Spire Leicester Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Leicester Hospital is run by Spire Healthcare Limited. The hospital is located in Oadby which is a residential area south of Leicester.

Healthcare is provided by the hospital to patients with private medical insurance, those who self-pay and through NHS contracts.

The service is registered to provide inpatient care to 54 patients at any time. Hospital facilities include a 30-bed inpatient ward, 14 bed day ward, five chemotherapy pods and five chemotherapy beds. Theatre provision includes: three theatres with laminar flow, a cardiac catheter laboratory and a minor procedures suite. From April 2014 to March 2015 there were 6,518 visits to theatre.

This was the first comprehensive inspection of Spire Leicester Hospital. We carried out an announced inspection of Spire Leicester Hospital between the 11 and 12 August 2015. Following this inspection an unannounced inspection took place on the 17 August 2015 between 12 and 3pm. The purpose of the unannounced inspection was to look at how the hospital operated at peak times and to follow-up on some additional information from the announced inspection.

The inspection team inspected the following core services:

- Surgery
- Medicine
- Outpatients and Diagnostic Imaging
- Children and Young People
- Termination of Pregnancy.

The hospital provided a health screening service which was not inspected as part of our inspection.

We rated Spire Leicester Hospital as 'Good' overall but the outpatients and diagnostic imaging service required improvement.

Our key findings were as follows:

Are services safe at this hospital

- There were information gaps in some children's and young people's records. We reviewed 16 sets of records; four records did not have completed fluid charts and five records had no risk assessment.
- We found gaps in some of the patient records we reviewed. We were told that some consultants used their own notes rather than Spire medical records in which to record the patient's outpatient consultation and not all those notes were retained within the Spire medical record.
- Medical notes were not always easy to read although the provider informed us notes were sometimes typed and staff could contact medical staff for an explanation if necessary.
- The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks and General Medical Council registration expiry dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. A senior manager informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for 34 consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Summary of findings

- Patients were protected from abuse and avoidable harm. Patients felt safe and staff had the skills, knowledge and tools to identify risks and knew how to escalate these if needed. Processes were in place to mitigate risks.
- Incidents were investigated, actions taken and learning disseminated throughout the hospital.
- All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly. Medicines were stored and administered safely.
- Staffing was managed effectively to ensure patients received good care with access to medical care obtained in a timely manner. Staff were well trained and records were kept securely.

Are services effective at this hospital

- The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on whole practice appraisals and biennial review dates.
- The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for 34 consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.
- No audits or monitoring of children's and young people's outcomes had taken place since this service had been set up in 2013. There was no audit system for ensuring that medical notes were fully completed within the children's and young people's service.
- Patient's pain was well managed.
- Staff helped patients if they needed support to eat and drink and they had access to drinks.
- Evidence based care and treatment was delivered to adult patients, which followed national guidance.

Are services caring at this hospital

- Patients we spoke with confirmed that staff were kind, considerate and treated them with dignity and respect.
- We observed staff being attentive and caring to patients during the inspection.
- Patient experience was reported on through local patient surveys and the NHS Friends and Family Test (FFT). The FFT score for June 2015 was 99%.

Are services responsive at this hospital

- Delays, cancellations and attendance rates had not always been monitored in an effective way. Data was collected but not audited or actioned further to prevent or reduce these events in future.
- Waiting times in the outpatient department were not always monitored effectively.
- Signage in all areas was small and only in English which could have proved a challenge for those with poor sight or whose first language was not English.
- Planned admissions and multidisciplinary meetings took place to ensure effective admission, treatment and discharge planning. Processes were in place for transfers to other hospital if a patient required a higher level of care.
- The hospital had a complaints policy and procedure in place and patients were given information about how to raise any concerns or make a complaint.

Are services well led at this hospital

- The leadership, governance and culture at the hospital promoted the delivery of high quality person-centred care. Members of the management team were well respected amongst both staff and patients.
- Staff felt valued and were positive about their roles.
- There was a shared vision throughout the hospital and safe patient care was paramount.

Summary of findings

- Patient feedback was a valued tool and the hospital strived to improve following any negative comments from patients or relatives.

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

Importantly, the provider must:

- Ensure that an accurate, complete and contemporaneous record is securely maintained in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. There was no audit system for ensuring that medical notes were fully completed within the children's and young people's service.
- Ensure arrangements are put in place to monitor outpatient appointment cancellations and delays.

In addition the provider should:

- Ensure paediatric and adult drug boxes for resuscitation are not of a similar colour to aid quick identification in an emergency.
- Ensure appropriate interpreting services following best practice are always available for those whose first language is not English.
- Ensure auditing samples for compliance with the five steps to safer surgery checklists are more representative of the number of patients undergoing surgical procedures.
- Ensure that there is an effective system in place for contacting a radiologist urgently.
- Ensure that the minor operations room has a plan in place for ensuring patient safety and that treatment can be provided rapidly without delay.
- Ensure that the privacy and dignity of patients using the imaging department is maintained.
- Ensure that all staff working with oncology patients in the chemotherapy unit are aware of the gold standards framework.
- Ensure practice is reviewed around the use of the malnutrition universal screening tool.
- Ensure a protocol for children with learning difficulties is developed.
- Ensure that staffing and workforce development plans are developed in parallel with the paediatric strategy.
- Ensure the areas where children are cared for are appropriate for the needs of the child.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	The hospital had systems in place to protect patients and keep them from avoidable harm. Patients felt safe and staff had the skills, knowledge and tools to identify risks and knew how to escalate these if needed. Staff showed a good awareness of incident management showing that the system was embedded. The use of professional guidance had ensured that patients' safety was maintained. The local audit programme and the changes identified from specific audits were acted upon in a timely manner. We saw that 100% compliance had been achieved against some audits, for example, the sepsis audit and consent. Staffing was managed effectively; staff were well trained, had received regular appraisals and professional qualifications were validated. The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates, whole practice appraisals and biennial review dates.The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Summary of findings

Patients received effective care and treatment that met their needs. Medical care was delivered by consultants who worked at local NHS hospitals. Patients were supported, treated with dignity and respect and involved as partners in their care. Patients told us they felt cared for.
Patients with specific individual needs such as dementia were met. We saw effective systems in place to capture and act upon patient feedback. Admissions were planned and multidisciplinary meetings had taken place to ensure effective admission, treatment and discharge planning. Processes were in place for transfers to other hospital if a patient required a higher level of care. The leadership, governance and culture at the hospital promoted the delivery of high quality person-centred care. Members of the management team were well respected amongst both staff and patients. Staff felt supported, spoke positively about the organisation and staff morale was high.

Surgery

Good

The hospital had systems in place to keep patients safe. Processes were in place to report incidents and staff demonstrated a good awareness of the process for identifying and reporting any safety incidents showing the system was embedded. Investigations were robust and staff learned from actions taken. However, because of the small monthly sample size (less than 2%) for the auditing of the five steps to safer surgery checklists we could not be assured of overall compliance with safe practices in theatre.
All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly. Medicines were stored and administered safely. Staffing was managed effectively to ensure patients received good care with access to medical care obtained in a timely manner. Staff were well trained and records were kept securely.
Evidence based care and treatment was delivered to patients following national guidance by competent staff. The hospital provided a seven-day week service with patients having good access to information.

Summary of findings

All the patients and relatives we spoke with were overwhelmingly positive about the care they had received and the way staff treated them. Patients told us they were involved in their care and staff explained care and treatment in a way they understood.

Access to care and treatment was monitored and exceeded the national average. Staff acknowledged patients' individual needs and responded to them in an appropriate way although we were not assured a suitable translator was always available for patients whose first language was not English.

Staff had a good understanding of the complaints process and the hospital learned from complaints, changing care practices if required.

Shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates, whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

The hospital had a governance system in place which included an audit system. Morale was excellent with staff talking positively about the organisation and their local management team. Staff felt listened to and supported in their role.

Summary of findings

Services for children and young people

Good

The children's service had a good track record on safety. The hospital safeguarded children and young people through offering care tailored to their needs. If a child was admitted overnight, a paediatric consultant and a children's nurse stayed on site to look after them. Staff working with children were qualified to 'National Society of Prevention of Cruelty to Children' safeguarding level three, in line with good practice. The children's nurses had specialist training in paediatric life support and the lead nurse promoted skills in nursing children.

The hospital routinely conducted a range of risk assessments and there were procedures to treat children whose health was deteriorating after an operation. However, some of these risk assessments were not signed or fully completed. The hospital lacked specific waiting areas and consulting rooms for children, but staff minimised the risk of mixing with adults.

The children's services were relatively new and did not have a quality dashboard to monitor their performance over time. They had not developed systems to carry out benchmarking or clinical audits, which limited organisational learning.

Parents said their children received compassionate care. They said the hospital gave them good information and involved them in decisions about their child's treatment and care. Child friendly information was available for children about their procedures, nurses and consultants encouraged them to ask questions about their care. Nursing staff offered children and parents emotional support when needed. The hospital planned care for children taking into account emotional, spiritual, social, mental and physical needs.

Children's and young people's services were responsive and provided access at times to suit children, young people and their parents.

Nurses encouraged children to keep in touch with friends and family and the hospital provided beds in children's rooms and a meal if a parent wanted to say overnight. The service was sensitive to children who had been inpatients and introduced them to the environment through a visit and a

pre-assessment appointment, so that everything would be familiar. Nurses and consultants ensured that children who had behavioural challenges also felt at home and were cared for well.
The service had a vision for expansion in the future.
There was a positive culture and staff showed clear motivation to do their best for children and young people. There was a good risk management structure and children's nurses worked well with consultants to develop policies and plan services.

Outpatients and diagnostic imaging

Requires improvement

Emergency equipment was not immediately available within the department. Staff in outpatients department had limited knowledge in regards to decontamination following patients with suspected communicable diseases.
The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates, whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.
Safety concerns were identified and addressed in a timely manner. All staff were aware of responsibilities in relation to reporting incidents and the duty of candour.

Summary of findings

There were effective systems in place to protect people from avoidable harm and lessons were learnt from any incidents within the department.
We found that equipment was appropriately serviced and calibrated.
Staff received training in mandatory and role specific areas. Patient risk was assessed and responded to appropriately.
We saw that staff were caring towards patients and respected their privacy and dignity. Patients understood options available to them and were able to choose appointments to suit their needs.
Information was available for patients throughout the department and staff had the appropriate skills and knowledge to seek consent from patients throughout their care.
Waiting times and attendances were not always monitored and collated effectively; this was not recognised as an issue within the hospital.
Patient outcomes were not looked alongside cancelled clinics to ensure there was not a negative effect. People could access the right care at the right time and patient needs were taken into account.
Signage was not always clear to patients visiting the outpatient and imaging department.
Consideration was not always given to those with cultural needs and staff said they would benefit from further training in this area.
Complaints were investigated and where necessary clinical and administrative practice had changed to prevent recurrence.
Radiation regulations were followed and staff received the necessary training and competency assessment to ensure patient safety.
Staff felt valued and were positive about their roles. There was a shared vision throughout the hospital and safe patient care was paramount.
Innovation and improvement was encouraged in outpatient and imaging areas, with evidence to support this. Feedback was a valued tool and the department strived to improve following any negative comments from patients or relatives.

Termination of pregnancy	**Good**		The termination of pregnancy service at Spire Leicester Hospital offered safe care to the patients.

Summary of findings

There were sufficient numbers of suitably trained staff available to care for patients.
The environment and equipment was visibly clean and infection control procedures were followed.
Staff were aware of safeguarding procedures and had received training in safeguarding adults, the Mental Capacity Act (2005) and Deprivation of Liberties (DOLs.)
Medicines management was safe and there was a clear audit trail for the request and receipt of the medication.
There were appropriate procedures to provide effective care. Care was provided in line with national best practice guidance.
Arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. Patients had access to Spire Leicester Hospital out of hour's aftercare 24 hours a day, seven days a week.
Patients were cared for by a multidisciplinary team working in a coordinated way. Patients received compassionate care that respected their privacy and dignity. All the patients considering termination of pregnancy had access to pre-termination counselling.
Patient's wishes were respected and their beliefs and faith were taken into consideration regarding the sensitive disposal arrangements for pregnancy remains.
The hospital was responsive to patient needs.
Professional interpretation service was available to enable staff to communicate with patients for whom English was not their first language.
The service was compliant with the guidance from the Royal College of Obstetrics and Gynaecology (RCOG) Guidance in Relation to Requirements of the Abortion Act and the Department of Health guidelines Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy Required Standard Operating Procedures (RSOP). The hospital monitored its performance against the RSOPs.
There were effective governance arrangements in place and staff felt supported by the senior management team.

