection

The hospital is co-located and physically linked to an NHS general hospital. Engineering and maintenance, pathology and theatre sterilisation and disinfection are provided by this NHS trust under a service level agreement. Pharmacy services are outsourced to an independent pharmacy provider.

We carried out an announced inspection visit on the 19 and 20 December 2016. During this inspection, we visited the ward, theatres, imaging and outpatients departments. We also visited the clinical support services. We spoke with 32 staff including; registered nurses, healthcare assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 11 patients and one relative. We also received 27 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 18 sets of patient records.

Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 2,349 inpatient and day case episodes of care recorded at the hospital; of these 56% were NHS-funded and 44% other funded.
- Thirty four per cent of all NHS-funded patients and 40% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 16,927 outpatient total attendances in the reporting period; of these 33% were NHS-funded and 67% were other funded.

Staffing

There are 83 medical staff with practising privileges including surgeons, anaesthetists, and radiologists. Two regular resident medical officers (RMOs) are employed under a contract with an external agency working a seven days on duty, seven days off rota.

The hospital employed 23.2 full-time equivalent (FTE) registered nurses, 5.2 FTE care assistants and operating department practitioners, and 39.1 FTE other staff as well as having its own bank staff.

Track record on safety (July 2015 to June 2016)

- There were no reported "never events".
- Sixty-eight clinical incidents were reported of which 40 were graded as causing no harm, seven as low harm, and 20 as moderate harm.
- No serious injuries were reported.
- One expected death was reported.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA) reported.
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA) reported.
- No incidences of hospital acquired Clostridium difficile (C.diff) reported.
- No incidences of hospital acquired E-Coli reported.
- No incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) reported.
- Six complaints were received by the hospital, but none were received by the CQC. No complaints were referred to the Parliamentary Health Services Ombudsman or the Independent Healthcare Sector Complaints adjudication service.

External Accreditation

The hospital holds BUPA accreditation as a bowel cancer centre, MRI centre and breast cancer centre.

Services provided at the hospital under service level agreement:

- Engineering and maintenance
- Occupational Health, theatre sterilisation and decontamination
- Resident Medical Officer

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Performance showed a good track record with clearly defined systems to report, investigate and learn from incidents and when things went wrong.
- There were sufficient numbers of staff with the necessary skills, experience and qualifications to meet patients' needs. They were supported by a programme of mandatory training in key safety areas. There were simulation exercises that kept staff skills current.
- There were systems and processes for recognising and reporting potential abuse, for preventing and controlling infection and for managing medicines. These were well understood and implemented by staff.
- Risks to patients were well understood, and there were arrangements to assess and mitigate clinical risks for individual patients.

Are services effective?

Good

We rated effective as good because:

- Patients' care was planned and delivered in line with current guidance and best practice standards. There were systems of audit that ensured these standards were implemented and maintained.
- Patients received appropriate pain control and food and drink that met their needs and preferences.
- Staff worked collaboratively as part of a multi-professional team to meet patients' needs. There were systems that demonstrated staff were competent to undertake their jobs and to develop their skills or to manage under-performance.
- There was a system for granting practising privileges to consultant staff which ensured they worked within the boundaries of their expertise and had all the necessary checks carried out.
- Patients consented to the care and treatment in line with legal and professional requirements. Where patients lacked capacity to make their own decisions, staff understood their obligations in relation to the Mental Capacity Act.

Are services caring?

Outstanding

We rated caring as outstanding because:

Summary of this inspection

- Patients' feedback about the quality of care and their experience was overwhelmingly positive. Staff were spoken of as "going the extra mile" and we saw examples of this. Interpersonal relationships were seen as supportive and caring and were valued by patients and those close to them.
- All staff provided care that respected patients as individuals. There was a strong commitment to providing care that maintained patients' privacy and dignity. All staff groups, both clinical and non-clinical, gave priority to providing a service that was dignified and caring.
- Patients were recognised as partners in care and were consulted and involved in decisions about their care through their entire pathway at the hospital.

Are services responsive?

Outstanding ☆

We rated responsive as outstanding because:

- The hospital worked collaboratively with local health commissioners to meet the needs of the local population.
- Patients could access care and treatment in a timely way and at a time that was convenient to them.
- There was a focus on identifying and meeting the needs of individual patients, especially those with particular needs due to a medical condition such as dementia, or for cultural or social reasons. The needs of people with physical disabilities were also considered and arrangements made to meet them.
- Complaints were managed promptly and were taken seriously. There was an appropriate level of investigation and responses were prompt. Changes to the service were made as a result of complaints or feedback and any emerging complaints trends were monitored and managed as part of governance processes.

Are services well-led?

Outstanding ☆

We rated well-led as outstanding because:

- There was a clear statement of vision and values that was well embedded and demonstrated in staff's daily work. There was a common focus across all staff groups on providing high quality care and a positive patient experience.
- There was collaborative working with NHS commissioners to ensure the hospital made a contribution to meeting the health care needs of the local population and to ensure they received effective, timely and safe care.
- There was a robust system of governance which gave the leadership team strong assurance of the quality of their

Summary of this inspection

services, identified areas for improvement and drove the delivery of high quality care. The governance frameworks enable the hospital to benchmark performance, especially in relation to other Spire Healthcare hospitals.

- There were high levels of satisfaction across all staff groups. Staff were proud of the hospital and of the service provided and spoke of a highly supportive and visible management team. There was a high level of staff engagement and staff were involved in planning major and more minor developments in the service.
- There were innovative systems for gathering feedback from patients and gathering their views on further developments that went beyond standard surveys.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Outstanding ☆

Surgery

Safe	Good ●
Effective	Good ●
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are surgery services safe?

Good ●

We rated safe as good.

Incidents

- The hospital did not report any never events related to surgery in the period from July 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There was one expected death during the reporting period (July 2015 to June 2016) and no serious injuries. There were 67 clinical incidents in surgery or inpatients in the reporting period (July 2015 to June 2016). It is noted that 60% of incidents caused no harm, 10% low harm and 30% moderate harm. There were no incidents reported as severe harm. The rate of clinical incidents in surgery and inpatients was lower than the rate of other independent acute hospitals that CQC hold this data for.
- The hospital policy stated that incidents should be reported through the hospital electronic reporting system. All the staff we spoke with told us they were encouraged to report incidents.
- Staff described the process for reporting incidents and told us they received feedback, which was shared by email, safety briefings and at departmental meetings. Staff in all departments told us that following any incidents and investigations the outcomes would be discussed at their meetings. An example of shared learning was seen in the December 2016 ward team meeting minutes. Staff were requested to the sign the minutes as evidence of having read them.
- We saw an example of learning from an incident. Following a patient fall on the ward the staff initiated a 'please call – don't fall' campaign. We saw in patient rooms, fixed to the locker next to the call bell there was a sign with the words 'please call - don't fall'. The same was repeated in the bathroom with the notice fixed to the wall where patients could see it. We saw seven patients and all had their call bells within reach and commented that if they called the nurses would respond immediately.
- We saw root cause analysis (RCA) investigations were completed as part of the investigation of incidents. The one we saw was completed appropriately on a standard template. A completed action log showed all actions had been completed.
- Reviewing incidents was seen as a standard agenda item on the quarterly clinical governance committee meeting and we saw evidence of this from meeting minutes. We were told and saw evidence of discussion concerning trends of incidents and planned action to be taken. We saw all incidents were reviewed by committee members monthly and summarised quarterly at the meeting.
- We saw all incidents were categorised by location and type and this was reviewed by the senior management team and reported onto the governance committee and medical advisory committee (MAC). Clinical

departments did not document on their meeting minutes, an incident review considering any near miss incidents. This meant there might be a missed opportunity for further learning and risk reduction.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. This regulation requires the organisation to notify the relevant person that an incident has occurred, provide reasonable support to the person in relation to the incident and offer an apology.
- We saw that the hospital had a duty of candour policy. We asked a number of staff both clinical and non-clinical about their understanding of duty of candour and all staff were able to give examples of how this would be applied. Their responses reflected an approach of openness and transparency.
- The policy contained a flow chart showing the escalation to candour and a record of notification. The hospital's electronic reporting system included prompts to ensure duty of candour obligations were undertaken, which we saw.
- On the ward and then in theatre we were given two examples of incidents when duty of candour was exercised appropriately.

Clinical Quality Dashboard

- We saw that at corporate level, Spire Healthcare had a clinical scorecard which included number of clinical key performance indicators (KPI) related to patient safety. Clinical scorecard KPIs were reported quarterly. Results for each hospital were benchmarked and tracked against group performance targets.
- We saw the clinical scorecard was displayed in all clinical areas showing the hospital's progress over the year. Staff were able to explain the clinical scorecard and understood it reflected the hospital's performance.
- We noted that the hospital was meeting its KPI's in most categories and when not, it was evident in the governance minutes and at departmental level, what actions were being put in place to improve performance. For example, where it was noted that temperature recordings of patients in theatre was not fully compliant, the theatre team meeting minutes showed this was discussed with the staff to improve practice.
- The safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patient, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins).
- We saw the safety thermometer was displayed in the ward area and showed no incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE). There were no new pressure ulcers, catheter or urinary tract infections.
- A VTE screening rate of 100% was consistently achieved for the reporting period (July 2015 to June 2016). The hospital had zero incidents of hospital acquired VTE or PE reported in 2015 or 2016 which is better than the rate for other hospitals we hold data for.

Cleanliness, infection control and hygiene

- There had been no cases of Meticillin-resistant Staphylococcus aureus (MRSA), Meticillin- sensitive Staphylococcus aureus (MSSA) or Clostridium difficile between reporting period July 2015 to June 2016.
- Patient-led assessment of the care environment (PLACE) is a system for assessing the quality of the patient environment. Patient representatives go into hospitals as part of the teams to assess how the environment supports patients' privacy and dignity, food cleanliness and general building maintenance. In the 2016 PLACE audit , Spire Sussex Hospital scored 100% for cleanliness and 97% in relation to the general building maintenance of the hospital which was better than the national average of 93%.
- We saw infection prevention and control (IPC) policies and procedures in place that were readily available to staff on the hospital intranet. Infection prevention and control was included in mandatory training programme and 100% of staff were up to date with this training.
- We saw an annual infection control plan 2016 /2017, which had been signed by the Director of Infection Prevention and Control (DIPC). The plan had clear objectives including a plan for meetings and training to be completed.

Surgery

- We reviewed a service level agreement (SLA) for the services of a microbiologist from the co-located hospital. The SLA was in date and included microbiology advice and outbreak management. The microbiologist attended the quarterly IPC meeting and had input to staff education.
- There were quarterly infection prevention and control meetings that were chaired by the matron, supported by the microbiologist and that linked representatives from departments attended. We saw evidence of review of actions against the annual action plan, review of surveillance, audit results, water quality and reference to antimicrobial stewardship. We saw that the IPC performance at the co-located NHS hospital was discussed enabling the Spire Sussex hospital to benchmark and share best practice.
- We saw that there had recently been a lead nurse appointed for infection prevention and control and we could see evidence of a newsletter in the clinical areas demonstrating her communication with the staff.
- We saw from meeting minutes, infection prevention and control was a standard agenda item on the quarterly clinical governance committee meetings.
- Areas we visited around the hospital were tidy and visibly clean. We saw weekly departmental cleaning checklists were being completed.
- In theatres, no dust was observed. Floors were clean and fit for purpose. There was a service level agreement for the management of decontamination. This agreement with another hospital was seen to be in date. There was assurance that MDD 93/42 EEC was complied with and other relevant guidance and manufacturer's instructions. A tracking system was seen to be in place and incorporated out of hours provision. Delivery and collection schedule was detailed and available for all staff to reference.
- We found the endoscopy service was not joint advisory group (JAG) accredited and all endoscopy procedures were carried out in theatre. We observed the decontamination process of endoscopes and saw leak tests performed on all scopes after cleaning. This was compliant with HTM 01/06 decontamination of flexible endoscopy. We saw a tracking process is in place and this was documented within the patients' notes. This made it possible to track which endoscope was used on each patient.
- We found the decontamination of scopes used in the outpatient department was also done in theatre. All decontamination records were kept in the theatre department.
- Domestic waste bins were available and contained no inappropriate items. When asked, staff were able to describe appropriate segregation of waste. This was in line with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations. The clinical waste unit was checked and seen to be secured.
- There were good processes in place for sharps management which complied with Health and Safety (Sharp Instruments in Healthcare) regulations 2013. The sharp bins were clearly labelled and tagged to ensure appropriate disposal. On the ward it was observed that there was a good process in place for waste disposal in particular sharps management where the bins were labelled correctly with the temporary closure in place. However, the final disposal of the full sharps bin left in the sluice area was non-compliant with EU directive 2008/98/EC and management and disposal of healthcare waste DH HTM 07-01 (2013) because the sluice was not sign-posted as a staff only area. This was bought to the attention of staff during the inspection and was corrected immediately.
- Patient rooms did not have clinical hand wash sinks, however we were told that the staff used hand sanitiser gel on entering and leaving the room and washed their hands in the treatment room. Posters promoting the World Health Organisation's "Five moments of hand hygiene" were clearly visible to patients and staff.
- We saw hand-sanitising gel was available at point of care in and outside patient rooms. This was in line with epic3: 'National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England' (epic3) and HTM 00-09. We saw staff using hand sanitiser when entering and exiting clinical areas.