Summary of findings

The culture in the hospital was caring and supportive. Staff said that the leadership and visibility of the hospital director, matron and senior managers was good.
Staff spoke positively about the high quality care and services they provided for patients and were proud to work for Spire Leicester Hospital.

Summary of findings

Contents

Good

Spire Leicester Hospital

Services we looked at

Medical care (including older people's care); Surgery; Services for children and young people; Outpatients & diagnostic imaging; Termination of pregnancy;

Summary of this inspection

Background to Spire Leicester Hospital

Spire Leicester Hospital is run by Spire Healthcare Limited and is located in Oadby a residential area south of Leicester. Healthcare is provided by the hospital privately and through an NHS contract. The registered manager registered with the CQC on the 1 October 2010.

The service is registered to provide inpatient care to 54 patients at any time. Hospital facilities include a 30-bed inpatient ward, 14 bed day ward, five chemotherapy pods and seven chemotherapy beds. Inpatient and outpatient services include: children's services, orthopaedics, cosmetic and plastic surgery, weight loss surgery, oncology and chemotherapy. Outpatient services operate from 8.30am to 9pm Monday to Friday Saturday mornings. Diagnostics include MRI, CT scans, ultrasound scans, fluoroscopy, mammograms and X-rays.

In addition, a private GP service and a number of rapid access and one-stop clinics such as the One Stop Cardiac Clinic and a Bupa-accredited Breast Cancer Service, for the rapid diagnosis, onward referral and treatment of breast disease are offered.

Spire Leicester Hospital was selected for a comprehensive inspection as part of the programme of comprehensive independent healthcare inspections. The inspection was conducted using the new methodology.

We carried out an announced inspection of Spire Leicester Hospital between the 11 and 12 August 2015. Following this inspection an unannounced inspection took place on the 17 August 2015 between 12 and 3pm. The purpose of the unannounced inspection was to look at how the hospital operated at peak times and to follow-up on some additional information from the announced inspection. The areas inspected included, surgery, medicine, outpatients and diagnostic imaging, children and young people and termination of pregnancy.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspection: Carolyn Jenkinson

Inspection Lead: Sue Stanton, Care Quality Commission

The team included eight CQC inspectors, an expert by experience and a variety of specialists including a consultant surgeon, a consultant anaesthetist, an oncology nurse, an outpatients nurse and a radiographer.

How we carried out this inspection

To get to the heart of patients' experiences of care we always ask the following five questions of every service and provider:

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

Before visiting the hospital, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. Patients were invited to contact CQC with their feedback. We carried out an announced inspection between 11 and 12 August 2015 and an unannounced inspection on 17 August 2015. We held focus groups with a range of staff in the hospital including nurses and medical staff. We also spoke with staff individually. We talked with patients and relatives and observed how people were being cared for and reviewed patients' records of their care and treatment.

Summary of this inspection

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at the Spire Leicester Hospital.

Information about Spire Leicester Hospital

Spire Leicester Hospital is registered to provide the following activities:

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

The hospital provides treatment and care for patients referred under the Standard NHS Acute Contract, insured and self-pay referrals and provides outpatient, inpatient, diagnostic and therapeutic services.

The types of services offered at the hospital include urology, ophthalmology, orthopaedics, pain injection.

The accountable CD officer is the Registered Manager.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Good	Requires improvement
Termination of pregnancy	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Medical care

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

Information about the service

Spire Leicester hospital has one inpatient ward, Ward 2, made up of thirty individual patient rooms. The ward catered for medical and surgical patients.

Medical services offered at the hospital were mainly in cancer care. Some medical procedures were carried out in the cardiac catheter laboratory and some medical endoscopies were performed. Some medical services were provided in the outpatients department, these will be covered in the outpatient section of this report.

At the time of the inspection there were no medical inpatients. We spoke to medical patients receiving day care treatment in the chemotherapy suite.

We visited Ward 2, the chemotherapy unit, endoscopy unit and the cardiac catheter laboratory. We spoke with endoscopy staff. We spoke with a total of ten patients which included a patient forum, and patients in the chemotherapy suite.

All areas we visited had adequate staffing ratios and were well supported by the housekeeping team.

Summary of findings

The hospital had systems in place to protect patients and keep them from avoidable harm. Patients felt safe and staff had the skills, knowledge and tools to identify risks and knew how to escalate these if needed. Staff showed a good awareness of incident management showing that the system was embedded.

The use of professional guidance had ensured that patients' safety was maintained. The local audit programme and the changes identified from specific audits were acted upon in a timely manner. We saw that 100% compliance had been achieved against some audits, for example, the sepsis audit and consent.

Staffing was managed effectively; staff were well trained, had received regular appraisals and professional qualifications were validated. The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates, whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practicing privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the

Good

Medical care

collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Patients received effective care and treatment that met their needs. Medical care was delivered by consultants who worked at local NHS hospitals. Patients were supported, treated with dignity and respect and involved as partners in their care. Patients told us they felt cared for.

Patients with specific individual needs such as dementia were met. We saw effective systems in place to capture and act upon patient feedback.

Admissions were planned and multidisciplinary meetings had taken place to ensure effective admission, treatment and discharge planning. Processes were in place for transfers to other hospital if a patient required a higher level of care.

The leadership, governance and culture at the hospital promoted the delivery of high quality person-centred care. Members of the management team were well respected amongst both staff and patients. Staff felt supported, spoke positively about the organisation and staff morale was high.

Are medical care services safe?

Good

Patients were protected from abuse and avoidable harm.

When something went wrong, people received a sincere and timely apology and were told about any actions taken to improve hospital processes to prevent the same event reoccurring. Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses; they said they had been fully supported when they did so. Monitoring and reviewing activities enabled staff to understand risks and gave a clear, accurate and current picture of safety

There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse. Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff took a proactive approach to safeguarding and focused on early identification.

Shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. These shortfalls related to current medical indemnity insurance and Disclosure and Barring Service (DBS) checks.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks and General Medical Council registration expiry dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practicing privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has

remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes to ensure staff could manage risks to people who used services.

We saw that risks to people who used services had been assessed, monitored and managed on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behavior that challenged. People were involved in managing risks and risk assessments were person-centered, proportionate and reviewed regularly.

Incidents

- Staff told us they knew how to report an incident through the electronic incident management system. Two staff described the incident reporting process and demonstrated this to us through the electronic reporting system.
- Between April 2014 and March 2015 the hospital reported 578 clinical incidents of which 19 were serious incidents. Of the 19 serious incidents five involved medical patients. We saw evidence of the investigation process, identification of lessons learnt and actions to be taken. For example, one incident involved a treatment delay to a patient who had developed an infection. One of the actions from the investigation included clinical staff's use of a sepsis flowchart to enable a rapid assessment of symptoms. Nursing staff in the chemotherapy suite showed us the United Kingdom Oncology Nursing Society (UKONS) triage tool which included assessment of fever.
- Staff had received an annual refresher session on the electronic incident reporting and management system. This was included on the clinical training day timetable and a rolling programme was in place.
- Staff told us a weekly Rapid Response Meeting took place to discuss incidents or complaints which occurred for that week. This allowed immediate dissemination of information to the rest of the hospital in relation to any required changes in practice. We saw on the agenda of the mandatory clinical training days that trends in incidents and complaints were discussed at the mandatory clinical training days.

Safety Thermometer

- The NHS Safety Thermometer report for July 2015 showed that all patients including medical patients received harm free care. The NHS Safety thermometer is an improvement tool for measuring, monitoring and analysing patient harms and harm free care. Areas covered were pressure ulcers, falls, catheters, urinary tract infections, deep vein thrombosis, pulmonary embolism and venous thromboembolism risk. We saw the quality report dated June 2015, which reported one case of pulmonary embolism. The report included a summary of the investigation, root cause analysis and learning points.
- The VTE screening for all patients was consistently 100% in the reporting period between April 2014 and March 2015: 95% is the targeted rate for NHS patients. CQC had assessed the proportion of patients risk assessed for VTE to be 'much better than expected' compared to other acute independent hospitals we hold this data for.
- The number of patients acquiring hospital provoked VTE or pulmonary embolus (PE) in the period between April 2014 and March 2015 was 13. A PE is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot.

Cleanliness, infection control and hygiene

- Minutes of the latest infection control Meeting dated 3 August 2015 identified actions and responsible persons. For example, an action identified the use of Clinel stickers in the outpatient department. When we inspected the department, Clinel stickers were in use and were applied to equipment to indicate it has been cleaned and ready for use.
- The hospitals annual patient led assessment of the care environment carried out on the 6 May 2015; scored 99% for cleanliness against a national average of just over 97%.
- Staff told us following the patient led assessment of the clinical environment catering staff had changed their headwear to a washable cap.
- Following an audit dated 26 March 2015 sterile services achieved accreditation by an inspection verification and testing company. We saw the documented audit report.
- Staff used personal protective equipment and we observed the safe use of spillage kit guidance and guidelines for dealing with blood and bodily fluids on textiles and carpets.

- Sanitising hand gel was available and was used by staff before entering clinical areas. Patients told us they observed nurses and consultants using hand washing facilities before and after administering care.
- The use of hand sanitiser gel had been audited monthly. The July 2015 rating was scored a green rating which meant that the use of hand sanitiser gel was on, or better than, target.
- Patient rooms were visibly clean and patients told us that their rooms had been cleaned daily. The hospital was aware that the carpets and sinks in patient rooms were not in line with best practice infection prevention and control guidance. To achieve compliance in these areas a refurbishment plan had started in July 2015.
- Carpets and sinks in some of the individual patient rooms did not comply with national best practice guidance, however a refurbishment plan was underway. Carpets were visibly clean and housekeeping staff told us they were deep cleaned six monthly. We looked at a room that had been refurbished and found that it was compliant with national infection prevention and control guidance.

Environment and equipment

- Patient accommodation was in individual rooms.
- We were told by facilities staff that emergency generators were tested regularly and if needed were able to back up essential power supply.
- We saw that there was sufficient equipment to care for bariatric patients.
- We inspected five infusion pumps in the day care unit. The infusion pumps were visibly clean and clearly marked with service check dates, and all were within the scheduled date for the next service.
- We checked the resuscitation trolley. The trolley was visibly clean, well-stocked and all items within expiry date. The daily check log was signed and up to date.

Medicines

- Drugs and intravenous fluids were stored securely and were within expiry date. 'Short Dated' stickers were in use to identify clearly those drugs nearing expiry.
- The drug fridge was locked and only contained relevant items. The fridge temperature had been recorded daily and was within the recommended range.
- Controlled drug records were complete. The hospital carried out audits of controlled drugs and we saw a report on the review of the management of Controlled Drugs dated April 2014 which showed that all actions had been implemented and closed.
- We reviewed the medication charts of six patients and found that records were completed accurately, writing was legible, and all risk assessments completed and charts signed and dated.
- Pharmacy updates were part of the annual clinical training day. The hospital reported that by July 2015, 47% of staff had attended the training day and were on target to achieve 95% compliance by the end of 2015.

Chemotherapy Suite

- The chemotherapy suite used prescription and medication administration records specific to the needs of their patients, which facilitated the safe administration of medicines. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for two patients on the unit. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed .The records showed people were getting their medicines when they needed them. This meant people were receiving their medicines as prescribed.
- Medicines, including those requiring cool storage, were stored appropriately. We saw controlled drugs were stored appropriately.
- The pharmacy team visited the unit daily. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct, that records were up to date and the medicines were prescribed safely and effectively
- There was access to spill kits extravasation packs and Savene. Savene is a drug used when chemotherapy drugs have leaked into surrounding skin tissues. The Savene had clear and detailed instructions with it on how to use it. A copy of the policy for the management of cytotoxic chemotherapy extravasation was seen, and a copy was available with the kits on the unit.
- Chemotherapy was manufactured on site in a sterile aseptic room next to the chemotherapy suite. The chemotherapy suite does not hold a manufacturing

licence so only produced items in response to a patient prescription. Standard operating procedures were in place for all aspects of prescribing and dispensing of cytotoxic preparations. The isolators (sterile units for the safe preparation of medications) were audited by an external pharmacist and action plans produced as a result of their reports. We saw that the latest report had very minor issues identified which had all been acted on. All staff working in the aseptic unit had received training through an accredited provider and we saw evidence to confirm this. The hospital had acquired membership of the 'British Oncology Pharmacy Association.'