- On the ward we observed all nursing staff to be bare below the elbow in line with best practice.
- We reviewed observational hand hygiene audits which had been included in the provider's clinical scorecard for national benchmarking. The most recent results showed 95% compliance. This audit was planned to be repeated quarterly
- Personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas. Staff were observed using PPE appropriately.
- Patient rooms were dust free and all fabrics in the room were wipeable in line with hospital building note (HBN) 00/09. The flooring was laminate with coved edges in line with HBN 00/10 part A (flooring).
- Carpets in corridors were cleaned appropriately and steam cleaned twice a year. The carpets were deep cleaned with an industrial cleaner every six months and we saw certificates which demonstrated this had been completed in November 2016. The hospital also had its own steam cleaner to clean carpets during quieter periods and for spot cleaning.
- The cleaning of the hospital was undertaken by hospital staff. Cleaning equipment was colour-coded and used appropriately. We were told that cleaning fluids were locked away at the end of the day as a safety precaution and in line with guidance and control of substances hazardous to health (COSHH).
- We spoke to a member of staff responsible for cleaning who said their role was to 'prevent infection and keep patients safe'. Staff told us that they introduced themselves to the patient and checked it was an appropriate time to clean. Room cleaning checklists were seen to be completed.
- There was good assurance that cleaning had been undertaken. A card was left in the patient room with the name of the responsible cleaner. This card informed the patient what to do and who to contact if not satisfied with standards of cleanliness.
- We saw nurse cleaning schedules for clinical equipment and these were up to date and complete.
- We reviewed 27 patient feedback cards many of which commented that the environment was clean and tidy. In the hospital's 2016 patient satisfaction survey, of the 635 patients that responds, 99% reported cleanliness as excellent of very good

Environment and equipment

- We observed that the theatre department was clean and tidy with appropriate storage of equipment.
- Medical gases were secured appropriately in an alarmed store. Manifolds were maintained under a lease agreement with the co-located NHS hospital and we saw records that confirmed this. Records were seen of cylinders being changed by porters that showed stock rotation.
- There was evidence of planned preventative maintenance (PPM) in the management of gases and it was seen that action had been taken to be compliant with recent safety alert NHS/PSA/D2016/009. We saw the alert and a documented action plan showing how the hospital had acted.
- We reviewed a service level agreement (SLA) being in place with the co-located NHS hospital for maintenance of equipment. This was seen to be in date and was supported by a full activity report and full inventory, which included planned preventative maintenance dates.
- We saw results of weekly water quality tests which showed no abnormalities. If there were abnormal results, we were told advice could be taken from the decontamination lead at the co-located NHS hospital, which had an in date SLA to provide this service to the hospital. The laboratory who undertook the water tests could also be asked for advice.
- In theatres, we saw the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic related equipment' (2009) was being adhered to. Anaesthetic equipment was being checked on a regular basis with appropriate logbooks being kept and we saw evidence of these being completed.
- We checked one anaesthetic machine which had been serviced in the last 12 months and the reserve oxygen cylinder was in date.
- We saw that theatres and anaesthetic rooms were well organised, dust free and single use items such as syringes and needles were readily available.
- We saw that both theatres had difficult intubation trolleys that were compliant with the Association of Anaesthetist of Great Britain and Ireland (AAGBI) and difficult airway society standard. The trolleys were set

up in line with those in the co-located hospital and as most of the anaesthetists worked at both that hospital and Spire Sussex, this would ensure familiarity with equipment and improve safety for the patient.

- We checked two resuscitation trolleys, one in theatre and one on the ward. We saw that equipment was appropriately stored and checked daily with no omissions. The staff we spoke to were familiar with the checking process and were familiar with the equipment.
- In theatre, we saw Health and Safety control of substances hazardous to health (COSHH) assessments were up to date.
- On the ward we noted that all areas were tidy with appropriate storage of equipment. The treatment room on the ward was secure with keypad access. Surfaces were kept clear of equipment.
- On the ward, we checked three blood pressure machines and they were clean, serviced and tested, which provided a visual check that they had been examined and were safe to use.
- The security of the building was maintained under the SLA with the co-located NHS hospital. Key services such as fire and police were informed. Controlled drugs were returned to pharmacy in the co-located hospital and we saw that patients were being given instructions what to do if they required advice or support at home during the period of closure.

Medicines

- The hospital had a medicines management policy dated 2016. The purpose of the policy was to make suitable arrangements for the recording, safekeeping, handling and disposal of drugs.
- Spire Sussex hospital did not have an onsite pharmacy department, but there was a service level agreement (SLA) in place with the co-located NHS hospital which provided a pharmacy service including daily weekday visits and reviews, an out of hours service and emergency stock control. Staff told us that the pharmacy technician did stock checks twice a week.
- In addition, there was an up to date SLA in place for pharmacy services with a third party for sourcing, delivery and storage of medicines. This meant that there were adequate stocks of medicines to meet patients' needs.
- Storage of medicines was seen to be appropriate. On the ward all medicines were stored in the treatment room which had a secure key pad. All cupboards containing medicines were locked and the keys were seen to be kept by the nurse in charge. On checking the medicines cupboards all medicines were in date with evidence of good stock rotation. However, two tubes of sterile gel had been opened and not dated. It is best practice that this should be single use only.
- All medicines, including patients' own, were kept in the treatment room enabling the visiting pharmacist to check any medicines to be dispensed.
- Robust procedures were in place for monitoring and recording of ambient room temperatures in the treatment room where the medicines are stored and showed that storage temperatures were appropriate.
- We saw that medicines were stored in dedicated medication fridges when applicable. Fridge temperature monitoring was done daily and when asked, staff knew what to do if the temperatures were found to be outside the recommended range. We checked this fridge and all medicines were in date and appropriately stored.
- We looked at controlled drugs (CDs) which are medicines liable to be misused and requiring special management in wards and theatres. We checked order records and CD registers and found these to be in order. We saw that staff checked stock balances of CDs daily and there were no omissions. In theatres we saw that all new stock was signed in by the resident medical officer (RMO) with a registered nurse checking.
- We saw that a CD audit was done in both wards and theatres every three months. We saw evidence of action being taken for example when a member of staff had signed for the drugs with a red pen which was not in line with guidance. An action plan had been put in place and as this was a recent event we were assured this would be discussed with all staff at the February team meeting in theatre.

- We reviewed a completed safe storage of medicine audit. This audit showed a number of security checks in the treatment room, drug trolleys and refrigerator. We saw two actions on the attached plan which had been acted on. All audits were reviewed at the Clinical Effectiveness committee meeting.
- It was noted that the management of private prescriptions was in line with NHS protect guidance 2015. The prescriptions were kept in a locked safe in an office. On checking the consultant was seen to need to use his general medical council (GMC) number to prescribe and records were kept of prescriptions used. All processes were found to be appropriate and correct.
- Medicines for patients to take home were dispensed by a third party pharmacy.
- We reviewed three prescription charts and found them to be legible and completed appropriately. Patient allergies had been clearly noted on the chart. The charts demonstrated that prescribing was in line with national guidance. We saw that the charts were marked as being reviewed by a pharmacist who had documented input regarding medications.

Records

- Spire Sussex Hospital had a corporate policy for Information, lifecycle and management of patient records. This policy was due for review in August 2016.
- We saw staff managing patient records in accordance with the Data Protection Act 1998. Records were kept securely preventing the risk of unauthorised access to patient information. We observed that patient medical notes were locked in a trolley, that patient charts were kept in the patient room and that consultants were reminded to write into the patient records every day when they visited.
- We looked at twelve medical and nursing patient records. We saw a good standard of record keeping by all clinical staff.
- We saw that consultants were writing in the notes when they visit and this was in line with GMC guidance 2013 "Good Medical Practice".
- Each patient surgical care pathway was generated individually depending on which procedure the patient was undergoing. All pathways included a pre-operative assessment, anaesthetic assessment, discharge planning, together with baseline observations and risk assessments.
- The patient record included multidisciplinary input where required, for example, entries made by the physiotherapist, resident medical officer and consultant. Entries were legible and a signature and designation list was integral to the pathway.
- Information governance is mandatory training for staff and we saw that 100% of staff had completed this training, which met the hospital target. The matron was the 'Caldicott guardian' for the hospital and there was a designated hospital information governance lead.
- Staff told us they were always able to access patient records when required to do so. We saw that patient records were tracked and traced using an electronic system.

Safeguarding

- We saw the hospital had a corporate safeguarding vulnerable adults policy dated January 2016. Staff were able to access the policy and were able to describe the process they would follow should they have any concerns about a patient. The registered manager and another senior member of staff were the safeguarding leads, both have level three safeguarding training.
- There had been no safeguarding concerns reported to the CQC in the reporting period (July 2015 to June 2016).
- We saw that all staff were compliant with level 2 child and adult safeguarding training as this was part of the mandatory training for all staff.
- Staff awareness of the need to take action for safeguarding and crime prevention purposes had been highlighted through PREVENT training. PREVENT is part of the government counter-terrorism strategy designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming involved in terrorism themselves. Staff completed a PREVENT training competency and we saw completed competencies. We saw that training about understanding and reporting female genital mutilation (FGM) was included within PREVENT training.

Mandatory training

- Mandatory training was monitored and all staff were expected to complete this on an annual basis. The training was organised corporately by Spire Healthcare. We saw records that showed mandatory training compliance was 100%.
- Staff were required to undertake mandatory training courses which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk.
- Staff told us mandatory training was a mixture of online training and face to face. Staff told us they were given time to complete the training at work and we saw the learning zone in the ward area which had computers available for the staff to do their on line training.
- We saw that staff compliance with mandatory training was discussed at departmental meetings. Compliance was also seen to be discussed when an appraisal was completed.
- On the same electronic system for mandatory training, we saw optional training that was role specific for example, the nurses would complete safe transfusion depending on where they worked. All records for mandatory and optional training were stored electronically. We saw that reports were run monthly.
- We spoke with a doctor who was employed by an external agency, they described a robust process of ensuring their mandatory training was completed and up to date.

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

- The World Health Organisation (WHO) "five steps to safer surgery checklist" (WHO checklist) is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from theatre.
- We observed two examples of the WHO checklist in use and in both cases, the staff followed a standardised, accurate approach. We observed good teamwork with all staff engaged in the process. We found evidence of staff completing the WHO checklist documentation when we checked patients' notes postoperatively. We were told that compliance with the checklist was closely monitored and quarterly audits of compliance took place.
- The June surgical safety checklist audit of the notes demonstrated a compliance with the WHO checklist of 99%. We saw an observational audit completed at the same time that showed a compliance of 77%, attached to this were actions to be taken and we could see this was discussed at the theatre team meeting. We were told that if any members of staff were not compliant with doing the appropriate checks that would be discussed with them and in the case of consultants not being compliant, this would be reported to the Medical Advisory Committee (MAC).
- We observed at pre-operative team briefs that all staff introduced themselves and highlighted any issues regarding the surgery. This was in line with the 'WHO Guidelines for safe Surgery' 2009 and Royal College of Surgeons, 'The high performing surgical team-Best Practice for Surgeons' 2014.
- The American Society of Anaesthesiologists (ASA) used a grading system of one to six, which determines the fitness of patients. Grade one patients were normally healthy patients, and grade two patients had mild disease, for example well controlled mild asthma. Only patients that are ASA grade one or two had their operations undertaken at The Spire Sussex Hospital to ensure the hospital had the resources to meet their needs. All patients underwent pre assessment and if there were any concerns about the patient's suitability this was discussed with the anaesthetist.
- All staff working in surgery were expected to undertake resuscitation training and this was completed at the co-located NHS hospital. All trained staff completed intermediate life support (ILS) training and in theatre there were three staff who have completed advanced life support training (ALS). On the ward we spoke to a member of staff who had recently been supported to complete their ALS training. All healthcare assistants had basic life support training.
- The hospital used a national early warning system (NEWS) track and trigger flow chart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood

pressure and pulse) already undertaken when patients present to, or are being monitored in hospital. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provided them with increased support. We reviewed 12 patient notes containing NEWS charts which were completed correctly.

- An audit for NEWS completion was undertaken in June 2016 and showed 99% compliance.
- We saw there was a service level agreement in place with the co-located NHS hospital so in the case of a patient's sudden collapse their resuscitation team would attend the hospital. Under the existing lease agreement patients may be transferred to either the High Dependency, Coronary Care unit or the Intensive Therapy unit (ITU) at the co-located hospital if this was required. We saw there was an up to date clinical standard operating procedure in the management of resuscitation which detailed the variances to the main corporate resuscitation policy.
- We were given an example of a patient who had an unexpected complication of surgery and required admission to the ITU at the co-located hospital. Staff told us how this situation was dealt with effectively and safely.
- We were told that if staff observed any unsafe practice in theatre this would be reported. An example was given describing when staff had a concern about one of the doctor's practice how this was reported on the electronic incident reporting system and was escalated to the appropriate committee and was resolved by senior management.
- We observed that any alteration of the theatre list, caused the list to be reprinted on different coloured paper to bring to the attention of all staff that there had been a change. Staff described this as a way of ensuring safe practice. On the day of inspection we observed this happened because a case had been cancelled.
- Local pre-operative assessment policies should ensure pregnancy status is checked within immediate preoperative period in accordance with NICE guidelines. We observed evidence of this guideline being used in practice and we saw evidence of this process being subject to audit with 100% compliance recorded in June 2016.
- Safety alerts were distributed on a monthly bulletin circulated to senior staff. We saw evidence in the medical gas store that the hospital had taken steps to be compliant with safety alert (recent) NHS/PSA/D2016/009. We saw the alert and documented action plan to respond which was being progressed.

Nursing and support staffing

- There was no acuity or labour management tool in use on the wards to assess staffing requirements. However the ward sister was able to describe how staffing levels were assessed using a risk based approach depending on patient numbers and acuity. Activities on the ward for the day were taken into account. This was evidenced by looking at the staff rotas for the past two months and on average the ratio of trained nurses to patients was 1:5. The minimum staffing on the ward at any time was two trained nurses.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 (RCN 2012). This means one registered nurse (RN) for eight patients and the ward was compliant with this.
- The ward did not have planned versus actual staffing displayed. Staff told us that understaffing would be reported on the hospital electronic incident reporting system.
- The staff and patients we spoke to said that there were enough staff to provide safe and compassionate care.
- There were no vacancies for inpatient staff as of 1st July 2016.
- In theatre the use of bank and agency nurses was lower than the average of other independent acute hospitals we hold this data for in the reporting period (July 2015 to June 2016). We saw that the use of agency staff was monitored by the senior staff.
- There were no vacancies for theatre staff as of 1st July 2016.

Medical staffing

- There were 83 consultants who had practising privileges at the hospital. Practising privileges is a term that means consultants have been granted the right to practise in an independent hospital.

- The resident medical officer (RMO) provided continuous medical cover to ensure that all patients were appropriately treated and safe. Any changes in a patient's condition were reported to the consultant and their advice was followed in respect of further treatment.
- The hospital had two RMOs who were employed by an external agency and provided immediate medical support 24 hours a day seven days a week. They slept on site and worked a shift pattern of working one week on and one week off.
- The RMO told us and staff confirmed that there was a formal handover process undertaken between RMOs however, we did not see this as there was no change over during our visit.
- An RMO told us that there was a robust support process in place should they require support or advice. They could contact the consultant by phone and the consultant would then attend the hospital. They said they had not experienced any difficulty in getting hold of consultant. All RMOs held a current advanced life support (ALS) certificate.
- We were shown that there is a nominated consultant covering when a consultant was away. Details of the consultant surgeons, anaesthetists and physicians nominated cover are recorded on the application form and details are kept on the ward.
- The RMO reported no problems in getting adequate rest periods. They attended the nursing handover of day to night staff and were able to complete all duties within a reasonable time. They told us they rarely got disturbed at night as patients were stable.
- The RMO was managed by the registered manager and completed mandatory training. The RMO's employment agency met with the registered manager once a quarter to ensure there were no concerns.
- There were systems to ensure there was access to consultants. Staff told us that after the leaving the hospital the consultant was available by telephone 24 hours a day as they maintained responsibility of the patient for the duration of the patient's stay. We were informed that the anaesthetist was available for telephone advice for 24 hours following a patient's procedure. Staff reported they did not encounter difficulties contacting the relevant anaesthetist during this post-operative period.

Emergency awareness and training

- We saw evidence of regular scenario training for clinical emergencies such as cardiac arrest, anaphylaxis and major haemorrhage. We saw evidence of these training exercises, feedback from them and learning for the staff. Staff told us that they found the scenario training valuable as it enabled them to keep their skills up to date.
- We saw evidence of recent fire drill completed in September 2016. There was a dated and completed action plan attached.
- We saw a lockdown policy dated April 2016 specific to the hospital in case of an emergency that threatened the safety of patients, staff and visitors. This detailed when a hospital lockdown should be actioned. The policy provided contingency plans to ensure the comfort and safety of patients, staff, contractors and visitors under disruptive circumstances. These could be caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage or due to external circumstances beyond the control of the hospital such as a bomb threat.
- Staff were aware of the business continuity plan which was issued in November 2015 and could be accessed on the hospital's internal computer system. This contained action cards and evidence of annual desktop exercises. A copy of this policy was also kept behind the reception desk in the outpatient department which meant if required this was easily accessible by staff.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Policies were developed in line with national guidance and best practice evidenced from professional bodies,

such as the Royal College of Nursing and National Institute for Health and Care Excellence (NICE). All the guidelines we reviewed were easily accessible on the hospital intranet and were up to date.

- Staff were able to access national and local guidelines through the intranet and we were shown this. We were told that there was a monthly newsletter containing details of any new guidance or alerts which was discussed at senior team meetings and was then cascaded to the ward team meeting.
- We were told that there were monthly safety bulletins which contained up to date guidance and examples of adverse events and learning. We saw evidence these were discussed at departmental meetings and that staff were being reminded to read this so they would be aware of any changes to policies and new policies.
- There was a range of clinical pathways that were developed corporately. We saw examples of the hip joint replacement pathway and the day surgery pathway. The pathways were easy to understand and those checked were fully completed.
- During the inspection we saw examples of patient care carried out in accordance with national guidelines and best practice recommendations for example, early recovery after surgery (ERAS) in knee and hip replacement surgery. The enhanced recovery programme aimed to improve patient outcomes and speed a patient's recovery after surgery.
- Following surgery patients were nursed in accordance with NICE guidance, CG50: Acutely ill patients in hospital. Recognition of and response to acute illness in adults in hospital. Sometimes the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example after surgery. Adherence to this guidance by monitoring patients (checking them and their health) regularly after surgery and taking action if they show signs of becoming worse can help avoid serious problems.
- Within theatre, we observed that staff adhered to the NICE guidelines, CG74 related to surgical site infection prevention and staff followed the recommended practice. This guideline offered best practice advice on the care of adults and children to prevent and treat surgical site infection. For example, we observed the patient's skin at the surgical site was prepared immediately before incision using an antiseptic (aqueous or alcohol-based) preparation.
- We saw that keeping patients warm pre operatively and monitoring their temperature was in line with Clinical guideline (CG65) 2016 Hypothermia: prevention and management in adults having surgery.
- NICE guideline updates were a standard agenda item on the Clinical Governance Committee meetings under the title clinical effectiveness. It could be seen that new guidelines were discussed and arrangements for their implementation made.

Pain relief

- Seven patients we spoke with had recently undergone surgery told us there were no problems in obtaining adequate pain relief.
- One inpatient commented that the nurses were 'always asking about pain and asking them to score on a scale', she felt this was helpful and enabled her to express how she was feeling. Another patient commented that there was no delay in her getting pain relief when she asked.
- We saw that medicines to relieve pain were prescribed for patients on their medication charts. We saw that patients were asked 'Are you comfortable?' and 'Do you have any pain?' on the two hourly intentional rounding chart that we saw was in place for all inpatients.
- We were told that pain management was discussed at the pre-assessment clinic and we saw evidence of patient information being available. It contained information about the pain relieving drugs available and possible side effects.
- The patient pathway documents showed evidence of a pain assessment tool and prompts post operatively for pain to be assessed.
- We saw that patients were asked about their level of pain when called post discharge and we saw completed forms that showed this was happening.
- We were told that there was a local pain audit conducted twice a year. We saw evidence of an audit

that pain scores were checked each time the patient's observations were taken on the clinical scorecard and that the hospital scored 100% for the past three quarters.

- We saw that the patient satisfaction survey for the hospital showed that in response to the question 'To what extent did staff control pain?', 97% responded a great deal and 3% responded fair amount.
- We saw that pain and medicines management was a standing agenda item on the Clinical Audit and Effectiveness Committee meeting and that any issues were then passed through to the clinical governance committee.
- We were told that the consultant anaesthetist or RMO supported nurses with advice on pain management and there were good links with the pain team at the co-located NHS hospital. One member of staff was designated as the acute pain lead which meant staff had one person to go to for advice and she was also responsible for the audit.
- If there was a palliative care patient, the hospital had close links to the local hospice who would advise staff with regard to pain management. Some of the ward staff had attended the hospice for training.

Nutrition and hydration

- There was a robust process in place to ensure patients were appropriately starved prior to undergoing a general anaesthetic. We observed a verbal check was made in addition to the documented check. The amount of time patients were kept nil by mouth prior to their operation was kept to a minimum. We saw evidence that in discussion with the anaesthetist and depending on the type of surgery to be undertaken most patients would be given small volumes of water until going to theatre. We saw this decision had been ratified by the MAC.
- In the theatre department there was discussion about compliance to theatre starve times in line with national guidance and scorecard key performance indicators (KPIs). The most recent results showed the hospital had recorded 80% compliance against a target of 50%. On the wards the same focus on starve times was discussed at their meeting.
- The Malnutrition Universal Screening Tool (MUST) was used to assess patients' risk of being under nourished. The 12 patient records we reviewed had accurately completed MUST assessments.
- Patients on the ward commented that they had access to cold fluids such as water throughout the day and hot fluids were offered at regular intervals. We saw staff offering drinks regularly.
- Patient menus were seen and we were told that patients could request a different choice if they wished. We were told by one patient that when they did not feel hungry post-surgery the chef came up to speak to them and cooked something they particularly wanted.
- We were told that when a patient was on a special diet there would be input from the dietitian. We saw there was an SLA in place with the co-located NHS hospital to provide nutrition and dietetic support.
- We were told the menus were all checked by a dietitian. There was email contact with the dietitian confirming this. The ward hostesses and chefs had received dietary training from the dietitian, which covered frequently encountered special diets and what these were.
- We were told that the patient would be asked about any special dietary requirements at pre assessment and on inspection we saw that a letter had been sent from pre assessment to the main kitchen to advise the chef that a patient due in had a shellfish allergy.

Patient outcomes

- National clinical audits were completed, such as Patient Reported Outcome Measures (PROMS) in relation to hip and knee joint surgery and groin hernia surgery for NHS patients only. The PROMs are used for the routine collection and use of patient reported outcome data. Data was collected for patients both before and after surgery to assess a variety of patient factors pre and post-surgery. This involved patients completing a score for a range of markers such as pain and functional level and gave a measure of improvement. This was in line with best practice and professional standards.
- The PROMs scores for primary hip and primary knee replacement were exceptional for 2015-2016 with the hospital scoring the second highest score nationally for primary hip replacements and the sixth highest score

nationally for primary knee replacements across all providers (NHS and independent). The small number of NHS groin hernia cases had meant the average health gain could not be calculated.

- The hospital had good outcomes and consent processes in relation to hip and knee replacement procedures. Outcomes were measured nationally for example via the National Joint Registry (NJR). Published NJR data for 2015 and 2016 showed consent for patients' data to be held on the NJR was 100% which was better than the national England average (92%).
- There were five cases of unplanned readmission within the 28 days of discharge in the reporting period (July 2015 to June 2016). This was not high when compared to a group of independent acute hospitals which submitted performance data to CQC.
- We were told that the hospital shared governance and patient outcome information with the co-located NHS hospital. This was not a formalised meeting but any concerns raised would be taken to the governance meeting for more formal discussion and would be noted in the minutes.
- Spire Healthcare was working with the Private Healthcare information network (PHIN) and their consultants to enable results and outcomes to be published on line. The programme for full implementation was seen to be minuted by the medical advisory committee (MAC) with the website expected to be live from April 2017.

Competent staff

- Staff at the hospital had appropriate job descriptions and we saw recruitment checks were made to ensure new staff were appropriately qualified, experienced and suitable for that post.
- We reviewed three members of staff's employment checks. Evidence of sickness recording, back to work interview, induction checklist and all other mandatory checks were completed. On one file, photo identification and registration detail was missing, but immediate action was taken to correct this.
- Staff members' registration status was checked on employment and the status was monitored by the electronic human resource (HR) system. Registration and disclosure status was reviewed every month when a report was run for the hospital director and matron. We saw recent records that were due to expire and had been updated.
- In the three staff records that we checked we could see evidence that staff undertook induction with a checklist showing what had been completed. We spoke to a member of staff that had started at the hospital in the last year. They had completed a role specific induction.
- The agencies used to supply clinical staff were corporately managed through a third party. We were assured that checks were made at a local level to ensure staff met NHS employment standards.
- We saw evidence on the ward of induction information that was used for agency staff. These were kept on file as the hospital tried to use the same agency staff, so they would be familiar with the environment and processes.
- We reviewed the pre-employment checks of two RMOs who were contracted to work at Spire Sussex hospital via an external agency. These checks were found to be complete.
- We saw all consultants who worked at the hospital had to have the correct pre-employment checks completed in order to be granted practising privileges. All applications for practising privileges went to the hospital director and was discussed with the chair of the MAC and ratified by the MAC. Qualifications were checked of any consultants applying to work at the hospital and their scope of practice should be the same as their practice in the trust. An example was given of turning down an application as the scope of practice proposed was not the same as in the NHS.
- Biennial review of practising privileges was seen to be reviewed at the MAC meeting and was noted to be consistently at 100%.
- We reviewed two consultants records and all checks were complete and in date. We saw evidence of monthly checks being run on the electronic HR system which showed any lapses with indemnity cover, General Medical Council (GMC) registration and appraisal information. Consultants were alerted of any

information that was out of date and consultant practising privileges would be suspended if not acted upon promptly. The chair of the MAC was informed of any such issues.

- During the period from January 2016 to December 2016, 100% of all ward and theatre staff had an appraisal undertaken. The appraisal system was based on the Spire Healthcare's vision and values. Learning and development needs were identified during appraisal. Staff told us they were supported in their learning and development by their manager.
- Staff told us that they were supported in completing their mandatory training and accessing other role specific training that was seen as required. We spoke to a member of staff who had been supported to complete management training, as this was relevant for them.
- On the ward we saw that staff were being supported to complete their professional revalidation and each member of staff had their own folder containing up to date information about the process of revalidation and their own personal record of achievement. We were told that staff were supported to keep these folders up to date. Validation of professional registration for doctors with practicing privileges and nurses was 100%.
- There was a designated area on the ward that staff could use for learning. There were two computers available and we saw a notice board that showed up to date learning material for staff. At the time of inspection the board displayed information on the Mental Capacity Act, 2005.
- In theatres, we noted that the staff did not carry out the role of first assistant as the consultant would bring an assistant with them. We were told that records of anyone working as a first assistant were kept in theatre and monitored by the theatre manager to ensure visiting staff had the right checks and qualifications to be working as a first assistant.