- Patients said that they are told about any new medicines prescribed and what they were for in a way that they understood; and that they continued to get their medicines at home where appropriate. One patient said, "Staff tell you what they are doing" "Side effects are explained so there are no surprises"
- Patients said that their pain was well managed; as was their nausea.
- Staff described access to medicines as adequate, they knew how to access medicines out of hours, and could access medicines to take home so that there had not been delays in patient discharge.
- A pharmacist visited the unit regularly throughout the day to see patients and work with the doctors to ensure that medicines were prescribed safely and effectively.
- Role specific controlled drug training is available through an e learning course. Staff could also access medical gases training. Training in the administration of Entonox, a pain relieving medical gas, was being rolled out to registered nurses.
- Staff said that they knew how to record and report drug errors and that learning was shared via clinical governance meetings.

Records

- Patients had paper medical records and electronic patient records. Paper medical records were stored securely and work stations, with access to electronic patient records, were password protected.
- We looked at six sets of medical records and found the documentation to be clear and fully completed including clinical risk assessments and where appropriate do not attempt resuscitation instructions. Nursing and medical reviews and observations were correctly recorded. We concluded that patient care records were completed accurately, timely and contributed to good patient care.
- The hospital training record showed that for the year April 2014 – March 2015 the hospital had achieved its target of 95% of all staff attending information governance training. Between April 2015 and July 2015, 47% of staff had attended information governance training. This showed that the hospital was working towards its 95% target, which was to be reached by the end of March 2016.

Safeguarding

- All staff had completed training on the protection of vulnerable adults at induction. Staff told us about the policy and the referral process.
- The Leicestershire safeguarding teams contact names and numbers were available for staff to access.
- The safeguarding training strategy dated April 2014 identified that level two training was mandatory for all clinically qualified staff working in day care, ward 2 and chemotherapy. It was difficult to ascertain from the training records what the compliance was for this training. However, the overall mandatory training rates for the hospital were 95%, which would indicate that training had been undertaken.
- The hospital weekly compliance report showed that on the 11 August 2015 84% of consultant staff had supplied evidence of their medical indemnity insurance whilst 87% of consultant staff had provided evidence of a Disclosure and Barring Service (DBS) check.

Mandatory training

- The hospital mandatory training could be accessed through the Access Academy. Mandatory training covered eighteen different topics including, incident reporting, mental capacity act, protection of vulnerable adults, manual handling, child protection and infection control. The training target for mandatory training was 95%. The hospital had achieved this for the year ending December 2014. Resident medical officers had received training in advanced life support.

Assessing and responding to patient risk

- The hospital did not accept urgent or unplanned medical admissions and we saw the admissions criteria policy, which clearly listed conditions requiring further risk assessment by nurse, consultant or anaesthetist depending on their severity.
- The national early warning score (NEWS) was used to detect if a patient's condition is deteriorating.
- Consultant medical staff could be contacted at all times and could attend the hospital within 30 minutes of the call if necessary. If a consultant was found to be not attending within the required time a clinical incident would be reported and investigated.
- Patients were reviewed daily by their consultant.
- The resident medical officer (RMO) rota was covered by two RMO's who worked on a one week on – one week off rota which meant there was continuous RMO cover to respond to nursing concerns or deteriorating patients.
- We observed a handover between nursing staff. It was effective and relevant safety information was passed between staff members.

Nursing staffing

- Spire Leicester told us they used an adapted version of a recognised safer nursing care tool. This is an acuity and dependency tool, which helps determine optimal staffing levels for inpatient wards. The tool was completed daily. The ratio of nursing staff to patients was one to four. This was reflected in the number of staff we observed on duty at the time of the inspection. This would increase if the dependency of the patient required additional staff.
- We reviewed the personal files of five nursing staff and found that appraisals, professional registration validation and disclosure and barring service checks were all up to date.

Medical staffing

- Resident medical officers (RMOs) were sourced through a healthcare medical recruitment agency. We saw the personal files of the three RMOs, which contained references, and a comprehensive list of self-declared competencies.
- At the time of inspection, 347 consultants with practising privileges worked at Spire Leicester.

Major incident awareness and training

- We asked staff if they were aware of the hospitals role in major incident planning. Senior nurses told us that the on call senior manager held the procedure for major incidents and would invoke this when required. Staff told us that regular simulations are carried out in order that they remain familiar with their role in the event of a major incident; however they seemed unclear about what constituted a major incident and talked about a patient with a major blood loss.
- Post inspection we were provided with information to show that major incident plans were currently being discussed with the head of emergency preparedness, resilience and response for the Central Midlands. The matron informed us that once plans had been developed further then staff would receive information and training.

Endoscopy Unit

- We were unable to inspect the endoscopy unit as it was being used for other procedures at the time of our visit. We spoke with endoscopy staff. We were told patients relatives were able to go into the endoscopy room with patients during the procedure. Patients requiring sedation were transferred to the recovery suite following endoscopy procedure.
- Endoscopy took place in one of the operation theatres where the ventilation and cooling systems were regularly tested and maintained. The number of air changes in the endoscopy area is important in reducing the risk of airborne infection.
- The endoscopy unit was working towards Joint Advisory Group (JAG) accreditation.
- The endoscopy unit employed a nurse who specialised in endoscopy. A JAG registered consultant from a neighbouring hospital supported her.
- There was a clear admission pathway for patient attending endoscopy, patients were admitted and prepared for their procedure the same way as a patient undergoing surgery, and they would then be transferred to the theatre department.
- People were offered the option of having medication to make them sedated during the procedure if they wished.
- A recovery area was near the theatres, which meant patients recovering from high levels of sedation were given a period of higher observation prior to transfer back to the ward.

Good

Medical care

- We were told patients relatives were able to go into the endoscopy room with patients during the procedures if they were anxious or had additional support needs for example a patient living with dementia.
- Chaperoning was offered to all patients attending for endoscopy.
- Systems, processes and standard operating procedures in infection control, medicines management, patient records and, the monitoring and maintenance of equipment were available in the department.
- There was sufficient numbers of probes available for use and we saw that equipment was stored and checks made to ensure that it was visibly clean and fit for purpose. We saw a standard operating procedure for the decontamination of the endoscopy probes after each use.

Cardiac Catheter Laboratory

- The Cardiac Catheter Laboratory operated on a patient need basis and had the facilities to undertake implantation of pacemakers and other complex devices procedures. Coronary angiography, cardioversions and trans-oesophageal echocardiography were also carried out. The laboratory was staffed by a catheter laboratory trained nurse, radiographer, cardiac physiologist and cardiology consultant when in use.
- We were told that patients were given information prior to the procedure and kept informed of progress during and after the procedure.
- The 'World Health Organisation' checklist was in place in the catheter laboratory however, at the time of our visit, no patients were scheduled to have procedures and so we were unable to observe its implementation.

Are medical care services effective?

Good

People received effective care and treatment that met their needs. Participation in clinical audits and other monitoring activities demonstrated positive outcomes. Patients' dietary needs were met and their pain managed effectively.

We saw evidence of multi-disciplinary working which included discussions about the patient's progress and where relevant their discharge needs.

Staff were well trained; high levels of staff appraisal achieved.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Evidence-based care and treatment

- The UK oncology nursing society (UKON) triage tool is used by ward staff and the chemotherapy team. This tool ensured patient safety in that oncology patients received robust reliable assessment over the phone, which had resulted in the appropriate prioritisation of care.

Pain relief

- We reviewed six sets of patient records; all included documentation on pain control. Pain was scored using a nationally recognised pain scoring tool and was recorded on the NEWS chart.
- Pain management training was included in the annual clinical training day.
- Patients told us that they felt pain was taken seriously by staff and the call buttons were answered promptly.

Nutrition and hydration

- We witnessed patients' dietary needs being discussed at the bed management meeting and staff handovers. The whiteboard in the Ward 2 kitchen clearly highlighted patients on special diets.
- We reviewed six sets of patient notes and all had Malnutrition Universal Screening Tool (MUST) assessments completed. The MUST assessment

identified adults who were malnourished, at risk of malnutrition or obese. Staff told us that if the MUST score was three or higher they referred the patient to the head chef for a tailored diet. MUST recommends that a score of two or higher should be referred to a dietician, nutritional support team or to implement local policy.
- The hospital had a contract in place with a neighbouring NHS trust for dietetics support.
- Patients told us that snacks were always available and if they wanted something that was not on the menu the head chef would prepare this for them. They told us that drinking water was changed regularly and relatives and carers could order and pay for meals if they wanted to eat at the hospital.
- We observed a patient in the chemotherapy suite make very specific requests for meal times. These requests were all met.
- We met with catering staff who told us that if patients stayed in hospital for longer than four days the head chef would visit them to ask if they had any special requests for a particular food.
- The ward hostess told us that they made sure patients can reach and eat their food. If they noticed patients leaving their meals they would report this to the nursing staff.

Patient Outcomes

- The deputy matron was responsible for clinical audit and monitoring processes. We saw the hospitals annual audit plan, which had listed audits already completed and audits planned for the rest of the year. Senior nurses told us they had been involved in recent audits such as the care pathway.
- The chemotherapy suite showed us their recent audit work. These included a Portacath audit (0% infection), sepsis audit and consent audit (100% compliance). A portocath is an implantable venous access system that allows easy access to veins for the administration of fluids, medication or to take blood. The audits were completed continuously and reviewed at the team meeting.
- The hospital had four cases of unplanned readmission for the period July to September 2014; CQC has assessed the proportion of unplanned readmissions to be 'Similar to expected' compared to the other independent acute hospitals we hold this type of data for.

Competent Staff

- Shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. Information from the weekly compliance report identified the required documentation for hospital wide consultants. The information showed that on 11 August 2015 84% of consultants had received a practice appraisal and 71% had received a biennial review.
- Although the percentages of compliance had increased since 15 April 2015, the provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of actions that would be put in place immediately to achieve compliance and mitigate risk. The Consultant's Handbook stated that consultants were at risk of suspension if they did not provide up-to-date documents.
- On 20 August 2015, we were informed that 84% of consultants had provided all the required documentation. Thirty-four consultants practising privileges were suspended until the documents were submitted to the hospital. Staff were made aware of whom the consultants were. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.
- The hospital reported appraisal rates of 94% for all staff in 2014. Nurses told us there were opportunities for temporary promotions and they were encouraged to consider succession planning for future promotion opportunities.
- The housekeeping and catering staff told us they had many opportunities for personal development. Catering and housekeeping staff all had the food hygiene NVQ to level three.
- The provider was reviewing requirements for care certification for health care assistants. At the time of our inspection, no National Vocational Qualification training was offered to care assistants new into the role. Formal documented assessments on their competencies were undertaken following induction and a mentor was assigned to all new care assistants.

Good

Medical care

- Nurses told us there were good opportunities for attending training courses. Eight out of the twelve nurses were attending the 'Management fundamentals' training course.
- One recently appointed member of staff described her induction. This included being supernumerary for three weeks and a meet and greet with heads of departments. In addition, they had a guided tour of the hospital, introduction to key staff and allocation of a personal mentor. She also received an induction pack which included information about policies, procedures and mandatory training.
- Nurses told us about the twice monthly clinical training days, which all clinical staff attended. We saw the timetable for the training days and we saw evidence on staff rotas of planned dates.
- Medical staff also completed an induction programme and a mandatory training checklist.

Multidisciplinary working

- Senior nurses told us that every day at 8.30am there was a multi-disciplinary meeting, which included the nurse in charge, physiotherapy, pharmacy, Resident Medical Officer and deputy matron. The purpose of the meeting was to discuss individual patient's progress and plan for discharge.
- The senior oncology nurse told us that an audit had been carried out on the numbers of patients who had a multidisciplinary team meeting prior to commencement of treatment. Compliance was good at 94% attendance.
- Patients told us they felt that all staff worked as a team, that communication between consultants and nursing staff was excellent.

Seven-day services

- The resident medical officer was available 24hours a day, seven days a week.
- Consultants could be called at any time and can reach the hospital within 30 minutes if required. Consultants performed daily ward rounds, outcomes of which were documented in patient's notes.
- The chemotherapy unit did not open weekends but the two senior nurses offered an on call provision out of hours until 20.00hrs.
- Physiotherapists provided a seven day service from 08.00 – 20.00hrs.
- Twenty four hour on call services were provided by a senior nurse, pharmacist, pathologist and radiologist.

Access to information

- Staff told us that referral notes from GPs were available for patients, which enabled consultants to carry out fully informed assessments of all new patients.
- There were systems in place for the transfer of medical information between neighbouring hospitals. This meant that consultants treating oncology patients could review their full medical history and previous test results in order to ensure the correct treatment was prescribed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed six sets of patient notes. Two sets of patient notes contained 'Do Not Attempt Resuscitation' (DNAR) forms, which were accurately completed.

The hospital reported all nursing staff had attended Mental Capacity Act training. Mental Capacity Act training was once only training for all clinical staff in Ward 2 and the day care unit. Staff told us they were aware of the act and knew what to do if they suspected someone of lacking capacity to consent.

Are medical care services caring?