Multidisciplinary working

- We saw that planning of care for patients took place at pre assessment with input from the multi-disciplinary team including doctors, nurses and allied healthcare professionals.
- Staff told us there was good multidisciplinary working within the hospital. We were told that once a week there is a clinical meeting involving clinical staff from the ward, theatre, imaging, physiotherapy and non-clinical staff from the business office to plan the week ahead. We were told this multidisciplinary meeting enabled correct staffing to be put in place depending on the workload.
- We were told there was good multidisciplinary working with the co-located NHS hospital and there were a number of service level agreements (SLAs) in place with this hospital.
- These SLAs covered some key clinical services and were seen to be subject to annual review. They were in date and had been signed in April 2016. Services included blood supplies and other intra venous fluids, pathology services, radiology including provision of a radiation protection advisor (RPA), engineering and maintenance, security and access, resuscitation services, nutrition and dietetics and hydrotherapy.
- We saw there was an in date SLA in place with the co-located hospital for multidisciplinary team (MDT) review of cancer patients. The agreement referenced national guidance 'The characteristics of an effective MDT NHS national cancer team' (Feb 2010).
- We reviewed SLAs for pharmacy, blood and blood products, occupational health, maintenance, theatre sterile stores supplies (TSSU) and an IPC consultant. All were signed, in date and contained reference to national guidance and standards to ensure compliance with these.

Seven-day services

- The hospital was routinely open seven days a week twenty four hours per day. However at times of low activity the hospital would close and at the time of the inspection prior to Christmas, we observed that the hospital was preparing for a period of closure.
- We saw consultants provided details of cover arrangements for when they were not available when obtaining practising privileges. This was documented and kept on record on the ward as well as in their personnel files.

Access to information

Outstanding ☆

Surgery

- We spoke to clinical staff who told us they had access to current medical records and diagnostic results such as blood results and imaging to support them to care safely for their patients.
- We saw that consultants wrote in the patient notes every time they visited so this information was always available for the staff caring for the patient.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). In addition to this, staff could access the neighbouring hospital's PACS. Pathology test results could also be accessed electronically.
- PACS was available on wards and in theatre, so images could be viewed prior to and during a patient's procedure.
- Staff could request patient records from other hospitals using an image exchange portal. This provided a secure transfer of information between providers. This included the discussion held at multidisciplinary meetings at the co-located hospital.
- Patients were given a paper copy of their discharge summary and a copy was sent manually to their general practitioner. There was evidence that the hospital were working towards electronic discharge and the nurses had been undergoing training on computers to enable the move across to a new system in the near future. The staff we spoke with were enthusiastic about this change and the training they had received.
- Staff told us clinical information and guidance was available on the intranet and we saw there were hard copies of policies and other relevant information on the ward for staff to refer to.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place which was based on guidance issued by the Department of Health. This included guidance for staff on obtaining valid consent and details on the Mental Capacity Act, 2005 (MCA) guidance.
- Staff were aware of their responsibilities under the MCA, 2005 and deprivation of liberty safeguards (DoLS) and were able to describe the arrangements that were in place should the legislation need to be applied.
- We were told that best interest decisions and DoLS decisions were taken when indicated and were formally documented but were unable to test this.
- Training on DoLS and the MCA was part of the mandatory training and the staff said it was easily accessible. We saw up to date information on the notice board in the learning zone for the staff about the MCA.
- Staff were able to describe the requirements regarding consent and confirmed that the policy was readily available to ensure that informed consent was obtained from the appropriate individual.
- Patients we spoke with told us they had been given clear information about the benefits and risks of their surgery in a way they could understand and they were given enough time to ask any questions.
- We reviewed 12 consent forms and in all cases they were fully completed, legible and contained details of the risks of surgery and were signed by both the consultant and patient.
- We observed patient information was available, issued by the General Medical Council (GMC), informing patients of their needs and what should be considered when planning cosmetic surgery.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- Data was submitted to the Friends and Family Test (FFT) for NHS patients only. The hospitals FTT score was 100% for patients saying they would recommend the hospital in October, November and December 2016. The FFT scores were better than the England average of 95%.
- Response rates were also better than the England average of NHS patients at 41% compared to the England average of 25% in October 2016. On our unannounced visit the hospital showed us an action plan they had devised to improve the response rate to the FTT even further.

- In the most recent patient satisfaction survey carried out by the hospital, 100% of the 635 patients who responded would recommend their friends and family. In the same survey, 93% of patients felt the care and attention they received form nursing staff was excellent.
- The hospital had received one item of rated feedback on the NHS choices website in the reporting period (July 2015 to June 2016). The comment was that the person was extremely likely to recommend the hospital.
- The patients we spoke with were overwhelmingly positive about the care they had received and said the nurses had time to give compassionate care. They all commented that call bells were always answered promptly and nurses regularly came to their rooms to check on their needs. One patient commented that the nurses were really attentive, polite and courteous and attended to all the little details that made their stay comfortable.
- Throughout our inspection, we witnessed excellent staff interaction with patients. We observed how the nurses assisted patients with compassion and skilled care.
- The hospital achieved 82% site score in the patient-led assessments of the care environment (PLACE) 2016, for treating patients with privacy, dignity and wellbeing, which is in line with the national average (which includes NHS hospitals).
- In theatres we observed staff delivering care with empathy and compassion, safeguarding the patient's dignity including when they were not conscious.
- We reviewed 27 patient feedback cards all of which contained positive comments. The comments included; 'I was treated with the utmost respect and care and I was most definitely listened to'. 'All staff have been excellent, I have felt confident and relaxed throughout and I feel as though I have my life back. I felt at all times that any concerns or questions would be dealt with quickly and willingly, facilities are first class and the whole experience has been reassuring.' 'I have always found staff to be courteous, respectful and caring, really excellent'.
- Patients commented most frequently that they were treated with respect and had all their questions answered and felt safe. The cleanliness of the environment was frequently mentioned. Many patients commented that they would recommend to family and friends.
- On the ward, we were told about and shown the use of an intentional rounding form. Staff felt this ensured that patients were seen regularly and patients we spoke to commented that they saw nurses on a regular basis.
- Patients gave us examples of staff going 'the extra mile'. We met one patient who told us they had a fear of hospitals and needles, when this was realised the consultant took time in explaining the procedure and anaesthetic. Following pre assessment and meeting the anaesthetist, physiotherapist and nurse the patient was so reassured by the caring approach, the procedure that had been delayed due to anxiety was now able to go ahead. The patient described being put completely at ease and did not think the staff could have been any more caring. They told us, "Doctors, nurses, all staff care here".
- We were given a further example, where a patient called to complain that staff had not called her following a procedure. A staff member had been trying to call, but the patient's phone would ring once then stop. The staff member called phone companies to find out who the patients provider was and arranged for an engineer to go and see the patient. There was a problem with the phone line and it was corrected.
- Staff demonstrated their commitment to going 'the extra mile' by ensuring on discharge all patients were escorted from the ward unless they specifically requested not to be. For example, they escorted every patient to the car park following a joint replacement, to ensure they were safe to get into the car.
- A staff member told us she had spent a long time sorting out transport for an NHS patient as the patient had found it very difficult to do so. We were told that porters will regularly get newspapers for patients if they had not requested one prior to admission, then decided they want one.

Understanding and involvement of patients and those close to them

- We spoke with patients at different stages of their surgical journey and they told us they felt involved in their care and treatment.
- One nurse was observed giving patient information ready for discharge home. Clear verbal and written information was given and the patient was given time to ask questions and was given information on what to do if they needed to contact the hospital for any information once they got home.
- We observed on the ward that nurses introduced themselves by their name and patients knew the name of the nurse looking after them. We also saw evidence of this on the patient feedback cards.
- We were told that it was routine to phone patients in the first forty eight hours following discharge. We saw evidence of calls being made and the forms used, which included prompts on actions to be taken if the patient had any concerns.
- On the ward we saw information on the board for all patients about the cost of physiotherapy aids that might be required after surgery. We saw a variety of health-education literature and leaflets produced by national bodies. Some of this information was general in nature while some was specific to certain conditions.

Emotional support

- Surgical services had arrangements to provide emotional support to patients and their families when needed. Patients told us that staff had enough time to provide them with adequate emotional support.
- Pre admission staff told us that when it was identified a patient required extra support this was arranged where possible before admission and discussed with the multidisciplinary team. For example, if a patient had complex needs they would try to schedule them for first on the list.
- We saw the availability of specialist services and nurses we were told for example if a patient required palliative care, the hospital has close links with the local hospice and nurses from Spire Sussex hospital attended the hospice for training on pain management.
- We saw chaperone information displayed throughout the ward area. This was clear and easy to read and informed patients of how to request a chaperone.
- In the hospital's 2016 patient satisfaction survey 2016, 98% of the 635 patients who responded said they were involved in decisions about their care and treatment as much as they wanted to be, and 100% said they found someone on the hospital staff they could talk to about their worries and fears.

Are surgery services responsive?

Outstanding ☆

We rated responsive as outstanding.

Service planning and delivery to meet the needs of local people

- Staff told us there was a flexible, patient focused approach to working during busy times. There was an ability to extend session times if necessary. Additional cases could be added to theatre lists allowing for appropriate consent and screening time. In theatre there was an on call team for out of hours.
- Free car parking was available on-site. The hospital recognised space was limited. To ensure as many spaces as possible were available, they purchased car parking passes for staff to park elsewhere. Managers monitored the car park to make sure staff did not use it.
- The hospital has a corridor link to the co-located hospital and we saw there were a number of SLAs with the local hospital to ensure their patients had a safe and timely access to services such as computed tomography (CT), pharmacy, pathology and a range of other services.
- Patient had a choice about the date of their operation. They told us staff accommodated their requests to allow planning for taking time off work. One patient told us that they had to turn down the first date for operation due to work commitments. We were told this change was made easily.
- The hospital management team collaborated with local NHS Clinical Commissioning Groups (CCGs) and offered treatment funded by the NHS. This gave local people a choice of where they could receive care and treatment and helped ensure that the local population could access care in a timely way.

- The hospital arranged public open evenings and arranged speakers for the local population to attend, for example an evening promoting men's health awareness.

Access and flow

- All visitors and patients accessed the hospital via main reception and were directed to the appropriate department. Staff at the reception were able to explain the need for confidentiality of patient information and were able to demonstrate how they managed this. All patients for admission were met by the ward clerk and escorted to their rooms.
- Patients were prepared for their surgery and walked to theatre escorted by a member of staff. Following the procedure they were transferred to the recovery area to ensure they were stable and pain free. The patient was escorted to the ward on their bed and was recovered either sufficiently to be discharged home or remain as an inpatient overnight.
- The theatre manager reviewed the operating lists in advance to ensure there was adequate time, staff and equipment. There was a weekly meeting with the clinical and non-clinical department leads to ensure the week ahead was planned taking into account admissions, patient need and type of procedures. We were told the theatre manager would agree any arrangements for unplanned surgery or additional cases.
- In the hospital's 2016 patient satisfaction survey 98% of the 635 patients who responded said the way in which they were prepared for home was excellent or very good. On discharge there were wheelchairs available or patients could walk to reception accompanied by a nurse. We were told that it was routine practice for a nurse to escort a patient to their car if support was needed.
- We saw that records were kept when patients had been transferred to an external organisation, such as the co-located NHS hospital. Copies of notes were sent with the patient to ensure continuity of care.
- We were told that there had been two cancelled procedures for a non-clinical reason in the last 12 months, both patients were offered another appointment within 28 days of the cancelled appointment.
- The Spire Sussex hospital achieved 90% for patients referral to treatment (RTT) waiting times in nine months of the reporting period from July 2015 to June 2016 and for four months had achieved 100%. In the three months they did not achieve 90%, the hospital had analysed the reasons for this this and in all cases this was due to patient choice, for example due to holidays.

Meeting people's individual needs

- We found the hospital was able to meet patients' individual needs. For example there were positive initiatives in place to support patients living with dementia. We were told that the work on improving care for patients with dementia started following a national dementia awareness day. Staff at the hospital were interested in understanding how they could put in place support for patients with dementia. Staff realised that this might only apply to a small proportion of their patients but were keen to get involved
- During our inspection we found that all staff clinical and non-clinical were energised and enthusiastic about the work being done on supporting patients living with dementia. Staff told us how the patient would be supported through each part of their hospital journey and how this approach would be used to manage similar patients with complex needs.
- Three members of staff were appointed as champions for dementia care; one each in theatres, outpatients and on the ward. The staff member in theatre was already experienced in this field and the other two staff members attended a course at a local college and we saw evidence of this in completed course work.
- We saw records showing staff had undergone basic dementia training and we saw the patient documentation appropriate for patients living with dementia and produced by the Alzheimer's Society called 'This is me'. All staff received training on how to complete this document.
- We discussed with a member of staff the preparation she was making for a patient living with dementia who was attending the hospital the next day. We saw appropriate documentation and were told of how the patient would be supported during the procedure.
- We saw information about supporting patients with dementia in all clinical areas. We saw information

presented as a poster in the recovery area of theatre with information under the heading 'Improve post anaesthetic care – understanding and management of pain in the dementia patient'. This information was detailed and used as a resource for the nurses in that area and shared with the ward nurses.

- The most experienced member of the dementia champions had both designed the poster in recovery and collated information about dementia. This champion acted as a resource for other staff, and had been asked to support other hospitals in Spire Healthcare in order to share best practice. This demonstrated an innovative approach to providing a patient centred approach to care and a willingness to share information in order to benefit others.
- In the patient led assessment of the care environment (PLACE) audit 2016, the Spire Sussex hospital scored 89% which was significantly better than the national average of 74% in relation to care for patients living with dementia.
- A pre-assessment service was in place and staff told us prior planning took place for patients admitted with special needs. Pre-assessment would notify the ward of the patient's specific needs so adjustments might be made. For example we were told that if bariatric equipment was required this was available. If a patient required extra supervision and a bedroom close to the nurse station then this would be organised.
- We were told that the pre-assessment service was supported by the anaesthetist and an example was given of a complex patient needing an urgent referral outside the hospital, which the anaesthetist supported the nurse in organising this in a timely way.
- We saw a wide selection of patient information around the hospital on a variety of topics including pain management and staff explained that they would direct patients to this information. We saw the information was well presented and accessible to patients and visitors.
- Staff could tell us how they would access translation services for people who needed them. This included British sign language and 50 languages. Face to face or telephone interpretation was available. However; we were told these were rarely needed.
- There were arrangements to facilitate communication for those with sensory problems. We noted that a hearing loop was available for patients. We were told that large print information was also available.
- We observed that patients were allocated a room on the ward according to their particular need and patients that required closer monitoring or support had a room close to the nurse station.
- The patients we spoke with said the food at the hospital was of a good quality with a variety to choose from and catered for individual needs and cultural requirements. We were given an example where a patient did not feel hungry post-surgery. The chef came up to speak to them and asked them what they thought they might want. The patient chose and the chef prepared that specifically for them.
- In the PLACE audit 2016, the Sussex Spire hospital scored 96% for standard of food which was better than the national average of 91%. They scored 93% for the standard of organisational food which was better than the national average of 91%. They scored 98% for standard of ward food which was significantly better than the national average of 80% In the hospital's 2016 patient satisfaction survey 94% of the 635 patients who responded rated the quality of food as excellent or very good.
- The hospital was purpose built, single storey and compliant with the Disability Discrimination Act, 2005. Entrances to the hospital were accessible for people with mobility problems. Accessible toilets for patients living with a disability were located close to the reception area, and within the departments.
- The most recent patient led assessment of the care environment (PLACE) for disability scored 92%, which was better than the England average of 81%.
- All patients we spoke with gave us overwhelmingly positive feedback about the service, giving examples of cleanliness of the environment, friendly staff, food and pain management.

Learning from complaints and concerns

- The hospital had clear processes in place for dealing with complaints. Staff were aware of the complaints process and were able to give examples of changes of practice following complaints investigations.

- The Hospital Director (HD) and matron reviewed all complaints received by the hospital. The Hospital Director had overall responsibility for the management of complaints. Either the HD or matron would request the departmental manager (if appropriate) to investigate and provide a response, which would include witness statements where relevant. Once investigated, a response was sent to the patient and where appropriate, the patient and their relative invited to a meeting to discuss the findings of the investigation.
- The hospital followed their corporate complaint policy for managing complaints. We saw evidence of 100% compliance with corporate targets for acknowledgement and final letters.
- The complaints process was managed on the electronic incident reporting system. Using the system we were able to follow the process taken for two complaints. We saw that the complaints had been risk assessed, holding letters were sent out and there was evidence of an appropriate level of investigation being carried out.
- Final letters were sent out within the corporate target of twenty days, we saw an apology and full explanation of process and outcome. We were told that the hospital director or matron would write the final letter and if appropriate the complainant will be invited in for a meeting to discuss the complaint and outcome.
- However the final responses to the complainants did not include information on how to escalate concerns to corporate or independent review. It was seen that there were corporate information leaflets containing this information that were available and could be included within the response letters. At the unannounced part of the inspection we saw that this had been corrected.
- There were six complaints received in the hospital in the reporting period (July 2015 to June 2016). No complaints had been referred onto the Ombudsman or ISCAS (Independent Healthcare sector complaints adjudication service). The CQC received no complaints in the same reporting period.
- Leaflets called 'please talk to us' were available on the ward and contained information for the patient or visitors on how to make a complaint. The information was clear and easy to understand. There was information on display that that asked patients to feedback on their stay and any concerns and this information was presented in six different languages.
- Staff told us that if a patient or visitor had a complaint they would try to resolve it at the time and if they were unable to resolve the issue they felt able to ask their line manager or a member of the senior management team for support.
- We found positive action was taken in response to complaints and feedback. On the ward area, it was observed that there was a board showing patient feedback. With the title 'You said..we did' this showed how following patient feedback, the chairs in patient rooms were refurbished. In the general reception area we saw a notice saying that following feedback there was now a notice on display on the main reception desk reminding all visitors to collect a token for the car park.
- We were told that there had been complaints about the difficulty in parking at the hospital. We were told there was now an information board put out into the car park and this prevented visitors being trapped in a full car park. We were told this has resulted in fewer complaints.

Are surgery services well-led?

Outstanding ☆

We rated well-led as outstanding.

Vision and strategy for this core service

- There was not a separate strategy for surgical services as staff were aware and understood the corporate Spire Healthcare vision and values and were able to give examples of how this affected patient care. Staff identified caring and teamwork as being important to them and how this made for good patient care.
- For example one house-keeping member of staff spontaneously told of their understanding of the vision and values and was able to relate to their role by explaining that they worked to 'prevent infection and keep patients safe'. This showed that all staff were focussed on the safety and well-being of patients regardless of their role.

- The staff on the ward supported and promoted the 6Cs of nursing, which are care, compassion, courage, communication, commitment and competence, which was drawn up by the Chief Nurse of NHS England in 2014. There was information displayed in the nursing office for all staff to access.
- Staff behaviours were in line with vision and values. We were told that the 'Enabling Excellence' appraisal system meant there was a focus on learning and development for all staff. Staff we spoke to were enthusiastic about training opportunities. The appraisal system required staff to reflect on how they demonstrated the values and behaviours.
- We were told that staff were proud of working at Spire Sussex hospital and the visions and values were displayed in clinical areas. Staff told us they were made aware of the hospitals vision and values at induction and this was reinforced through the 'Enabling Excellence' appraisal programme. Staff were encouraged to demonstrate the values through their behaviours.
- Staff spoke with overwhelming pride in how they provided care for patients, which demonstrated 'caring was their passion'. Dedication and commitment of teams to provide the best patient experience demonstrated 'succeeding together'. The commitment of managers to engage staff and encourage their development demonstrate them 'driving excellence'. The appraisal system 'Enabling Excellence' required staff to reflect on how they demonstrated the values behaviours. We saw a variety of staff appraisals and saw this was an integral part of the process. This all contributed to Spire Healthcare's mission which was to bring together the best people who were dedicated to developing excellent clinical environments and delivering the highest quality patient care.

Governance, risk management and quality measurement (and service overall if this is the main service provided)

- There was an effective governance framework in the hospital which gave robust assurance about the quality and safety of services. The hospital held meetings through which governance issues were addressed. The meetings included the Medical Advisory Committee (MAC), Heads of Department (HOD), Clinical Audit and Effectiveness and Clinical Governance Committee. We saw the hospital committee structure organisation chart for 2016 and it was clear which committees were active and who chaired each meeting.
- The hospital had a clinical scorecard that had key performance indicators (KPIs) that were reported quarterly. Results were benchmarked and tracked against group performance targets. We were told that this was used for quality improvement. We saw evidence at Clinical Governance and departmental meetings that results were discussed.
- There was strong engagement with consultants working at the hospital. The MAC was seen to have representation from different clinical specialties. Most consultants worked at the co-located NHS hospital. There were reviews of consultant practice to ensure that the consultants were working within their own scope of expertise.
- We saw there was a nominated consultant who supported the Clinical Governance Committee and also sat on the MAC, the minutes showed they supported the feedback of any governance issues to the MAC.
- The Clinical Governance Committee met quarterly. Regular agenda items included incidents, key performance indicators, clinical audit plan, patient safety, patients experience and the risk register.
- We were told the young person's service was suspended in September 2016 in order to ensure all staff had the required training to enable this service to continue. We saw this was discussed and minuted at the Clinical Governance and MAC committee demonstrating a good governance process. This demonstrated the hospital leadership team made decisions based on the need to provide safe services of good quality, even if they may have negative commercial consequences.
- There was a wide range of audits carried out in the hospital and these were seen to be reviewed at the Clinical Audit and Effectiveness Group, which in turn fed through to the Clinical Governance Committee and HODs meeting. Patient safety was seen to be an agenda item for all committees. There was a regular audit plan at the hospital and we saw they were up to date with the plan.

- There was a robust system of governance to monitor, identify and mitigate risk. We saw that the hospital had a risk register in place, which covered hospital wide and specific departmental risk. This detailed the expectation of staff to work in a manner that reduced risk and encouraged escalation of risk through the management structure. Managers were able to identify risks relevant to their department and how they mitigated that risk in practice.
- All staff we spoke with were aware of the risk register. We were told that all incidents, risks and complaints were logged and managed on the hospital's electronic reporting system.
- All staff were aware of the clinical scorecard which had a number of key performance indicators related to patient safety. The scorecard was seen to be displayed in all clinical areas visible to staff.
- We raised a number of minor issues with the management team during our announced visit such as response rates to the FTT. When we returned on our unannounced visit remedial action had been taken, or was in advanced planning stages to correct these. The demonstrated the leadership team responded immediately to safety concerns when made aware.

Leadership/culture of service related to this core service

- We saw clinical leaders and managers encouraged supportive, cooperative relationships among the staff and teams. Senior team were very visible around the hospital and staff said that they receive regular patient feedback information.
- Staff were highly complementary about the management team. All members of the senior team were seen to be approachable. One member of staff said there was a culture of everyone being there to support each other.
- There was clear leadership, and staff knew their reporting responsibilities and took ownership of their own working areas. We saw evidence of staff being supported with relevant leadership and management training.
- The MAC had a stable membership and our discussions showed there was open communication with the hospital senior management team. This demonstrated a shared focus on delivering good governance and quality patient care.
- Staff told us that any concerns about disrespectful or discriminatory behaviour or attitudes could be addressed with reference to the policy 'Raising Concerns'. Staff were confident they would be supported if they needed to do this. Two examples were given of managers dealing internally with staff behaviour and competence issue and how this was resolved to ensure staff did not feel intimidated and that patients were kept safe.
- A number of staff within the department had long-standing service within the hospital. Staff members told us they felt respected, liked coming to work and that there was an open and honest culture in the hospital. Staff told us they felt proud to be working at the hospital.
- We were told that regular staff meetings were held in all departments and we saw meeting minutes that supported this. It was seen that meetings kept staff up to date with relevant information, gathered their views and feedback and celebrated successes. The regularity of these meetings was seen in all departments.
- Staff told us the culture of the service was focussed on meeting the needs of the patient and it was a supportive place to work. Human resources data supported the views of the staff. Sickness rates for theatres were lower than the average of other independent acute hospitals that we hold data for. There were no vacancies in theatres for theatre staff as at 1st July 2016. Inpatient departments also had no vacancies and low sickness rates. There were high levels of staff stability for all staff working in theatre and inpatient areas with no turnover of staff in theatre and below average in the inpatient area.

Public and staff engagement

- The hospital used various means of engaging with patients and their families. These included surveys such as the 'friends and family test' and a survey for all patients. Results of these surveys and an action plan was seen.

- We were told that the hospital had looked at ways of encouraging more people to give feedback. One patient suggested pens, so they have pens available for patients, which we saw during inspection. They have developed an action plan since the last survey which shows how the matron will encourage patient feedback during her patient round and how they will communicate at corporate level with other hospitals to share best practice.
- The hospital had established a patient forum group. Minutes were seen of the patient forum meeting that was held quarterly. At all meetings the patient's journey was discussed and participants at the meeting were able to give feedback on each stage of their journey. Each meeting was seen to produce an action plan.
- We saw evidence that changes had been made following feedback. For example the development of patients walking to theatre when able and additional posters to ensure that patients were aware that chaperones were available. Following one meeting when it was discussed that clocks in the patient's rooms were ticking too loudly, silent clocks were sourced.
- We were told that the hospital had nominated a previous patient as patient champion, this person then completed the 15-step challenge. The fifteen-step challenge is a simple toolkit with a series of prompts and questions designed to look at hospital care through the eyes of patients and relatives, helping to identify what good looks like. Staff we spoke to saw this as a positive initiative and we saw the feedback and completed action plan resulting from this.
- We were told there were regular forums with the hospital director. There were regular team meetings and email alerts with information. We saw evidence of these emails and staff we spoke to were positive about the staff forums. All staff had an email account to enable communication across the hospital.
- The Spire Sussex Hospital had been in the top three hospitals for the Spire group for positive staff survey results for the last three years. We saw a current hospital wide staff engagement action plan which showed the hospital was striving to improve these results with increased engagement with all staff. Actions included time spent at induction informing staff that all departments should work together and taking actions to the MAC so consultants were reminded of the importance of appreciating staff especially non-clinical staff.
- We saw there was an awards scheme. On the ward area we saw evidence of the inspiring people award (an internal award scheme). We also saw an 'extra mile card' that could be completed and given to staff that have done something that is appreciated. Staff said they appreciated this reward system. The hospital awarded 17 individual and two team awards in the last year.
- There was a scheme in place called 'walk in my shoes', when a staff member worked a shift in another department. Examples were given where an administrative staff member spent the day working in the kitchen. Another staff member worked as a senior nurse for the day. They found the experience challenging at times but said they got a lot out of it and appreciated their own role more and how their role supported others. All staff we spoke to were very enthusiastic about this learning experience.
- Staff said they were highly satisfied with the benefits of working for the company. One staff member told us flexible working at the hospital allowed a better work/life balance. One staff member said the hospital enabled her to give good patient care.
- The hospital had a GP liaison officer, who helped to develop an educational programme for local GP's to attend with the hospital's consultants. We saw these educational sessions advertised on the hospital's website.