Good

People were supported, treated with dignity and respect, and had been involved as partners in their care. Feedback from people who used the service, those who were close to them and stakeholders about their experiences was positive. We saw people were treated with dignity, respect and kindness during all interactions with staff and that relationship's with staff were positive. People said they felt supported and said that staff cared about them.

People were involved, encouraged to be partners in their care and were supported in making decisions. Staff spend time talking to people, or those close to them. They communicated with and received information in a way that patients understood.

Staff responded compassionately when people needed help and support them to meet their basic personal needs. They anticipated people's needs and people's privacy and confidentiality are respected at all times.

Compassionate care

Good

Medical care

- Friends and Family Test (FFT) results consistently scored above 98% for the reporting period October 2014 to March 2015 which is above the national average. Response rates were low in 2014 (29.9%) but have improved in 2015 and latest available data (to the end of June), shows the response rate was 58.5%, again higher than the national average of 26.1% in the same period
- The results of the latest patient survey were clearly displayed on notice boards.
- Chemotherapy staff told us they contacted patients six to eight weeks after they had finished their course of chemotherapy to check how they were. We saw evidence of this on a documented sheet.
- We saw people were treated with dignity, respect and kindness during all interactions with staff and that relationship's with staff were positive. People said they felt supported and said that staff cared about them.

Understanding and involvement of patients and those close to them

- Staff told us that relatives or carers could stay overnight with patients if they wished. We witnessed this when a relative asked a member of staff if they could stay overnight and was told that it would not be a problem.
- Spire Leicester commissioned the 'Compassion in Practice' training course and 69% of staff had attended this training by May 2015. There were plans in place for the remainder of the staff to attend the training.
- Patients told us staff had time to talk, were friendly and made them feel at ease during embarrassing moments. Patients said they felt involved at every stage in decision making about their treatment.
- Three patients in the chemotherapy suite said that staff had treated them with dignity and had always respected their privacy. They also said that staff were caring and attentive to their needs.
- The Spire Leicester website contained a range of information for patients including types of treatment available and costs. The business development manager also told us that an information pack was sent to all patients with their appointment letter.

Emotional support

- Two patients felt they could have been offered more advice on how to obtain information about welfare benefits they may have been entitled to.
- Staff told us and we observed how staff had supported one patient who had a recent bereavement. The patients nurse told us they had talked to the patient about their bereavement, had spent time with and checked frequently that the patient was not becoming too upset or anxious.
- Staff said that clinical psychologist referrals had taken place for patients when necessary. Additional information in the form of patient leaflets was available for patients in the chemotherapy suite, for example, 'Practical and emotional support for anyone affected by cancer' a leaflet produced by 'Coping with Cancer.'
- In addition 'Coping with Cancer' staff visit the unit regularly to speak with patients and offer additional emotional and financial support needed

The oncology unit had also recently started contacting patients by telephone six to eight weeks after completing treatment to check on how they were feeling. This enabled patients to express any concerns they were having. Staff could arrange for patients to be seen back at the hospital if necessary.

Are medical care services responsive?

Good

The majority of people's needs were met through the way services were organized and delivered. However, unplanned transfers of inpatients to other hospitals had risen in the reporting period (April 2014 to March 2015).

Staff acknowledged patient's individual needs and responded to them appropriately, however, we could not be assured that a suitable translator had always been available for patients whose first language was not English.

The hospital had taken steps to improve the care for people living with dementia. This had been corroborated by the hospital 'patient led assessment of the care environment' which had scored dementia as 80% compared to the national average of 75%. Learning had resulted from complaints received.

Service planning and delivery to meet the needs of local people

- The hospital was established in 1989 under the ownership of a different provider as a purpose built

private hospital. In 2007 the hospital changed ownership. Whilst the focus had remained on the core of private patient business, the hospital had attracted additional NHS patients through local contracts with NHS trusts and commissioners in Leicester. This had resulted in local people receiving timely interventions for their required procedures.

- The hospital cared for people of all sexes and from all backgrounds. Care and treatment pre and post operatively was undertaken in areas where individual patients could be segregated via curtains or doors to provide privacy.

Access and flow

- The hospital did not accept emergency or unplanned admissions. Patients were referred via their GP, insurance company or NHS Choices.
- The hospital had five cases of unplanned transfer to another hospital from July to September 2014 CQC has assessed the proportion of unplanned transfers to be 'Similar to expected' compared to the other independent acute hospitals. However the rate has risen greatly in January to March 2015. There had been 15 cases of unplanned transfers of an inpatient to another hospital in the reporting period (April 2014 to March 2015).
- When a patient's condition deteriorated and they required a higher level of care they had been transferred to a suitable NHS hospital. A protocol was in place for the transfer of patients to an NHS hospital. The hospital had reviewed all incidents of patients who had been transferred out to NHS hospitals. We saw the documented reviews including lessons learnt and actions taken.
- A one stop shop approach was taken with oncology patients in the outpatient department. A pre chemotherapy assessment was completed, blood tests taken, insurance assessment completed, consent forms signed and the patient seen by the consultant.

Meeting people's individual needs

- An external company provided Interpreting and translation services. Interpreters were booked for meetings between the patient and the consultant. Referral letters indicated if an interpreter was required for the patient.
- Staff told us that they used relatives and carers at other times or members of staff who were fluent in other languages. We saw a list of the staff that were able to speak in different languages. The use of family and carers is not considered good practice.
- The hospital did not provide any training for staff to support them in providing interpreting services. We were told that when staff had been used as an interpreter this had been documented on the patient's notes, we were unable to find evidence of this in the example given.
- We did not see any patient information leaflets in different languages displayed which meant these were not readily available to patients.
- The hospital had a named nurse for dementia who was working on a dementia pathway. A 'forget- me- not flower sticker attached to their medical records easily identified dementia patients. There were five dementia champions who included staff from the housekeeping team; we saw the dementia friend badge being worn by one of the housekeeping team.
- Staff had created two memory boxes. Memory boxes have been shown to distract dementia patients from becoming anxious, they contained memorabilia and personal items.
- In the staff hand over we attended we witnessed staff discussing the mini mental capacity test for one patient who appeared confused. The mini mental test is a series of questions and tests which score points and can be used to help diagnose dementia.
- The hospital had taken steps to improve the care for people living with dementia. For example, we found they had meetings about dementia and their patient led assessments of the care environment scored dementia as 80% for the hospital compared to the national average of 75%.
- The service was responsive to people's needs. An example of this was when the staff had opened the chemotherapy suite especially on a Sunday for a patient so that the oncology nurse could remove her portocath.
- Patients attending the chemotherapy suite were referred to an organisation called 'Coping with Cancer'.
- The hospital employed a breast care nurse on a bank basis who saw all newly diagnosed breast cancer patients in the outpatients department. After this, their care was handed over to the spire staff for continuing support.

- A reflexology service was offered to oncology patients and their relatives.

End of Life Care

- The hospital had several policies and documents in place relating specifically to end of life care (EOLC) such as; an end of life care policy, end of life care plan, syringe driver policy, care of deceased patient after death policy and the 'rest in peace' hospital pack.
- Staff told us occasionally patients had requested that the hospital be their preferred place of care and that this happened about three to four times per year. However patients were usually referred to the local hospital.
- Staff working in the chemotherapy suite received additional training in relevant topics. We saw the certificate of attendance for one member of staff on the training course, 'securing quality and compassion in end of life care' and another attending a degree level chemotherapy course.
- One doctor we spoke with was unable to tell us how many oncology patients who received care at the hospital were deemed to be in the last twelve months of life, they were also not clear about the gold standard register. The gold standard register is held by GP's and should include all their patients deemed in the last 12 months of life. All patients on the register should be discussed at a multidisciplinary meeting held at the GP practice.
- The lead pharmacist confirmed that pharmacists had been involved when prescribing anticipatory medicines for end of life care situations

Learning from complaints and concerns

- Complaints were logged on an electronic system.
- Spire Leicester reported that there had been 77 complaints logged in 2014. All complaints had been reviewed by the hospital director.
- We saw the complaints flowchart displayed on the ward notice board. Staff told us patients were encouraged to discuss complaints so that local resolution could be achieved if possible. We saw the complaints leaflet,' Please Talk to Us' which was included in the admission information pack.
- During our review of five nurse personal files, we saw good evidence of reflective practice following one member of staff's involvement in a complaint relating to pain control.

Are medical care services well-led?

Good

The leadership, governance and culture promote the delivery of high quality person-centred care. Robust governance and audit systems were in place.There was a clear statement of vision and values, driven by quality and safety. It was translated into a credible strategy and well-defined objectives that were reviewed to ensure that they remained achievable and relevant. Staff in all areas knew and understood the vision, values and strategic goals. Staff morale was high and the management team well thought of by staff and consultants alike.

Shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. We escalated these findings to the provider who acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. Immediate actions were implemented by a senior manager to achieve compliance and mitigate risk. By the 20 August 2015, 84% of consultants had provided all the required documentation.

Vision, strategy innovation and sustainability for this core service

- Spire Leicester Hospital plans to open three outreach clinics in Stamford, Market Harborough and Husbands Bosworth to promote and increase referrals from these areas. In addition, the service plans to attract additional oncology patients in conjunction with a new cancer centre at Castle Donnington, which will result in an overall increase in cancer services.
- Staff we spoke to were aware of the vision and values of the hospital and described them to us.

Governance, risk management and quality measurement for this core service

- Shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. Shortfalls in the receipt of medical staff information were monitored by the hospital. These shortfalls included up to date information on whole practice appraisals, medical

indemnity, disclosure and barring checks, biennial review and General Medical Council registration expiry dates. We escalated these findings to the provider who acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of immediate actions to achieve compliance and mitigate risk. By the 20 August 2015, 84% of consultants had provided all the required documentation. Thirty-four consultants practicing privileges were suspended until they had submitted their documents to the hospital.

- The governance structure showed clear lines of accountability from staff delivering the service to the hospital director. Meetings were in place for key areas such as clinical governance, health and safety, medical advisory committee and medicines management.
- Senior nurses told us they felt informed about and involved in the governance of the hospital.
- Team meetings and key points from these meetings were disseminated to staff, which included the lessons learnt from complaints and incidents. Minutes of meetings were emailed to staff unable to attend in person.
- The hospital attached a monthly staff bulletin to pay slips advising of any issues and actions taken. A monthly newsletter is circulated to staff.
- The 'Medical Advisory Committee' linked with the hospital clinical governance meeting.

Leadership/culture of service

- Patients were complimentary about the visibility of the hospital matron. Staff told us they saw matron and the hospital director in the departments and wards on almost a daily basis.
- Nursing staff told us that if they were mentioned in an accolade from a patient they would receive a personal letter of thanks from matron.
- A consultant told us that he felt he was working in a supportive environment and that the hospital director demonstrated a strong 'top down' management approach.
- Housekeeping staff told us that the leadership team are approachable and lead by example.
- All staff we talked with told us the hospital was a good place to work. They said there were more than adequate training and development opportunities, and they felt valued by managers.

Public and staff engagement

- The matron informed us it had been difficult to involve patients as much as they would like to. Phone calls were made to many ex-patients and a new patient focus group had been set up with three ex-patients; two more had been recruited prior to our visit. Two meetings had been held to help resolve any concerns raised by patients with clear action plans from recommendations / feedback from patients to drive relevant improvements. In addition, in 2014, patient forums were held involving NHS, Private Insured and Self-Pay patients. A report from this activity was generated and actions have all been closed out.
- Staff had encouraged patients and visitors to visit a newly refurbished room on Ward 2 to receive their feedback on décor and layout. Some patients were asked to stay overnight in the room. Patient comments had informed the final design of the new rooms. One example of this was feedback, was about the taps in patient rooms. These taps were now going to be changed.
- A senior member of staff informed us the relationship between the local Healthwatch group and the hospital was very good. Healthwatch had not received any complaints relating to the hospital.

Payment for Care and Treatment

- NHS referred patients received exactly the same care as private paying and insured patients. This was evident on the wards.
- The Spire group website had very good information about the cost of procedures. The business development manager told us that information packs were sent out with appointment letters which gave clear instruction about cost and payment. We viewed the website and the information pack.
- Patients were advised to check with their insurer if there were any limitations to services covered in the insurance policy.
- Costs and payment were discussed at all stages of treatment by the consultant at the initial appointment and later by nursing staff. For example, the patient's policy reached the limit of their outpatient diagnostic testing budget.