Innovation, improvement and sustainability (local and service level if this is the main core service)

- We saw examples of innovative practice and innovation was encouraged at the hospital. Examples of innovation included the positive approach to meeting peoples individual needs and there was a lot of work done to support patients living with dementia. The three dementia champions supported all the clinical areas. The poster in recovery 'Improve post anaesthetic care – understanding and management of pain in the dementia patient' developed by the dementia champion in that area demonstrated innovation and improvement. We were told this was to be shared with other Spire Healthcare hospitals showing sustainability.

Outstanding ☆

Surgery

- Staff across the hospital showed themselves to be patient focussed. Patient feedback was extremely positive. Good examples were seen of patient feedback being taken into account to improve the service with an active patient forum and good engagement with all stakeholders.
- We saw that staff worked well together as a team across the hospital. Staff were energised and enthusiastic and saw the value of supporting each other to deliver best care. The initiative called 'walk in my shoes' was spoken about by all the staff we discussed this with as a positive experience that helped the team to improve working together.

Outstanding ☆

Outpatients and diagnostic imaging

Safe	Good
Effective	Good
Caring	Outstanding ☆
Responsive	Outstanding ☆
Well-led	Outstanding ☆

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good.

Incidents

- The hospital did not report any never events related to the outpatients or diagnostic imaging departments in the period from July 2015 to June 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There was one clinical incident reported between July 2015 and June 2016 in the outpatients and diagnostic imaging departments. The rate of incidents was lower than the other independent acute hospitals the Care Quality Commission (CQC) holds data for. Ten non-clinical incidents were reported in the same period, which is similar to other independent acute hospitals CQC holds data for. We spoke with managers about the low numbers of incidents in outpatients. Incidents were recorded depending on where it was raised. For example, an incident with regard to an appointment, would come under administration and not outpatients. Managers showed us data which detailed where incidents were raised in the last 12 months and we saw there were a number raised in the different areas of outpatients, for example, the waiting area and administration. This gave assurance there was a good reporting culture in the outpatient department.
- All staff we spoke with had a good understanding of the incident reporting process. They could give examples of what they would report, for example a patient feeling faint following a blood test. Staff told us an incident would be discussed with individual staff and shared with the team. Incidents that occurred within the hospital were discussed regularly at head of department meetings and this information was cascaded down to staff meetings. We saw minutes of all these meetings, which indicated this was occurring.
- Under regulation 4(5) of Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000, providers are obliged to submit notifications of exposures 'much greater than intended' to CQC. We received no notifications from July 2015 to June 2016.
- Staff in the diagnostic imaging department had a clear understanding of what was a reportable incident. A Radiation Protection Advisor (RPA) was available for advice, by telephone or email, if required.
- Staff were able to describe the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008. This 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 explained that service users and their families were told when they were affected by an event where something unexpected or unintended had happened. The hospital apologised

and informed people of the actions they had taken. We were given an example of when a patient had attended for an X-ray of one area of the body, and a different area was documented on the referral. Staff gave an explanation of what the problem was, apologised and ensured the referral was corrected by the referrer.

Cleanliness, infection control and hygiene

- All areas of the outpatient and diagnostic imaging departments we visited were visibly clean and tidy. The most recent patient led assessment of the care environment (PLACE) score, completed April 2016, was 100% for cleanliness, which was better than the national average of 98%.
- Housekeeping staff understood their responsibilities, cleaning frequency and standards. All areas were cleaned each morning. We saw checklists which indicated this was occurring. An audit of the checklists indicated in October, November and December 2016 all areas had been covered. The hotel services manager, who managed housekeeping staff also carried out daily spot checks to check areas were clean.
- Staff in the outpatient and diagnostic imaging department also completed daily checklists of rooms, to ensure equipment within treatment and examination room was clean at the start of the day. We saw disinfectant wipes were available in each room. Equipment was cleaned with these, between each patient use and a green sticker placed on it to show this had been done. We saw equipment with green stickers on indicating equipment was clean and ready for use.
- There were hand washing sinks available in all patient examination areas in line with Health Building Note (HBN) 00-09: Infection control in the built environment. Soap and disposable hand towels were available next to sinks. We saw information displayed demonstrating the 'five moments for hand hygiene' near handwashing sinks.
- We saw hand sanitising gel was available at point of care in all clinic rooms, this was in line with epic 3: 'National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England' (epic 3) and HTM 00-09. We saw staff using hand sanitiser when entering and exiting clinical areas.
- We saw staff in clean uniforms and all staff we saw that interacted with patients were bare below the elbow. They demonstrated appropriate hand washing technique in line with 'five moments for hand hygiene' from the World Health Organisation (WHO) guidelines on hand hygiene in healthcare.
- Personal protective equipment was available in all outpatient and diagnostic imaging areas and we saw staff using it appropriately.
- Attendance of staff in outpatients and diagnostic imaging to infection, prevention and control training was 100%.
- Chairs in waiting areas, consultation and examination rooms were covered with wipeable fabric. This was in line with Hospital Building Note (HBN) 00-09, 3.133 which states: Soft furnishings (for example, seating) used within all patient areas should be chosen for ease of cleaning and compatibility with detergents and disinfectants. They should be covered in a material that is impermeable, preferably seam-free or heat-sealed.
- Waste in the clinic rooms was separated and placed in different coloured bags to identify the different categories of waste. Housekeeping staff removed clinical waste daily and placed it in bulk storage bins. We saw all waste was kept appropriately in locked, bulk storage bins on the hospital premises until collected. This was in line with the Department of Health (DH) Technical Memorandum (HTM) 07-01, control of substance hazardous to health and Health and Safety at Work regulations.
- We saw sharps bins were available in treatment and clinical areas where sharps may be used. This demonstrated compliance with health and safety sharps regulations 2013, 5(1) d. This required staff to place secure containers and instructions for safe disposal of medical sharps close to the work area. We saw the labels on sharps bins had been fully completed which ensured traceability of each container.
- Some areas of outpatients used endoscopes (an instrument used to examine the interior of a hollow organ or cavity of the body). They were delivered to the department sterile, in a covered, solid walled, leak proof

container in line with health and safety executive standards for endoscope reprocessing units. Used scopes were placed in a container, covered and sent to the sterile services department at the end of the clinic.

- All ultrasound probes were cleaned between each patient use with a triple cleaning system. At each of the three stages of cleaning, a label was stuck in a record book, which demonstrated which wipe staff used. The records we saw showed each time a probe was cleaned with the three stages completed and by which member of staff, which indicated all steps were being completed.
- We saw that consulting rooms 1, 3, the minor operations room, physiotherapy treatment rooms, the gymnasium, all areas of diagnostic imaging and corridors around the outpatient department had seamless, smooth, slip-resistant flooring, which could be easily cleaned. This was in line with Hospital Building Note (HBN) 00-09.
- Consultation rooms 4 and 5 consisted of two rooms each. One of the rooms was carpeted, which was intended for consultations only. The adjoining room had appropriate flooring in line with HBN 00-09, where any examinations or procedures would take place. The carpets were due to be removed as part of the on-going refurbishment program in the department in 2017.
- Consultation room 2 was carpeted, but was the next room to be refurbished in the department and this would include removal of the carpet, which would be replaced with appropriate flooring.
- Carpets in all three rooms were cleaned every morning and we saw checklists to indicate this was occurring. The carpets were deep cleaned with an industrial cleaner every six months and we saw certificates which demonstrated this had been completed in November 2016. The hospital also had its own steam cleaner to clean carpets during quieter periods and for spot cleaning.
- Staff told us rooms would receive a deep clean following the attendance of an infectious patient and if this was known prior to examination, this patient would be scheduled at the end of the list.
- Staff told us following any body-fluid spill, housekeeping staff would attend very quickly to clean the area.

Environment and equipment

- In the outpatient department, the most recent result for the patient led assessment of the care environment (PLACE), completed in April 2016 for environment, condition appearance and maintenance, scored 96.5%.
- Equipment was serviced by a co-located hospital as part of a service level agreement. Individual pieces of equipment had stickers to indicate equipment was serviced within the last 12 months. Staff told us if equipment failed, they could email the electrical engineering team who would collect the equipment for testing or repair.
- We saw electrical testing stickers on equipment, which indicated the equipment was safe to use.
- We saw competency certificates, which indicated staff were competent to use equipment.
- We saw an individual area within the minor operations room was available for patients to have blood tests in. This was in line with Health Building Note (HBN) 12, 4.42, which recommends areas providing blood tests should provide individual cubicles for patients.
- All diagnostic imaging equipment was serviced regularly and we saw service reports, which indicated this was being done. Servicing of equipment following a fault was also recorded and we saw documentary evidence of this.
- We saw records of regular quality assurance tests of diagnostic imaging equipment. In addition to this, a radiation protection committee reported annually on the quality of radiology equipment, which we saw. These mandatory checks were based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000).
- Lead aprons were available in the diagnostic imaging department. They were stored correctly on hangers. We saw evidence which showed checks of the effectiveness of their protection occurred regularly and equipment provided adequate protection as per regulations.
- The ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR (ME) R2000) state medical facilities operating x-ray machines are required to post 'in use' warning signs outside room doors. The diagnostic imaging department had warning signs in place to prevent staff and patients entering when an examination was ongoing.

Outstanding ☆

Outpatients and diagnostic imaging

Medicines

- The hospital had a medicines management policy dated 2016. The purpose of the policy was to make suitable arrangements for the recording, safe-keeping, handling and disposal of drugs.
- No controlled drugs (CDs) were kept or administered in the outpatient department. CDs, are medicines liable for misuse that require special management.
- Consultants administered medicines in the department. Medications were kept in locked cupboards, which were secured to the wall. The keys to the cupboards were kept in a small locked cupboard secured to the wall. Only authorised staff had access to keys.
- Staff stored prescription pads in a locked cupboard and the key to the cupboard was stored in a locked cupboard secured to the wall. Only authorised staff could access the key. Staff recorded each prescription given. We saw the register for recording of prescription pads; this indicated when a prescription had been issued, to whom and what for. This was in line with guidance from NHS Protect, security of prescription forms, 2013. Prescription pads were carbonated, which meant three copies were produced each time. The top copy was given to the patient, one copy was stored in the medical record and the third was kept with the prescription register.
- Some medicines need to be stored within a limited temperature range. They should be stored in a dedicated fridge. Regular temperature checks should occur to ensure the limited temperature range is maintained. We saw a dedicated, locked fridge and documentation which indicated the minimum and maximum temperature was checked and recorded daily.
- The outpatient department had an anaphylaxis kit. Anaphylaxis is a life threatening allergic reaction that requires immediate treatment. The drugs were in a tamper proof box and easily accessible to outpatient staff.

Records

- From June 2015 to July 2016 no patient were seen in the outpatient department without the full medical record being available.
- We saw that the outpatient and diagnostic imaging departments stored records safely and securely in line with the Data Protection Act, 1998.
- The hospital had implemented a single patient record in May 2016 and these records did not leave the hospital.
- The medical records department was in the basement of the hospital. Access was via a restricted key to which only authorised staff had access. The medical records department appeared tidy and well ordered.
- Records could also be stored in the post room, which could only be accessed using a swipe card. A patient's record would be stored in this area three months following an attendance. This was so staff could access these records quickly if patients telephone for advice or had any concerns.
- Records had different coloured covers, which indicated if the patient had surgery, was an outpatient or an NHS patient. This helped staff to locate records quickly, in addition to filing all records in numerical order.
- Records were tracked around the hospital using an electronic tracking system which meant records could be located at any point around the hospital.
- When referrals were received in the booking office, staff checked the computer system to see if the patient had attended before. Staff in the medical records created a new record if required.
- Staff pulled all notes for clinics the day before. They took them to the medical secretaries' office in a trolley and transferred them to boxes. The medical secretaries' office was accessed by swipe card, by authorised personnel only. The secretaries then sorted them into the different clinics and gave the records to the consultant at the start of clinic.
- One hundred percent of outpatient and diagnostic imaging staff had completed information governance training.
- We reviewed five sets of patient records. We saw records were complete, legible and signed. They contained referral letters, results of diagnostic tests and discharge letters.
- The diagnostic imaging department received paper referrals, but were planning to transfer to an electronic system. Details of the referral were checked and were

scanned onto the hospital's patient administration system, this then sent a message to the electronic radiology information system (RIS). Only authorised staff had access to this system.

- All images from scans and X-rays were stored on a Patient Archiving Communication System (PACS). Staff needed a passcode to access this and only authorised staff had access to view images.