Good

Surgery

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

Information about the service

Surgical services at Spire Hospital Leicester provided day and overnight facilities for adults and children undergoing a variety of procedures. The majority of patients attending the hospital for surgery were privately funded (insured and self-paying). Twenty three percent of patients in the year April 2014 to March 2015 were funded by the NHS through the 'NHS e-referral' service system. Choose and Book is a national electronic referral service which gives low risk patients a choice of place, date and time for their first out-patient appointment in a hospital or clinic. Since June 2015 this has been replaced by the NHS 'E-Referral Service.' The hospital offers general surgical and orthopaedic procedures only through this system.

From April 2014 to March 2015 there were 6,518 visits to theatre. These included general surgery orthopaedics, ophthalmology and cosmetic surgical procedures. The most commonly performed surgery was for patients with cataracts. Facilities included two wards, four theatres and one area where minor procedures were undertaken. Patients recovering from surgery were cared for in a five-bedded recovery area. In addition two enhanced recovery beds with appropriate equipment had been allocated for patients requiring a higher level of care for short periods of time, for example, following surgery for weight loss.

The hospital provided its own sterile supplies department. This enabled reusable equipment to be cleaned, sterilised and packed for further use.

During our inspection we spoke with 13 patients and two accompanying relatives. We also spoke with staff including nurses, medical staff, anaesthetists, therapy, supporting staff and senior managers.

Summary of findings

The hospital had systems in place to keep patients safe. Processes were in place to report incidents and staff demonstrated a good awareness of the process for identifying and reporting any safety incidents showing the system was embedded. Investigations were robust and staff learned from actions taken. . However, because of the small monthly sample size (less than 2%) for the auditing of the five steps to safer surgery checklists we could not be assured of overall compliance with safe practices in theatre. All patient areas were visibly clean, infection prevention and control processes were in place and equipment had been checked regularly. Medicines were stored and administered safely.

Staffing was managed effectively to ensure patients received good care with access to medical care

obtained in a timely manner. Staff were well trained and records were kept securely.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates, whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges

Good

Surgery

for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Evidence based care and treatment was delivered to patients following national guidance by competent staff. The hospital provided a seven-day week service with patients having good access to information.

All the patients and relatives we spoke with were overwhelmingly positive about the care they had received and the way staff treated them. Patients told us they were involved in their care and staff explained care and treatment in a way they understood.

Access to care and treatment was monitored and exceeded the national average. Staff acknowledged patient's individual needs and responded to them in an appropriate way although we were not assured a suitable translator was always available for patients whose first language was not English.

Staff had a good understanding of the complaints process and the hospital learned from complaints, changing care practices if required.

The hospital had a governance system in place which included a comprehensive audit system. Morale was excellent with staff talking positively about the organisation and their local management team. Staff felt listened to and supported in their role.

Are surgery services safe?

Good

The hospital had systems in place to keep patients safe. Processes were in place to report incidents and staff demonstrated a good awareness of the process for identifying and reporting any safety incidents showing the system was embedded. Investigations were robust and staff learned from actions taken as a result. However, because of the small monthly sample size (less than 2%) for the auditing of the five steps to safer surgery checklists we could not be assured of overall compliance with safe practices in theatre.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks and General Medical Council registration expiry dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Infection prevention and control processes were in place, equipment was checked regularly and medicines were stored and administered safely.

Incidents

- The hospital had reported one 'never event' in 2014, which had related to an issue in theatre. Never events are classified as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by

healthcare providers' The event had been investigated thoroughly and appropriate actions taken to prevent any re-occurrence. Staff we spoke with were aware of the incident and the actions taken.

- All the staff we spoke with were aware of their responsibilities and had individual access to the hospital's electronic incident reporting system; they all knew how to use it. This allowed staff to report all actual incidents and those where patient safety may have been compromised. Staff gave examples of reportable incidents where lessons were learned and practices changed as a result. Staff we spoke with informed us there was no blame culture in the service and they felt empowered to report incidents without fear of reprisal.
- Data we had received from the provider showed there had been 578 clinical incidents across the hospital services between April 2014 and March 2015. Overall, the rate of clinical incidents per 100 inpatient discharges across the hospital had remained largely consistent in the same period.
- In the same period there had been 19 serious incidents that had required investigation. The provider had taken appropriate action to reduce the risk of these occurring again.
- The hospital had reported seven expected deaths between April 2014 and March 2015 across all services. In the same period, there had been two unexpected deaths, both reported in March 2015. Although both patients had been treated in the hospital, one had died at home and the other in a local acute trust. Both deaths were investigated thoroughly and the provider had responded appropriately.

Safety thermometer

- The hospital had monitored performance through a series of assessments to reduce risks to patients. These included, falls, pressure ulcers (damage to the skin caused by a patient being in the same position for too long), and venous thromboembolism (VTE). VTE's or blood clots can form in a vein of a patient and have the potential to cause severe harm.
- The VTE screening for all patients was consistently 100% in the reporting period between April 2014 and March 2015: 95% is the targeted rate for NHS patients. CQC had assessed the proportion of patients risk assessed for VTE to be 'much better than expected' compared to other acute independent hospitals we hold data for.
- The number of patients with hospital acquired provoked VTE or pulmonary embolus (PE) in the period between April 2014 and March 2015 was 13. A PE is a blockage of an artery in the lungs. The most common cause of the blockage is a blood clot.
- A nutritional assessment had been undertaken for all patients even if those who had a local anaesthetic.
- Three cases of hospital acquired grade two pressure ulcers had been logged as incidents in the twelve month period March 2014 to April 2015. All had been investigated with actions taken and lessons learned documented.

Cleanliness, infection control and hygiene

- The service had a newly appointed infection control nurse in post who had attended a recognised infection control course. Infection control link nurses were in place in each ward and department.
- Monthly committee meetings with terms of reference had commenced for the link nurses to discuss their concerns and ideas for moving forward. The committee fed into the clinical governance meetings. All infection control issues fed into the infection control Spire corporate lead. This gave staff responsible for infection control the opportunity for peer support and shared learning.
- The hospital had forged good links with personnel working in infection control at a local NHS acute trust; these included a microbiologist. They met on a regular basis to discuss shared learning.
- Two members of staff had taken part in a study day at Public Health England with regard to surgical site wound infections.
- Information the provider sent us showed their infection control audits between July 2014 - March 2015 ranged from 85% and 94% compliance. The infection control nurse informed us they would like to see 100% above their target rate of 95%.
- The hospital had reported one incidence of Methicillin Staphylococcus Aureus (MRSA) one case of Clostridium Difficile (C Diff) and no cases of Methicillin-sensitive Staphylococcus Aureus (MSSA) in the reporting period between April 2014 and March 2015. MRSA, MSSA and C.Diff are all infections that have the capability of causing harm to patients. A root cause analysis had been undertaken for each case to highlight any actions that needed to be taken. Appropriately trained staff undertook the root cause analysis processes.

Good

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- As part of the pre-operative process for patients admitted for procedures, high risk patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) and Methicillin-Sensitive Staphylococcus Aureus (MSSA). These included patients scheduled for orthopaedic procedures, those who had been in hospital previously and patients who had previously tested positive for the bacteria. Those patients were screened at between two and six weeks prior to admission.
- Two weeks prior to our visit the hospital had put in place a protocol for all high risk patients, for example joint replacement, prescribing a routine five day treatment for MRSA whether they tested positive for the bacteria or not. The updated protocol covered short notice bookings only for patients having surgery within five days when there was insufficient time for the reporting of the samples taken.
- Anti-microbial stewardship was in place in the hospital to ensure the use of antibiotics was controlled and used appropriately.
- All of the areas in which patients were seen and treated and where equipment was stored were visibly clean and well maintained. Equipment was stored off the floor. Equipment not used regularly was covered to prevent the collection of dust.
- The hospital used a system for ensuring equipment was identified as having been cleaned, for example 'I am clean' stickers. These were clearly visible, dated and signed appropriately.
- A local policy and procedure was in place for the scrubbing, gowning and gloving of staff prior to surgical interventions. We observed staff following the procedure to ensure infection risk was minimised.
- Processes and procedures were in place for the management, storage and disposal of general and clinical waste, disposal of sharps, environmental cleanliness and the prevention of healthcare acquired infection guidance. Clinical waste bags and sharp bins were closed effectively and identified with a unique number. Sharps bins were given to patients on discharge if they were required, for example, for the administration of certain medicines
- Cleansing gel was available at the entrances to each area and in each room; patients and visitors were encouraged to use it. There was access to hand washing facilities and supplies of personal protective equipment, for example gloves and aprons.
- Staff were seen to wash or apply alcohol gel to their hands on entering and exiting from patients' rooms and different areas of the hospital.
- All staff were observed complying with the bare below the elbows policy and nursing staff were comfortable challenging medical staff to comply with this policy where required.
- A hand hygiene benchmark audit had been carried out monthly. In July 2015 this showed a good compliance rate. In addition, a hand glow audit using a special light to indicate clean hands had been carried out on staff by the infection control link nurse in every department.
- On the in-patient ward patients had been asked to complete a questionnaire on the use of hand sanitiser by staff. Any staff not undertaking this were identified and the issue taken forward.
- Three of the four operating theatres had higher levels of air filtration (laminar flow) in place; this was particularly important for joint surgery to reduce the risk of infection. We saw annual checks had been undertaken on the filtration systems to ensure compliance.
- Deep cleaning of theatres had been undertaken on an annual basis.
- The provider had a wound care management policy and procedure in place which was in use in the hospital. Staff were aware of this.
- Patients were given written information regarding wound management from the staff before discharge. This was supported by verbal discussion; the information included what the patient should do if they were concerned. Patients were given telephone numbers of the hospital to contact them if they required help or support.
- Information received from the provider showed that one incident of wound infection had occurred between April 2014 and March 2015. The incident had been logged on the hospital's on-line incident reporting system. An investigation had been undertaken and the patient had been treated appropriately.
- All members of staff had been provided with an easy to use pocket guide that included such items as hand hygiene and infection prevention control.
- Senior managers informed us fitted carpets and fabric curtains were being replaced in patients' rooms. The hospital had acknowledged these were difficult fabrics to keep clean. The replacement programme was due to be completed by the end of 2016.

Good

Surgery

Environment and equipment

- Storage facilities within the hospital for supplies and equipment were well organised. For example, the anaesthetic consumable store room was well stocked and clearly labelled.
- The second floor suite of four theatres appeared visibly clean, well-organised and tidy. The theatre in the outpatients department was also visibly clean and fully equipped to undertake minor procedures such as biopsies and removal of skin lesions.
- Flooring in theatre store rooms were marked to identify where equipment was stored and corridors were completely clear. Staff informed us this was usual practice.
- Resuscitation equipment for both adults and children was available in the operating theatres and ward areas. Single-use items were sealed and in date and we saw evidence the equipment had been checked on a daily basis; this included expiry dates. This meant the equipment was ready for use in an emergency.
- In theatres separate drug boxes for adults and children for use in an emergency were sealed. However, the colour of the boxes were similar and stored in the same place. This meant the wrong box could be picked up in an emergency.
- On the first floor a resuscitation trolley was located in the oncology department; this was also used for Ward 1.
- On the second floor' resuscitation equipment included a special bag containing all the equipment needed for a child's emergency resuscitation.
- We found anaesthetic machines were in working order and safe to use although it had been acknowledged by the provider they required replacing because of their age. This would take place in 2016 as part of a refurbishment programme.
- Anaesthetic equipment was checked by an operating department practitioner (ODP) at the start of each day. We observed regular service checks were also in place.
- The service had equipment for dealing with patients who may present with uncommon situations that may occur during the course of their operation.
- We saw all equipment used for patient-care to be visibly clean and ready for use. Equipment had been routinely checked for safety with portable appliance testing labels stating when the next service was due.
- On wards we saw equipment was readily available, for example walking crutches.
- The hospital had its own sterile supplies department (SSD) Staff in SSD performed sterilizations and other actions on medical devices, equipment and consumables for use by healthcare professional's workers in the operating theatre of the hospital.

Medicines

- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines.
- Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- We looked at the prescription and medicine administration records for three patients on the two wards. We saw appropriate arrangements in place for recording the administration of medicines. These records were clear and fully completed .The records showed people had received their medicines when prescribed. If people were allergic to any medicines this had been recorded on their prescription chart.
- Medicines, including controlled drugs and those requiring cool storage, were stored appropriately. Controlled drugs are medicines which are stored in a designated cupboard and their use recorded in a special register.
- The pharmacy team visited all wards daily. We saw that pharmacy staff checked that the medicines patients were taking when they were admitted were correct, that records were up to date and the medicines were prescribed safely and effectively.
- Patients were responsible for completing their own pre-admission questionnaire prior to their procedure. This included information about the current medicines they were taking.
- If required, additional information for the patient was requested from their GP.
- The records were clear and complete. If people were allergic to any medicines this was recorded.
- The hospital used a number of different medicines for relieving pain post-operatively dependent upon the surgery. Eye drops were also used for patients following ophthalmic surgery. All patients were given information about the medicine they had been prescribed how to use it and any side effects they may experience.