Assessing and responding to risk

- Medical cover was provided by the resident medical officer (RMO) who would attend to any unwell patients in the outpatient or diagnostic imaging departments, if required. All RMO's held a current advanced life support (ALS) certificate.
- All staff in the outpatient and diagnostic imaging departments had attended basic life support training.
- We saw risk assessments completed in the outpatient and diagnostic imaging departments. Both areas had raised risks on their own risk registers, which were reviewed regularly by managers at clinical governance committee meetings. We observed good radiation protection compliance as per national policy and guidelines during our visit. The department displayed clear warning notices and doors were shut during examination. There was keypad entry to examination rooms and only authorised staff had access.
- We observed good practice for reducing exposure to radiation in the diagnostic imaging departments. Local rules were available in areas we visited, which were in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000). Staff had signed them to indicate they had read them. Diagnostic imaging staff had a clear understanding of protocols and policies.
- The diagnostic imaging department had a radiation protection supervisor and radiation protection advisor (RPA) who was contactable by phone or email, if required. This was in line with IR (ME) R 2000.
- Diagnostic reference levels are used to help manage the radiation dose to patients so that the dose given was appropriate for the clinical purpose. All staff used diagnostic reference levels and we saw they were in line with national reference dose levels.
- We saw radiation surveys were undertaken every year. The last one was completed in January 2016 and we saw surveys dating back to 2011. This ensures the radiation dose is as low as reasonably possible and is in line with Ionising radiation regulations (IRR), 1999.
- Patients attending the diagnostic imaging department were booked onto the radiology information system. Staff were able to see when the result of the scan was available and if the referrer had read the result. This was monitored daily to ensure referrers had read results. This ensured early identification of failure to act on diagnostic imaging results, which is in line with recommendations of the National Patient Safety Agency and Royal College of Radiologists, 2007.
- Staff were thorough in checking patient identification details on receipt of the referral. They checked the clinical information matched the request, whether the patient had attended the department previously, what examination they had and in what timescale. We saw staff complete this process.
- Diagnostic imaging referrals were signed by the referrer and the diagnostic imaging team had a list of signatures to check the referral was signed by the appropriate clinician. We saw staff checking signatures. This gave assurance that only authorised referrers were requesting examinations.
- We saw pregnancy guidance displayed in the x-ray room. Staff explained they ticked a box on the referral form to indicate they had asked a patient about their pregnancy status and this was then scanned onto the computer system.
- When patients were treated in the hydrotherapy pool, there was always one member of staff in the pool and one on the side. Staff practised the evacuation of patients from the pool annually.

Safeguarding

- Nursing and diagnostic imaging staff demonstrated a good awareness of what to do if they had safeguarding concerns. They could explain what to do if they had concerns and who to contact.
- Staff completed vulnerable adult training and safeguarding children training as part of their mandatory training and 100% of staff had completed these modules in the last 12 months.

Outstanding ☆

Outpatients and diagnostic imaging

- The hospital had not raised any safeguarding concerns in the last 12 months.
- Staff awareness of the need to take action for safeguarding and crime prevention purposes had been highlighted through PREVENT training. Prevent is part of the government counter-terrorism strategy designed to tackle the problem of terrorism at its roots, preventing people from supporting terrorism or becoming involved in terrorism themselves. Staff completed a PREVENT training competency and we saw completed competencies.
- The hospital was working toward the completion of level three safeguarding training for children and young people, in order to prepare to the reintroduction of a service for this group of service users.

Mandatory training

- Staff were required to undertake mandatory training courses which were designed to cover the areas where the provider was subject to regulation from other bodies and was under a duty to ensure that all staff complied. The courses included health and safety, information management, equality and diversity, vulnerable adults and children at risk. Staff told us they were given protected time to complete mandatory courses.
- We saw that 100% of all staff in the outpatient and diagnostic imaging department had completed all their mandatory training courses within the last 12 months.

Nursing staffing

- There were sufficient staff with the qualifications, skills and experience to meet the needs of patients in the outpatient and diagnostic imaging department.
- The outpatient department had one sister, three registered nurses and three health care assistants.
- There was always one registered nurse and two health care assistants, working in the department. We saw rotas over a four-week period, which indicated this occurred.
- The use of bank and agency nurses in outpatient departments was lower than the average of other independent acute hospitals we hold this type of data for in the reporting period from July 2015 to June 2016.

Allied Health professional staffing

- The physiotherapy department employed five therapists who were contracted for part time hours. Staff told us there was sufficient staff to provide the service.
- There were two permanent radiographers and one bank member of who worked in the department regularly. No agency staff had been used in the diagnostic imaging department for five years.

Medical staffing

- There were 10 radiologists working at the hospital under practising privileges.
- One radiologist was available in the department each day to ensure someone was always available for urgent reporting and to deal with any queries.
- An on-call radiologist was provided out of hours by a co-located NHS hospital under a service level agreement. Their duties included any reporting of urgent imaging investigations.

Emergency awareness and training

- We saw the hospital's business plan dated 2015. This was to ensure all staff understood their response and action to be taken in the event of an incident. The policy provided contingency plans to ensure the comfort and safety of patients, staff, contractors and visitors under disruptive circumstances. These could be caused by total or partial shutdown of the hospital due to one or more major failures of equipment, systems and/or services, fire damage or due to external circumstances beyond the control of the hospital such as a bomb threat. Staff we spoke with were aware of the business continuity plan which could be accessed on the hospital's internal computer system. A copy was also kept behind the reception desk in the outpatient department.

Are outpatients and diagnostic imaging services effective?

Good

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

Evidence-based care and treatment

- Policies were developed in line with national guidance and best practice evidenced from professional bodies, such as the Royal College of Nursing, National Institute for Health and Care Excellence (NICE), College of Radiographers and the Royal College of Radiologists (RCR). All the guidelines we reviewed were easily accessible on the hospital intranet and were up to date.
- The department undertook clinical and non-clinical audits. These included infection prevention and control, environmental, procedure checklists, documentation audits and radiology equipment. Findings were reported to the departments and through to the management board meetings. Trends were identified and action plans created to improve the service to patients, which was communicated back to the clinical departments for their action.
- The diagnostic imaging department had policies and procedures in place. They were in line with regulations under IR (ME) R 2000 and in accordance with the Royal College of Radiologist's standards.
- The Radiation Protection Advisor (RPA) and the radiation protection supervisor provided annual reports. They were discussed at the radiation protection meeting and we saw minutes of these meetings, which indicated this was occurring. This was in line with regulations under ionising radiation (medical exposure) regulations (IR (ME) R 2000.
- We saw patient dose, audit reports, the most recent one was in December 2016 and we saw others dating back to 2012. This was in line with IR (ME) R, 2000.
- The imaging department followed iRefer, the Royal College of Radiologists radiological investigations guideline tool accredited by NICE and this was also used by anyone who referred patients to the service.

Pain relief

- In the outpatient and diagnostic imaging department doctors could prescribe pain relieving medicines if required.
- In the diagnostic imaging department, there was a variety of pads and supports available to enable patients, having examinations, to be in a pain-free position.
- The physiotherapy department provided acupuncture for pain relief, which they offered to appropriate patients.

Patient outcomes

- We saw the hospital audited patient outcomes by participating in national and local audit programmes. The hospital was committed to partaking in the patient led assessment of the care environment (PLACE).
- The physiotherapy department completed patient reported outcome measures for each patient. This involved patients completing a score for a range of markers such as pain and functional level. Patients completed the score before they started a course of treatment and on completion of their treatment. This gave a measure of improvement. If staff identified no improvement, they were able to alter the treatment plan to improve the outcome. This was in line with best practise and professional standards. Staff had identified the treatment pathways were different for each patient, but they were scoring the outcome for all patients. They decided to start recording the outcome scores for different conditions and different treatments.

Competent staff

- All new nursing staff and HCAs had completed an induction programme. Part of their induction included staff spending time with members of staff in all areas of the hospital. This enabled them to have a good understanding of how each department worked together. We saw induction packs were comprehensive and contained reflective documents for staff to complete on completion of their induction.
- We saw competency certificates for staff including the administration of eye drops, aseptic technique and blood taking. A senior member of staff signed them off and indicated staff were competent to perform these tasks.
- We saw staff had the relevant qualifications and memberships to professional societies, appropriate to their position.
- Nursing, physiotherapy and radiography staff told us they had access to local and national training. This

contributed to maintaining their registration with the Nursing and Midwifery Council (NMC) and Health Care Professions Council. We saw training certificates which confirmed this.

- In addition to mandatory training, staff had access to optional training. Staff told us they felt additional training enhanced their roles and they were keen to develop their skills. Staff accessed and completed this training and we saw a training matrix, which confirmed this.
- The appraisal system was based on Spire Healthcare's vision and values. All the staff we spoke with had received an annual appraisal. We saw their records which showed during the annual review individual responsibilities and objectives were outlined. Staff told us this process was effective in developing their skills and knowledge further. It also contributed to maintaining registration with their regulatory bodies.
- From January 2016 to December 2016, 100% of outpatient staff had an appraisal.

Multidisciplinary working

- Staff told us they worked well as a team in their departments and all other areas of the hospital. We saw a strong multidisciplinary approach across all the areas we visited. We observed good collaborative working and communication amongst all staff in the outpatient departments and with other staff around the hospital.
- The physiotherapists told us they had a good working relationship with consultants. They would access further support and information by means of email or visiting members of staff in clinic or on the ward, when required.

Access to information

- The implementation of one patient record meant all information about the patient's investigations, procedures, treatment and consultation was available in one location.
- Clinical staff were able to access results of diagnostic tests via a picture archiving and communication system (PACS). In addition to this, staff could access the co-located NHS hospital's PACS. Pathology test results could also be accessed electronically.
- PACS was available on wards and in theatre and in outpatients, so images could be viewed prior to and during a patient's care and treatment..
- Staff requested patient records from other hospitals using an image exchange portal. This provided a secure transfer of information between providers. This included the discussion held at multidisciplinary meetings at the neighbouring hospital. This also prevented unnecessary exposures being made.
- Staff accessed the hospital's policies and meeting minutes on a shared computer drive. Staff had individual logons and passwords. We saw staff locking computers prior to walking away from their desks.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Spire Healthcare had a policy for consent to examination or treatment, dated January 2016. The policy demonstrated the process for consent, documentation, responsibilities for the consent process and use of information leaflets to describe the risks and benefits.
- We saw signed consent forms in five medical records which showed patients had consented to treatment in line with the hospital's policy. We saw the forms outlined the expected benefits and risks of treatment so patients could make an informed decision.
- Spire Healthcare had a policy for Deprivation of Liberty Safeguards (DoLS), dated April 2016. The policy set out procedures staff should follow if a person lacked capacity. Staff had access to flowcharts to prompt them of the process.
- Mental Capacity Act was part of the role specific training programme staff completed. Data provided by the hospital showed that 100% of staff had completed the training.
- We spoke with a range of clinical staff who could all clearly describe their responsibilities in ensuring patients consented when they had capacity to do so or that decisions were to be taken in their best interests.
- Doctors gave patients two appointments prior to gaining consent for cosmetic procedures. These appointments were at least four weeks apart to give patients time and information they needed to reach a

voluntary and informed decision about whether to go ahead with the procedure. This was in line with the Royal College of Surgeons Professional Standards for Cosmetic Surgery, 2016.

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

We rated caring as outstanding.

Compassionate care

- See information under this sub-heading in the surgery section. In this section we cover the results of hospital wide patient surveys.
- We reviewed 27 patient feedback cards all of which contained positive comments. The comments included 'I was treated with the utmost respect and care and I was most definitely listened to'. 'All staff have been excellent, I have felt confident and relaxed throughout and I feel as though I have my life back'. I felt at all times that any concerns or questions would be dealt with quickly and willingly, facilities are first class and the whole experience has been reassuring' and 'I have always found staff to be courteous, respectful and caring, really excellent'.
- 'Caring is our Passion' was a core Spire Healthcare value and staff displayed behaviours which demonstrated this was the case. Without exception, staff told us patients were at the heart of everything they did. One staff member told us a patient had difficulty accessing transport services in order to attend their appointment. The staff member spent a considerable amount of time liaising with the transport services and arranged for the patient to have transport to their appointment.
- We spoke with four patients during our visit. Patients told us "I can't fault the service", "they are so kind and always smiling" and "I have received first class care". Results of patient satisfaction surveys were unfailingly positive. Patients told us the care they received exceeded their expectations. There was a strong, visible person-centred culture.
- We saw staff treating patients in a kind and considerate manner. Patients and their relatives told us staff treated them with dignity and respect without fail. We saw staff introduce themselves to patients and explain their role. It was visible that staff were motivated to offer care which was kind and promoted people's dignity.
- We saw all treatment and consultation rooms had a sign on the door, to indicate when the room was in use. We saw staff knock and wait when the sign indicated the room was in use.
- The physiotherapy department had individual walled cubicles, each had a door with frosted glass and 'in use' signage. Consultations could be conducted in private.
- Spire Healthcare had chaperone guidelines, dated July 2016. We saw signs in the patient waiting areas informing patients they could have a chaperone, if required. Staff would record if a chaperone had attended a consultation, by stamping the medical record. We saw this was occurring. Staff told us there were always enough staff on duty to be able to act as chaperone.
- We saw there was an individual changing cubicle attached to the diagnostic imaging department, which ensured patients privacy and dignity was maintained.

Understanding and involvement of patients and those close to them

- We saw appointment letters, which contained clear information about appointments and what to expect. Booking administrators sent information about how to get to the hospital and specialist information depending on which clinic they were attending. They also sent out information about which telephone number to use, should they have a query, so patients did not have to go through the central switchboard each time they called.
- All patients we spoke with told us they received clear and detailed explanations about their care and any procedures they may need. Patients consistently told us they felt valued as individuals.
- Staff supported patients and their relatives prior to and during their appointment if this was required. They accessed specialist support if needed and care was tailored to each individual, dependent on their preferences.