Records

- We saw records were kept securely when not in use on the wards. Access to them was via a key code. Any records not used for six weeks were sent off site into secure storage. We were informed they could be obtained within 24 hours if they were required.
- Staff, including reception staff, were aware of their responsibilities with regard to the safekeeping of records and patient confidentiality.
- We looked at five patient records from patients who had undergone different types of procedures.
- Medical (operation notes and consent form) and nursing records (risk assessments and care pathways.) were filed separately. However, all records for one patient were kept together which meant they were easy for staff to locate. Medical notes were not always easy to read because of the lack of clarity in doctor's handwriting.
- Nursing and medical records were filed in a specific order which meant they were easy for staff to locate and use.
- We saw three records where pieces of information on separate sheets of paper had not been placed into the file securely. These related to blood test results, fluid charts and an anaesthetic record. The provider informed us loose documents were checked and filed in the correct order prior to sending notes to medical records for filing.
- All records were complete and up to date. Each patient had the appropriate care pathway in place dependent upon the procedure they had undertaken and whether it was a local or general anaesthetic. Evidence was available to show discharge was planned and physiotherapy arranged where necessary.
- Care pathways were comprehensive in content and included pre-operative assessments, anaesthetic, recovery and discharge planning including pain management and wound care. The pathways could be personalised to reflect patient's individual needs, for example, if a patient's first language was not English; we saw this in one record we viewed.
- Records showed where staff had completed patient risk assessments. These included risk assessments for pressure ulcers, falls, and malnutrition. All the risk assessments completed followed national guidance, for example, a score for prevention of pressure ulcers.
- Additional information relating to patient's individual care was documented in a communication page.
- One senior manager was due to attend Caldecott Guardian training in October 2015. A Caldecott Guardian is a senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information sharing with other agencies.

Safeguarding

- The hospital had adopted the corporate safeguarding policy and procedure which included guidance on safeguarding adults and children. We saw the hospitals' policy had been reviewed in June 2015.
- The hospital had a senior named nurse lead for safeguarding both adults and children.
- Leicestershire safeguarding teams contact names and numbers were available for staff to access.
- Safeguarding was a standing agenda item on the quality report for the hospital; we saw the report for June 2015.
- The safeguarding lead for the hospital received three-monthly safeguarding supervision with the local Clinical Commissioning Group lead safeguarding nurse. We saw evidence of those notes for June and July 2015.
- Staff we spoke with had an understanding of how to protect patients from abuse. They understood the process and who to refer any concerns to.
- Safeguarding adults and children training was included in the mandatory training for all staff, with clinical staff and clearly identified clerical staff in certain areas trained to level 2.
- Four safeguarding incidents had been raised in the last twelve months and the hospital had acted appropriately. Discussions held with a senior manager identified there had been learning from the first safeguarding event which had improved practice in relation to the following safeguarding events.
- The hospital weekly compliance report showed that on the 11 August 2015 84% of consultant staff had supplied evidence of their medical indemnity insurance whilst 87% of consultant staff had provided evidence of a Disclosure and Barring Service (DBS) check. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Mandatory training

- Mandatory training for all groups of staff was comprehensive with many modules accessed through

an on-line learning system. Other training was role specific, for example, food hygiene. Mandatory training modules included moving and handling, infection control, fire and health and safety.

- There was an expectation that all staff completed annual mandatory training. Information provided by the hospital evidenced that percentage completions of mandatory training varied between staff groups. For example 100% of the senior management team had completed the five annual modules for 2015 including fire safety, health and safety and infection control. Qualified nursing staff and healthcare support workers percentages for the same modules varied between 71% and 92% although it is acknowledged the year had not finished. The training year ran from January – December.
- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process.
- The resident medical officers who worked in the hospital 24 hours a day were required to undertake mandatory training with the agency that supplied them as part of their contract. This included health and safety, fire training, and equality and diversity.
- Other mandatory training included advanced life support and advanced paediatric life support. Completion rates varied between 74% and 76%. The training target for the hospital was identified as 95% and the hospital had until the end of the year to achieve that.

Assessing and responding to patient risk

- All patients saw their named consultant at each stage of their patient journey.
- Anaesthetists calculated the patient's American Society of Anesthesiologists (ASA) grade as part of their assessment of a patient about to undergo a general anaesthetic. The ASA is a system used for assessing the fitness of a patient before surgery and is based on six different levels with level one being the lowest risk. The hospital generally undertook procedures for patients graded as levels one to three.
- Information from the hospital showed that in the year 2015 to date 89 patients had received an anaesthetic with an ASA grade of three and one patient with an ASA grade of four. ASA grade three patients were discussed with the appropriate consultant and only treated if the risks were acceptable. The hospital informed us the patient with an ASA grade of four had only received a local anaesthetic.
- Because of the narrow entrance to the smaller theatre in outpatients, any patients deemed at risk were operated on in the main theatre suite to ensure staff and equipment could be gained quickly.
- Staff in the hospital used a system to record routine physiological observations such as blood pressure, temperature and heart rate in order to monitor a patient's clinical condition. This was used as part of a national early warning score (NEWS). If a patient's score increased, staff were alerted to the fact and a response was instigated. The response varied from increasing the frequency of the patient's observations up to urgent review by the consultant surgeon and/or consultant anaesthetist. Observation of five records showed these were completed.
- The hospital also used a document called a rounding chart to reflect how frequently patients should be observed. This varied between one and two hours dependent upon individual patient need. It included pain control, mouth care, skin care, continence and nutrition.
- The hospital had a service level agreement with the local NHS acute trust. This stated patients could be transferred to their care if they deteriorated. An emergency call to the ambulance service would be made to transport a patient.
- In the period from April 2014 to March 2015 there had been 20 cases of unplanned transfer. Of those 20 cases, 12 patients had been transferred following surgery but no themes had been identified. The data we reviewed showed a rising rate of unplanned transfers due to complications following surgery. Root cause analysis was completed for each transfer and any lessons learned was documented. For example, new fluid charts had been put in place to improve the accuracy of the document following a deterioration of a patient that had not been monitored effectively.
- A resident medical officer (RMO) who had been recruited through a medical agency was on duty 24 hours a day in the hospital to respond to any concerns staff may have. A paediatric consultant/anaesthetist was always resident in the hospital if children had undergone surgery.

Good

Surgery

- Staff we spoke with felt confident about contacting the patient's consultant by telephone and told us they would attend the patient in a short period of time.
- The hospital followed the five steps to safer surgery in the operating theatre. Staff used a document based on the World Health Organisation (WHO) five safer steps to surgery safety procedures for use in an operating theatre to ensure any risk to patients was reduced. Medical records we reviewed showed the checklist completed in all cases.
- During our observation in theatres, we observed staff adhering to the checklists and signing them off. A rolling programme of monthly audits was in place for the checklist. The results showed 100% compliance in every month. However, only ten patient files per month were audited, equating to less than 2% of the total surgical procedures undertaken, which averaged 543 per month in the period April 2014 to March 2015. The provider informed us they were guided by their corporate arm with regard to sample sizes for audit purposes. However, we could not be assured the small sample size was sufficient to determine overall compliance with safe practices in theatre.
- The hospital had a service level agreement in place with a local acute trust to supply adequate blood in the hospital for patients requiring major surgery such as a hip revision or bariatric surgery. If further or unplanned supplies were needed the hospital could be in receipt of blood within 20 minutes.
- Scenarios were held on a regular basis to ensure staff responded appropriately. The week before our inspection staff had responded to a staged situation involving a patient with a large blood loss.

Nursing staffing

- The provider undertook the acuity level of patients on the wards at 2pm each day retrospectively. The tool used was adapted from a tool that had been used widely across the NHS, private sector and in some hospitals overseas for ensuring correct nurse staffing levels
- The nurse to patient ratio was 1:4 and staff were allocated patients to be responsible for when they came on duty.
- Qualified nurses were responsible for any tasks they had requested care assistants to undertake.
- During our inspection all the nursing staff we spoke with told us they had enough staff on duty to deliver good quality care even though they were sometimes very busy.
- Patients told us there were sufficient staff to meet their needs during their visit to the hospital and the care they received from those staff was extremely good.
- The provider informed us there was a ratio of 1:1.9 nurse managers to nurse team leaders, one nurse team leader to other nurses of 1:2 and a ratio of 1: 0.5 of nurses to care assistants.
- Usage of agency nurses was minimal for the year April 2014 to March 2015.
- During periods of sickness and annual leave staff generally undertook additional hours to ensure cover was acceptable. This meant only staff that knew the hospital and had undertaken an appropriate induction and competency based framework worked in the hospital.
- Daily staffing levels in each area was flexed dependent upon the type of surgical procedures being undertaken. Procedures requiring a general anaesthetic required a higher nurse to patient ratio than local anaesthetics.
- An escalation policy was in place for concerns relating to nurse staffing levels. Staff were aware of it and knew what to do if they had concerns about safe staffing levels.

Surgical staffing

- There were 347 consultants who had been granted practicing privileges at the hospital. The majority of these also worked at a local NHS trust. They included consultants with specialties such as ophthalmology, urology and orthopaedics. The term "practising privileges" refers to medical practitioners being granted the right to practise in a hospital. Staff informed us they had no concerns obtaining help quickly if it was needed to review a patient's care.
- The two resident medical officers provided 24-hour medical cover for patients. They alternated their working hours to ensure one doctor was always on duty.
- Operating theatres were generally in use between 8.30 am and 9.00 pm Monday to Friday and 8.30am and 5 pm on a Saturday.
- The hospital worked within the recommendations of the 'Association for Perioperative Practice' with regard to

numbers of staff on duty during a standard operating list. This comprised of two nurses, an operating department practitioner, a healthcare assistant, a consultant and an anaesthetist.
- If an operation was scheduled when other departments or services were not normally available this was discussed and planned for at the time of the booking of the procedure.
- If a patient was required to return to theatre out of hours because of complications, a comprehensive on-call system was in place to notify staff quickly.

Major incident awareness and training

- The hospital did not have designated roles and responsibilities in the nearby trust's major incident policy. However, a senior nurse informed us they would always give assistance if requested to do so.
- We were informed of a recent accident occurring outside the hospital when staff had responded appropriately.
- The hospital had a comprehensive business continuity plan in place in case of potential emergencies, which was reviewed in June 2015. The plan included how to respond to a widespread fire or flood, prolonged loss of power, water or communications. Staff were aware of the plans in place. Teams of staff had specific roles to co-ordinate the emergency response.

Are surgery services effective?

Good

Staffing was managed effectively to ensure patients received good care with access to medical care obtained in a timely manner. Staff were well trained and records kept securely. Evidence based care and treatment was delivered to patients following national guidance by competent staff. The hospital provided a seven day week with patients having good access to information.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Evidence-based care and treatment

- The delivery of day surgery was consistent with the 'British Association of Day Surgery (BADS).' BADS promotes excellence in day surgery and provides information to patients, relatives, careers, healthcare professionals and members of the association.
- Patient needs were assessed throughout their care pathway and care and treatment was generally delivered in line with 'National Institute of Health and Care Excellence' (NICE) quality standards and the Royal Colleges guidelines.
- NICE guidance was sometimes referred to within the care pathways, for example, reducing the risk of venous thromboembolism (VTE).
- The hospital did not follow the recommended NICE guidance for medicine prophylaxis for VTE. Prophylaxis means medication or a treatment designed and used to help prevent a disease from occurring. Patients who had received a planned hip or knee replacement had not been given the NICE recommended treatment for 28 to 35 days post operatively; this was highlighted on the hospital's risk register and regularly reviewed. The hospital followed instead a process which was in line with that of the local NHS acute trust to ensure a standardised regime across the local area which was familiar to all consultants and GP's.
- Of the five 2014 - 2015, commissioning for quality and innovation (CQUIN) requirements by the clinical commissioning group (CCG) all but one had been met by the hospital. These had included the friends and family test and 'theatre time to starve'. This is the length of time between stopping a patient eating and drinking and going to theatre for their operation. The latter was not met but significant improvement was reported by the CCG.
- Three CQUINS had been agreed with commissioners for 2015/2016 and included older persons and dementia

champions, ensuring patients were adequately hydrated prior to theatre and staff training to ensure patients received appropriate nutritional advice during admission.
- There had been no incidents of surgical sepsis in the previous twelve months. Staff used a pro-forma for documenting patients' physiological signs post-operatively with a clear pathway in place if the signs were outside the normal parameters with a possible risk of sepsis.
- Comprehensive care pathways were in place for patients undergoing any form of anaesthesia for surgery including local and general. This included main quality indicators of anaesthesia, management of pain and recommendations for the management of post discharge complications. This meant there was a standard system in place for each patient admitted.