Emotional support

Outstanding ☆

Outpatients and diagnostic imaging

- Nurses gave us examples of when they would attend clinic appointments with patients to provide emotional support if required. Staff told us they were able to provide patients and their families extra time if necessary and could take them to a separate area of the department, if required. They had sufficient staff to provide extra support to patients, without affecting the delivery of the service.
- Pre admission staff told us that when it was identified a patient required extra support this was arranged where possible before admission and discussed with the multidisciplinary team.
- Staff showed us how they could access counselling services and other psychological support for a patient if it was needed. Information was readily available for patients to access emotional support from other sources.
- We saw all groups of staff interacting with patients in a way that supported them emotionally in their care and treatment.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

We rated responsive as outstanding.

Service planning and delivery to meet the needs of local people

- Spire Sussex Hospital worked collaboratively with local commissioners of service to enable NHS patients to access care and treatment without delay, and to allow people to have a choice where they received their care. By offering services to NHS patients, Spire Sussex Hospital helped local NHS providers to manage their out-patient and imaging waiting lists more effectively.
- Waiting areas were clean and comfortable with adequate seating, hot and cold drinks available. Toilets and reading material were available in the reception area. General information leaflets relating to services provided, including complaints, were also available in the waiting areas.
- Free car parking was available on-site. The hospital recognised space was limited. To ensure as many spaces as possible were available, they purchased car parking passes for staff to park elsewhere. Managers monitored the car park to make sure staff did not use it.
- The main waiting area was within the reception area of the hospital. All patients waited in one waiting area, where they were collected by staff and taken to the appropriate area. There was clear signage throughout the hospital to guide patients to the relevant outpatient, radiology, and physiotherapy departments.
- The outpatient department provided a five-day clinic service, which included evening clinics up to 7:30pm. Saturday morning clinics could be run if required. Patients told us they were offered a choice of dates and times for their appointment.
- The diagnostic imaging department was open from 9am to 5pm on Monday, Tuesday, Thursday and Friday. On Wednesday, the department opened at 8am. Staff told us they would keep the department open later if evening clinics were booked in outpatients. They could also support the clinics on Saturday morning, if needed. Radiographers provided a 24-hour, seven-day a week service for urgent examinations. A radiologist at the co-located NHS hospital provided 24-hour, seven-day service via a service level agreement (SLA). Diagnostic imaging administrative staff were available from 7:30am to 5:30pm, four days a week. This meant local people could access imaging at a time that was convenient to them.
- The diagnostic imaging department was having an MRI scanner installed in the hospital at the time of inspection, which would be in service in January. This was to provide this additional service to the local population and could provide some additional appointments to the co-located NHS hospital to help manage waiting times. MRI was due to operate between 9am and 5pm from Monday to Friday.
- The physiotherapy department provided appointments from 8:30am to 5pm three days a week and appointments were available until 7pm, two days a week. The department was able to provide a hydrotherapy service and group exercises classes, using

the facilities at a co-located NHS hospital through an SLA. The department provided specialist physiotherapy services such as acupuncture, women's health physiotherapy and vestibular rehabilitation.

- The hospital had a variety of SLAs with a co-located NHS hospital to ensure their patients had timely access to services such as MRI, CT, pharmacy and pathology.

Access and flow

- The diagnostic imaging department consisted one X-ray and one ultrasound room. Services offered included X-ray (an effective way at looking at the bones); ultrasound (uses high-frequency sound waves to create an image of part of the inside of the body). Other diagnostic testing, for example computerised tomography (CT) and magnetic resonance imaging (MRI), are outsourced services and are not currently provided on site. CT provides detailed images of the inside of the body and MRI uses magnetic field and radio waves to create detailed images within the body. The hospital was in the process of installing an MRI scanner at the time of inspection.
- The physiotherapy department was in a dedicated location with three treatment rooms and a gymnasium. The department also had access to a hydrotherapy pool and a larger gymnasium in order to provide classes for greater numbers of patients.
- A legal requirement by NHS England gives patients the right to access services within a maximum waiting time. This applies to NHS funded patients only.
- Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month. On average 99% of patients were on incomplete pathways from June 2015 to July 2016.
- Non-admitted pathways are waiting times (time waited) for patients whose treatment started during the month and did not involve admission to hospital. On average 98% of patients started non-admitted treatment within 18 weeks of referral from June 2015 to July 2016.
- No NHS patients waited six weeks or longer from referral for MRI, CT or non-obstetric ultrasound from June 2015 to July 2016.
- At the time of inspection the waiting time for MRI was 1 to 2 weeks, the waiting time for CT was 1-2 weeks as was the wait for general x-ray or ultrasound.
- Reports for investigations were available within three days and inpatient reports were done the same day as the scan.
- The waiting times for patients on arrival to the hospital until their admission to the consultation room was audited by the hospital. The most recent audit in August 2016 indicated, on average patients waited nine minutes to see a doctor.
- GP's could refer patients electronically via a secure login from the hospitals website.
- Patients could also be referred by post and fax. All referrals were received into a central office. Patient details were entered into the patient administration system and checked to see if the patient had attended before. Consultants reviewed all referrals prior to being booked an appointment. Appointments were often available at short notice. Booking administrators would call patients if an appointment was at short notice.
- The hospital monitored the time it took for clinic letters to be typed following a consultation. From January 2016 to December 2016, on average, clinic letters were complete 24 hours following clinic, this was better than the target time of 48 hours.

Meeting people's individual needs

- See information under this sub-heading in the surgery section. In this section we cover access for disabled people.
- Staff could tell us how they would access translation services for people who needed them. This included British sign language and 50 languages. Face to face or telephone interpretation was available. However; we were told this were rarely needed.
- We did not see any leaflets in any other languages apart from English in the outpatient department. However, staff told us these were rarely needed and they could access leaflets in other languages if required, from a central database. The Physiotherapy department could

provide exercise leaflets in a variety of languages. All exercise leaflets included a pictorial description, which was suitable for patients who had difficulty with the written word.

- We saw a variety of health-education literature and leaflets produced by national bodies was available. Some of this information was general in nature while some was specific to certain conditions. This literature was available in all waiting areas of the outpatient departments.
- A dementia care lead had been nominated in outpatients. They had attended training and became a dementia champion. The dementia care lead shared their learning with their colleagues in outpatients. They had sourced information about patients living with dementia and displayed it in clinical areas, which we saw. This included ways of communicating with patients living with dementia. The dementia care lead was involved in planning for a patient living with dementia attending the hospital to ensure all the correct resources were in place. The dementia care lead attended when a patient living with dementia came into the hospital and helped support other members of staff who contributed to the patient's care.
- There was no flagging system for patients with learning disabilities. However, staff told us, due to the small nature of the service, if a patient was attending with learning disabilities, staff would be aware. They would liaise with the attending carer so they could individualise care.
- The hospital had previously offered services to children in the outpatients and diagnostic imaging departments and saw 379 children from April 2015 to March 2016. The hospital had stopped offering services to children in September 2016 and was in consultation with regard to starting again in 2017. We spoke with the hospital director who outlined what the hospital needed to do to provide children's services that met current guidance, for example safeguarding training at appropriate levels.

Learning from complaints and concerns

- See information under this sub-heading in the surgery section. In this section we cover the hospital complaints processes and how complaints were managed.
- We found positive action was taken in response to complaints and feedback. The hospital director (HD) and matron reviewed all complaints received by the hospital.
- Once investigated, a response was sent to the patient and where appropriate, the patient and their relative invited to a meeting to discuss the findings of the investigation. We saw evidence of 100% compliance with corporate targets for acknowledgement and final letters.
- The complaints process was managed on the electronic incident reporting system. Using the system we were able to follow the process taken for two complaints. We saw that the complaints had been risk assessed, holding letters were sent out and there was evidence of an appropriate level of investigation being carried out.
- However the final responses to the complainants did not include information on how to escalate concerns to corporate or independent review. It was seen that there were corporate information leaflets containing this information that were available and could be included within the response letters. At the unannounced part of the inspection we saw that this had been corrected.
- Leaflets called 'please talk to us' were available in the department and contained information for the patient or visitors on how to make a complaint. The information was clear and easy to understand.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

We rated well-led as outstanding.

Vision and strategy for this this core service

- See information under this sub-heading in the surgery section. In this section we cover the hospital's vison and values.
- There was no specific strategy for outpatients and diagnostic imaging. The departments based their

service on the local population needs. For example, they outsourced their MRI service to a local trust but when capacity was becoming an issue, the hospital undertook a major investment plan to install an MRI scanner.

- The outpatient nursing staff supported and promoted the 6C's of nursing, which are care, compassion, courage, communication, commitment and competence, which was drawn up by NHS England Chief Nursing Officer and launched in December 2012. This was evident in the daily work of the team. Every member of staff we saw interacting with patients did so with care and compassion. Staff demonstrated courage, by speaking up when they saw practise by a member of staff they did not feel was appropriate. They demonstrated competence by maintaining their professional registration and making the most of additional learning opportunities. For example, staff attended additional training for managing patients living with dementia and palliative care patients. Communication was effective throughout the hospital, in person, via email and newsletter. By visiting all other areas of the hospital during the induction period, any potential barriers to communication were removed at the start of a staff member's employment. Staff demonstrated commitment to the hospital by being in post since the hospital had opened. We spoke with a number of staff who had worked continuously at the hospital since either it had opened or who had left and returned to continue their career there.

Governance, risk management and quality measurement

- See information under this sub-heading in the surgery section. In this section we cover the hospital's systems for assuring the quality and safety of care.
- In this core service, staff were clear about their roles, how they fitted within the hospital structure, and who held the relevant lines of reporting responsibility.
- The physiotherapy department recorded patient reported outcome measures. They identified variability in the recorded difference following physiotherapy intervention. The team decided to divide the results into musculoskeletal patients and post-surgery patients, as they felt the treatment of these patients was different which could result in different outcomes.
- Both departments in this core service had their own risk registers. Risk registers were discussed at the senior leadership team meetings, the hospitals governance committee meetings and we saw minutes of these meetings, which indicated this was occurring. We saw the registers had items listed with their identified initial and current risk level. The list showed the likelihood, current consequences of the risk and review date due.

Leadership and culture of service

- Nursing staff reported to the outpatient department sister, who reported to matron. The diagnostic imaging staff reported to the theatre/radiology manager. Housekeeping staff reported to the hotel services manager. The hotel services manager and physiotherapy staff reported to the operations/ physiotherapy manager. The operations manager and matron reported to the hospital director.
- There were clear lines of leadership and accountability. Staff had a good understanding of their responsibilities in all areas of the outpatient and diagnostic imaging services. Staff told us they could approach immediate managers and senior managers with any concerns or queries.
- A number of staff within the department had long-standing service within the hospital. Staff members told us they felt respected and welcomed, liked coming to work and that there was an open and honest culture in the hospital.
- There was no sickness for outpatient nurses or healthcare assistants from June 2015 to July 2016. In the diagnostic imaging department, there was no staff sickness absence or staff turnover in the last year. This was lower than the average of other independent hospitals CQC hold data for and suggests good morale and staff wellbeing.
- Staff overwhelmingly spoke with pride about the hospital and their colleagues. They told us the hospital had a 'family feel', they 'enjoyed coming to work'. Several staff had been working at the hospital since its opening. Some staff had moved onto other jobs and returned to work at the hospital. They said it felt like they were 'coming home'.

Public and staff engagement

Outstanding ☆

Outpatients and diagnostic imaging

- See information under this sub-heading in the surgery section. In this section we cover the hospital's arrangements for engaging with the local population, and with their staff.
- Staff in this service told us they were made aware of the hospitals vision and values at induction and this was reinforced through the 'Enabling Excellence' appraisal programme. Staff were encouraged to demonstrate the values throughout their behaviours.
- Staff told us ideas were raised and listened to at staff meetings.
- The installation of an MRI required a major configuration of two departments at the hospital. Staff told us they were involved in the planning and redesign through the whole process. Their views on the design were sought and taken in to consideration, for example in the choosing of equipment.
- In the diagnostic imaging department, patient survey comments were put up for staff to view.
- An awards scheme was available to recognise staff who went the extra mile or had an initiative for the hospital. The hospital awarded 17 individual and two team awards in the last year.

Innovation, improvement and sustainability

- The diagnostic imaging department was having an MRI scanner installed in the hospital at the time of inspection, which would be in service in January. This was to provide this additional service to the local population and could provide some additional appointments to the local hospital. The MRI was due to operate between 9am and 5pm from Monday to Friday. On our unannounced inspection this scanner was in service.
- The hospital had trained staff to provide leadership in care for patients living with dementia. Although the hospital had no admitted or treated many patients living with dementia, they had identified they were likely to encounter more in the future and were preparing for this eventuality.

Outstanding practice and areas for improvement

Outstanding practice

- Staff engagement was seen as a priority by the senior management team. There was a consistent focus on strengthening this through consistent communication and imaginative initiatives such as 'walk in my shoes' which united the team in their experiences and drove them to be the best at what they do.
- Staff were well supported to do their jobs to the best of their ability. There was 100% compliance rates with mandatory training and appraisals.
- The staff had a continued focus on delivering a service that was not just fit for purpose, but was outstanding in meeting the needs individuals, particularly those with complex needs, for example those living with dementia. Expertise developed by the staff was being shared outside the hospital with other Spire Healthcare hospitals.
- This hospital team was outstanding in complaints management. Response to complaints always met agreed deadlines in all stages of the process. Learning from feedback and making practice changes as a result of this was evident.
- Public engagement was taken seriously by this hospital team with the aim of understanding 'what good looks like' and to improving the patient journey and experience. Initiatives such as the patient forum and the appointment of a patient champion who completed the fifteen step challenge resulting in an action plan positively influenced the patient journey.

Areas for improvement

Action the provider SHOULD take to improve

- The hospital should consider how it incorporates tests of effectiveness into action plans devised in response to learning from safety incidents and complaints.