Pain relief

- Prior to surgery patients were informed about pain management following their operation. This enabled the patient to communicate effectively with staff and obtain the correct pain relieving medication following their surgery.
- We were informed pain relief was given as routine on discharge.
- The theatre care pathway ensured staff enquired about pain from patients and adequate pain relief given in a timely manner. On reviewing two patients post-surgery we found neither of them were in any pain or distress.
- The hospital's patient satisfaction survey for 2014 indicated that 98% of patients thought staff did everything they could to control their pain.
- The hospital was supported by a pain team from a local NHS acute trust with a pain specialist nurse available if required.
- For patients requiring palliative (end of life) pain management support this was obtained from doctors who worked at a local hospice.

Nutrition and hydration

- All patients were screened for malnutrition and the risk of malnutrition on admission. This included patients attending for day-case surgery only for both local and general anaesthetics. The tool used was the Malnutrition Universal Screening Tool (MUST).
- Staff followed guidance on fasting prior to surgery which was based on best practice. For healthy patients who required a general anaesthetic this allowed them to eat up to six hours prior to surgery and to drink water up to two hours before.
- One of Spire's objectives was to improve the hydration of patients before they underwent surgery and to ensure patients were encouraged to drink water up to two hours before they went to theatre. We were informed that patients received a phone text message at home reminding them of the need to drink.
- One patient we spoke with had not received the text message and had not had anything to drink for three and a quarter hours prior to surgery. However, we confirmed that fasting instructions were provided verbally at pre-assessment and in writing in the admission paperwork, so we were assured patients were in receipt of the information and were not solely reliant on the text messaging service.
- The hospital provided three meals a day for in-patients. Choices could be seen on the menus plus a daily 'special'. We were told the chef routinely saw all patients who had been in hospital for longer than four days to discuss any individual needs
- Special diets were catered for including vegetarian, Kosher and Halal foods
- If patients were unable to feed themselves staff would assist them.
- The ward kitchens had sufficient food stocks to enable staff to supply sandwiches, soup, toast and cereals if patients were hungry at any time.
- A white board in ward kitchens indicated those patients requiring special diets.
- Nurses informed us of patients they would refer to a dietician; these included those with a weight loss or patients receiving treatment for cancer.
- Nutrition and hydration prompts were part of the rounding charts in use by staff on the ward to ensure their patients were safe and comfortable.

Patient outcomes

- Under a service level agreement with a local acute NHS trust, twelve patients had been transferred in the year April 2014 to March 2015 because of post-operative complications.
- For the time period July to September 2014 the proportion of unplanned transfers was found to be

'similar to expected' when compared to other independent acute hospitals we hold this data for. However the rate had increased between January and March 2015.

- There had been 18 cases of unplanned readmission within 29 days of discharge in the reporting period April 2014 and March 2015. CQC had assessed the proportion of unplanned readmissions to be 'similar to expected' compared to other independent acute hospitals we hold this data for. There had been a falling rate of readmissions over the same period.
- The hospital took part in six national audits focussing on patient outcomes; these included the national joint registry and surgical site infection rates.
- Patient reported outcome measures (PROMS) for NHS patients only for the period April 2014 to December 2014 assessed patient outcomes for the repair of groin hernias were better compared to the England average. For hip replacements the results were similar to expected.
- Patients did not leave the hospital after their procedure until they had received a discharge letter for their GP. This ensured the GP knew as soon as possible of the procedure and any further treatment required.

Competent staff

- The provider had put systems in place to ensure qualified doctors and nurses' registration status had been renewed on an annual basis.
- However, shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. Information from the hospital weekly compliance report identified the required documentation for hospital wide consultants. The information showed that on 11 August 2015 84% of consultants had received a practice appraisal and 71% had received a biennial review. Information was not available for consultant General Medical Council (GMC) registration status for the 11 August. However, the compliance level for GMC registration for the 7 August 2015 was identified as 98% on the weekly compliance report.
- Although the percentages of compliance had increased since 15 April 2015, the provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of actions that would be put in place immediately to achieve compliance and mitigate risk. The Consultant's Handbook stated that consultants were at risk of suspension if they did not provide up-to-date documents.
- By the 20 August 2015, 84% of consultants had provided all the required documentation. Thirty-four consultants practising privileges were suspended until the documents were submitted to the hospital. Staff had been made aware of whom the consultants were. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.
- The percentage of staff that had an appraisal in 2014 was 94%. We reviewed three appraisal documents and found the template used for this purpose had been fully completed. Personal objectives had been added to standard corporate ones and there was evidence of one-to-one meetings with line managers.
- For consultants with practising privileges, the compliance lead in the hospital kept a record of their employing NHS Trust together with the responsible officer's (RO) name. The term "practising privileges" refers to medical practitioners being granted the right to practise in a hospital.
- Applications for practising privileges from consultants were granted or rejected by the Medical Advisory Committee (MAC) of the provider. This involved checking their suitability to work at the hospital, checks on their qualifications as well as references and disclosure and barring checking with the Disclosure and Barring Service (DBS). There was a system in place to ensure doctors had undergone revalidation.
- We looked at data relating to the numbers of consultants who had undergone an appraisal in the previous year undertaken by their primary employing trust; this was 84%.
- We were informed there had been no competency issues with regard to any of the consultants working in the hospital. There were processes in place for all staff working for the provider to ensure issues were dealt

with appropriately. The responsible person for medical staff at the employing NHS trust would be contacted if concerns regarding a consultant's working practices were raised.

- A group of nurses within the hospital had been set up to review the processes required for nurse revalidation for the Spire group of hospitals. Validation is a process that all nurses and midwives will need to undertake to demonstrate they practise safely and effectively throughout their career in order to protect the public; it will commence in April 2016. The group had developed a draft version of a portfolio for nurses to use to help them in the revalidation process.
- A formal comprehensive induction system was in place for new staff which included local induction for the department/ward they were working in as well as two days clinical training. Induction included responding to a cardiac arrest, infection control and reporting adverse events. The clinical training programme was on-going and held monthly; existing staff were required to attend every year as part of their mandatory training. The training programme was updated on a regular basis and at the time of inspection included nurse revalidation and prevention of thromboembolism. Staff remained supernumerary (additional to the rostered staff) for three weeks. New staff were expected to complete their induction programme and be signed off as competent within this timescale.
- Competency programmes were available for all groups of staff on the provider's intranet system including core and specific competencies. For example, for qualified staff one of the extra competencies was blood transfusions. Staff were not permitted to undertake tasks until they had been deemed competent to do so.
- The provider was reviewing requirements for care certification for health care assistants. At the time of our inspection there was no National Vocational Qualification training offered to care assistants who were new into the role. Formal documented assessments on their competencies were undertaken following induction and a mentor was assigned to all new care assistants.
- Staff were able to access additional training to ensure they kept up-to-date and acquired additional skills to ensure good quality care for patients. We reviewed a list of additional training that had been completed in 2015 or been booked to attend either on site or externally. These included transfusion, recovery skills and crisis management and palliative care. Staff theatres and wards had been identified. A staff member we spoke with told us there was always a lot to learn because of the different patient's needs they cared for but that senior staff were always approachable if they required help.
- The critical care lead nurse for the hospital was able to access the local acute trust to keep updated with clinical practice and have competencies assessed.

Multidisciplinary working (in relation to this core service only)

- A multidisciplinary review was held for any patient requiring it and referrals were made to an acute trust when necessary.
- Specialty oncology nurses were involved in the meetings if this was appropriate.
- A team brief was held in theatre prior to each list commencing. These were brief face-to-face meetings with staff involved in the operating list. Any concerns about safety and the forthcoming operating list were discussed. The meetings were not documented although we were informed there were plans for this in the future. Following our inspection we were informed by the provider this had commenced.
- A physiotherapy service was available in the hospital. This was provided by a team of qualified professionals who saw all patients requiring physiotherapy input, for example following joint surgery. Physiotherapists we spoke with felt they were providing a good service for patients.

Seven-day services

- The hospital had four operating theatres and a minor procedures theatre which were utilised between five and six days a week. An on-call rota was in place for staff able to attend quickly if a theatre was needed on a Sunday or out-of-hours.
- On-call arrangements were in place to ensure patients had speedy access to services.
- Physiotherapy services were provided seven days a week and an on-call system was in operation if they were required out-of-hours.
- Consultants were responsible for the care of their patients from pre-admission consultation until the conclusion of their episode of care.

Good

Surgery

- Medication could be prescribed and dispensed to patients prior to their discharge. This was available at all times the hospital was open. A pharmacy on-call system was operated to provide a seven day service when required.
- Patients had access to the hospital and its staff 24 hours a day as an inpatient and following their discharge when it was required.
- Other services, for example x-ray facilities were on-call out-of-hours and equipment engineers were called for when it was necessary.
- We spoke with a consultant about supporting services such as histology and pathology. They told us blood tests were returned very quickly, mostly the same day but that histology (tissue specimens) results could take up to two or three weeks unless they were marked 'urgent'. In that case they were returned within three or four days.

Access to information

- For some patients referral notes from a GP were available with comprehensive patient information prior to their initial consultation. For example, NHS e-referral' patients. This ensured the hospital had the information required to make informed judgements about patient care.
- Patients were required to complete a comprehensive pre-admission questionnaire prior to surgery which included their past medical history and their current medicines. Dependent upon a patient's history, patients may be requested to undertake a physical face to face meeting with assessment staff where a number of investigations could take place, for example, an electrocardiogram or ECG. This would provide health professionals information of the patient's current state of health.
- For some private patients who had previously undergone surgery the assessment team requested the patient's permission to contact their GP for further information. This meant care could be tailored to an individual patient's needs to ensure it was safe because they had access to the information required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a consent policy and staff we spoke with were aware of it. Within the policy was a section on ensuring the patient could make informed consent to treatment and what to do if they were unable to do so.
- A senior member of staff informed us the hospital occasionally treated patients who they were concerned lacked the capacity to make informed choices or give consent. Staff knew what to do in those circumstances and how to document it.
- Staff we spoke with had received training about consent and the Mental Capacity Act 2005 (MCA). Staff stated if they had concerns about a patient's capacity they would refer the issue to a senior member of staff. Senior members of staff were aware of their responsibilities under the Mental Capacity Act 2005.
- We reviewed three consent forms. All had been completed appropriately although one relative had acted as an interpreter prior to the signing of the consent.
- Patients we spoke with informed us they were given as much information as they required from their consultant prior to their operation to give informed consent to the procedure and any risks had been explained to them.
- In the past twelve months, the hospital had referred one patient for a Deprivation of Liberty Safeguard (DoLS) which had been granted. DoLS is part of the Mental Capacity Act 2005. This aims to make sure that people in such places as care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards ensured the hospital only deprived the patient of their liberty in a safe and correct way. The application was undertaken because it was in the best interests of the patient and there was no other way to look after them.

Are surgery services caring?

Good

All the patients and relatives we spoke with were overwhelmingly positive about the care they had received and the way staff treated them. We observed staff speaking in a friendly and polite manner to patients and treating them with dignity and respect as well as providing emotional support when required. Patients told us they were involved in their care and staff explained care and

treatment in a way they understood. The provider had achieved high scores in patient feedback from the NHS Friends and Family test and the hospital's satisfaction survey.

Compassionate care

- All the patients and relatives we spoke with were very complimentary about the staff and gave us positive feedback about the care they received. One patient told us 'all the staff are fantastic, nothing is too much trouble'; another said the care they had received was 'outstanding.'
- Staff spoke to patients in a polite and friendly manner.
- Several of the staff we spoke to said they had the time to talk to their patients and were able to give the care they wanted to. One nurse spoke of how rewarding her role was and that it made her proud to be a nurse.
- The hospital supported the 6Cs initiative. The 6Cs is a national initiative to promote care, compassion, competence, communication, courage and commitment. We saw posters displayed promoting the 6Cs, and some of the nursing staff were able to talk to us about it.
- Patients told us staff treated them with respect and their dignity was maintained. We observed nurses knocking on room doors before entering and waiting for a response before entering. The hospital conducted a patient satisfaction survey every month and between January 2015 and June 2015 at least 98% of patients said they had always been treated with respect and dignity.
- Patients also told us the staff had time to care without rushing and patients felt their wellbeing really mattered to staff.
- The NHS 'Friends and Family Test' is a satisfaction survey that measures patients' satisfaction with the care they have received and asks if they would recommend the service to their friends and family. For the period October 2014 to March 2015 around 80% of patients who completed this would recommend this hospital. Response rates for this period were between 20% and 40%. The monthly hospital survey asked the same question and for the period between January 2015 and June 2015 this survey showed that at least 98% of patients would recommend the hospital to their friends and family. It can therefore be seen that there is a difference of 18% who would recommend the hospital in the two questionnaires.

Understanding and involvement of patients and those close to them

- Patient records we looked at included a preadmission assessment that took into account individual needs and preferences for example dietary requirements.
- Patients and relatives told us they had felt involved in their care. They told us they had received full explanations of all procedures and the care they would need following their operation. The hospital's patient satisfaction survey, for the period between for January 2015 and June 2015 showed that between 88% and 94% of patients said they were involved as much as they wanted to be in decisions about their care. We observed staff explaining to patients exactly what would happen after their operation and we saw examples of written information that was given to patient's to take home.

Emotional support

- We observed staff giving reassurance to patients. For example we witnessed staff encouraging a patient as they mobilised for the first time following knee surgery. During our visit one of the patients required extra emotional support, we saw a nurse spend time with this patient and made arrangements for their priest to visit.

Are surgery services responsive?

Good

Access to care and treatment was monitored and exceeded the national average. Staff acknowledged patient's individual needs and responded to them in an appropriate way although we were not assured a suitable translator was always obtained for patients whose first language was not English. Staff had a good understanding of the complaints process and the hospital learned from complaints, changing care practices if required.

Service planning and delivery to meet the needs of local people

- The hospital had been established in 1989 under the ownership of a different provider as a purpose built private hospital. In 2007 the hospital changed ownership. Whilst the focus had remained on the core of private patient business, the hospital had attracted

additional NHS patients through local contracts with NHS trusts and commissioners in Leicester. This had resulted in local people receiving timely interventions for their required procedures.
- Equality and diversity training for staff meant the diverse needs of all patients were met.

Access and flow

- The national standard for referral to treatment (RTT) time states that 95% of patients should start consultant led treatment within 18 weeks of referral. Data showed that between April 2014 and March 2015 100% of patients were seen within this 18 week target.
- Appointments for surgical procedures were routinely made on the same day as the patient saw the consultant at their initial outpatient appointment.
- Occupancy rates in the in-patient area were below 'full' at all times between April 2014 and March 2015. This meant any day-case patients who were not fit enough to go home on the day of their surgery were able to stay overnight.
- Only qualified nursing staff who had been trained or were competent in the process undertook pre-operative assessments of patients.
- All pathways stated the average length of stay a patient should experience for the procedure they had undergone. Staff told us this was generally achieved with the good care and treatment they were able to give patients. However, if complications occurred the time could be extended.

Meeting people's individual needs

- Relatives were able to stay with their loved ones overnight if this was required; a collapsible bed was provided for them.
- The hospital used representatives from an interpreting company based locally for accessing interpreters for patients whose first language was not English.
- A patient information leaflet "Pain relief after your operation," was handed to patients prior to their surgery. It explained the different types of pain relief and how they could be administered.
- Staff informed us they had many colleagues who could speak different languages and who were often used to act as interpreters when required.
- We saw a care plan for a patient whose first language was not English; this had been completed appropriately and indicated a family member would translate for them. Documentation stated that they had been rung to ensure the patient received the correct meal. The use of family and carers is not considered good practice when clinical issues are discussed.
- In the same care plan documentation was in place that confirmed the patient had signed a consent form to receive blood. It was not signed by the translator who, we were informed had been present when consent had been given. This would indicate the patient may not have understood what they were signing for as the translator was also required to sign the consent form as part of the process.
- Any information leaflets given to patients were in English only. A member of staff told us they could obtain leaflets in other languages if required.
- Specialist nurses for specific patient groups were available, for example, stoma care and breast care, although a diabetic specialist nurse was not available. The endocrinologist would be made aware of any diabetic patient admitted.
- We saw that patients with specific needs for example, poor mobility, had been individually assessed, their needs addressed and documented.
- All people over the age of 75 had been assessed for dementia as part of the hospital's targets for commissioning for quality and innovation (CQUIN) requirements. Any patient with a raised score was referred back to their GP for follow-up.
- Patients living with a dementia were able to have their main carer present for most of their treatment.
- A senior member of staff had set up a new dementia group in the hospital six months prior to our visit. Personnel included patient services staff, housekeepers, the resident medical officer and nursing staff. The group lead had undertaken training for chefs and housekeeping staff to raise their awareness of the condition and improve the care for patients living with dementia by teaching staff how to respond to them.
- Although there was no room available specifically equipped for patients with a dementia, plans were in place to develop one during the refurbishment programme.
- Signage in all areas was small and only in English which could have proved a challenge for those with poor sight or whose first language was not English. The provider informed us after the inspection that patients were collected and accompanied by a member of staff from

the waiting area to the department they were visiting. Visitors were directed by reception staff to the area they wished to visit verbally and were accompanied where additional assistance was required.
- A pastoral service was available for patients to provide support for families and their relatives if required. This also included an out of hours service when necessary.
- The provider informed us key members of staff had received training in breaking bad news to families; we did not speak with any of those staff during our visit.
- The hospital had a chaperone policy in place. Staff we spoke with told us that almost every time a chaperone was required they were asked to assist. However, occasionally they did not realise doctors were present on the wards and doctors did not always approach staff to provide a chaperone.
- Staff could access social services support to aid patients with discharge arrangements if required Staff informed us they received a good service when this was used.
- Patient information leaflets, followed national guidance and were available for those surgical procedures undertaken at the hospital.

Learning from complaints and concerns

- The provider had received 77 complaints from patients or relatives in 2014. They had policies and procedures in place relating to complaint handling. This included ensuring all complaints were logged and reported.
- Complaints leaflets were available ('Please talk to us') for patients to use when required. It explained the three stage process used for complaint handling.
- Staff informed us they would speak to anyone raising a complaint at the time they raised it. The aim was to try and resolve the issue at the earliest opportunity.
- A senior manager from the hospital wrote to all complainants, reviewed the complaint and sent a written response after an investigation had been completed.
- There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why.
- The Clinical Governance Committee reviewed all complaints and discussed possible trends. If the complaint involved a consultant this was raised with the chair of the Medical Advisory Committee (MAC) to take forward.
- Complaints were discussed with all members of staff with any learning points identified and addressed. The meant the hospital learned from complaints and improved services where appropriate.
- The hospital's Medical Advisory Committee regularly reviewed all complaints involving a clinical element.
- Complaints were discussed in the provider's quality report. The report dated June 2015 reviewed 13 complaints. Any actions taken to respond to the issues and changes of practice were documented.

Are surgery services well-led?

Requires improvement

Shortfalls were found in hospital wide consultants' information; with the exception of consultant staff working with children and young people and termination of pregnancy services. We escalated these findings to the provider who acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. Immediate actions were implemented by a senior manager to achieve compliance and mitigate risk. Despite this, by the 20 August 2015, 84% of consultants had provided all the required documentation.

However the hospital had a governance system in place which included an audit system. Morale was excellent with staff talking positively about the organisation and their local management team. Staff felt listened to and supported.

Vision and strategy for this service

- The staff we spoke with were aware of the provider's purpose; providing excellent individualised care to all patient and generating income.
- Staff were aware of the plans for refurbishment in 2015/16 and looking forward to it. No date had been set for the commencement of this work. Since our inspection we have been informed the work commenced on 1 October 2015.
- Senior staff had knowledge of a new contract awarded to the hospital, which would mean additional services being required for children and young people. Plans for this were just beginning.

Good

Surgery

Governance, risk management and quality measurement

- Shortfalls in the receipt of medical staff information were monitored by the hospital. These shortfalls included up to date information on whole practice appraisals, medical indemnity, disclosure and barring checks, biennial review and General Medical Council registration expiry dates. We escalated these findings to the provider who acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. A senior manager informed us that actions would be put in place immediately to achieve compliance and mitigate risk. Despite this, by the 20 August 2015, 84% of consultants had provided all the required documentation. Thirty-four consultants practising privileges were suspended until they had submitted their documents to the hospital.
- A rolling programme of monthly audits was in place for example, five steps to safer surgery checklists and infection control. The results showed consistent high levels of completion.
- The hospital had a governance process in place as laid out in the clinical governance and quality assurance policy dated October 2014, which incorporated the governance structure and reporting channels.
- Eleven different staff groups met to discuss issues related to incidents, risk, complaints management and clinical audits. These groups included the hospital's medical advisory committee and clinical governance committee. The latter fed into the provider's executive meetings and upwards to the Board. All staff groups were represented.
- Team meetings were held in each department and ward including theatres. These were used for the passing of two-way information. Staff forums gave staff the opportunity to raise issues.
- The risk register was up to date. It documented a named individual responsible for the actions taken to reduce the risk with a review date. The risk register was monitored through the clinical governance committee meeting.
- The clinical governance meeting was held monthly and included items such as medicines management, health and safety and infection control.
- There was a positive working relationship with the commissioners of the service, a local clinical commissioning group (CCG). Senior managers met with the commissioners quarterly to review the hospital's performance via their results of specific measured outcomes for quality and innovation (CQUIN). Three CQUIN's were in place for the year 2015/16. The hospital provided the CCG with a monthly report on the progress of the CQUIN's.
- The last visit by the local CCG was in May 2015. Actions had been highlighted including the documentation of the volume of fluid taken by a patient pre-operatively and ensuring temporary closure mechanisms were used on sharps bins; these had been actioned.
- The matron was aware of the new regulation relating to Duty of Candour and was aware of their responsibilities. She was able to assure us the hospital viewed their duty seriously and was able to give an example of where the hospital had apologised to a patient following an accident although the patient had not suffered any serious injury.

Leadership of service

- Team leaders were available in all areas of the hospital and were visible to staff. Staff told us they knew who to approach if they had any concerns and would not hesitate to do so.
- The hospital had a matron and medical director who provided professional leadership for all clinical staff. Both of those members of staff were visible and staff informed us of their ability to approach them without question for guidance and support when necessary.
- All the staff we spoke with described both members of the senior team as having adopted an 'open door' policy.

Culture within the service

- Staff we spoke with told us of their commitment to providing safe, compassionate and caring services to their patients. They spoke positively about the morale in the hospital and the care they delivered; we saw this when undertaking observations Staff said that although at times they could be very busy they felt they had the time to care for their patients on an individual basis; this created a calm atmosphere in the hospital which benefited both patients and staff. Staff felt valued and involved in operational changes and told us they were proud to work at the hospital.

Good

Surgery

- There was an open culture in the hospital with non-medical staff feeling able to speak to medical staff on an equal footing.
- We viewed the staff safety culture survey results for 2014. Two of the top scoring items included peer support for staff (86%) and ensuring patient safety issues were resolved to prevent any reoccurrence (85%). The five bottom scoring items had actions to address each of them. These included not having enough staff to handle the workload (46%) and staff feeling able to question the decisions of actions of those with more authority (63%)
- We viewed the results of the staff survey for 2014.Top scores included the fact that staff believed that what they did at work made a positive difference to the hospital (98%) and 94% of staff got personal satisfaction for the work they did. Only 39% thought other departments understood the impact their action had on another staff team and 65% thought senior managers provided the rationale for decisions that impacted on a member of staff.
- As a result of the 2014 staff survey the hospital had increased its staff by 11.8 whole time equivalents in response to comments made. The 2015 staff survey will be undertaken later in the year.
- The provider had an equal opportunity policy in place.

Public and staff engagement

- The matron informed us it had been difficult to involve patients as much as they would like to. Phone calls had been made to many ex-patients and a new patient focus group had been set up with three ex-patients; two more had been recruited prior to our visit. Two meetings had been held to help resolve any concerns raised by patients.
- Staff had encouraged patients and visitors to visit a newly refurbished room on Ward 2 to receive their feedback on décor and layout. Some patients had been asked to stay overnight in the room. Their comments had been noted and would be taken into consideration prior to the final design of the new rooms being decided upon. Matron informed us the taps would be altered because of feedback received.
- A senior member of staff informed us the relationship between the local Healthwatch group and the hospital was very good. Healthwatch had not received any complaints relating to the hospital.

Innovation, improvement and sustainability

- Two senior nurse managers were developing a score card for the hospital which all departments will use to audit outcomes on a monthly basis for such issues as high impact interventions, cannula care, wound care and hand hygiene. Any low score areas will be targeted for improvement. The small team were hopeful that this will be rolled out corporately.

Good

Services for children and young people

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

Information about the service

Spire Leicester Hospital established its service for children and young people in 2013. The hospital offers limited outpatients consultation services for children under three. Services available to children and young people from the age of three to 18 include outpatient consultation, diagnostic testing, day case, overnight surgery and physiotherapy. The hospital did not offer critical or urgent care for children and young people.

From January 2014 to December 2014, the hospital held 148 outpatients appointments for under threes, 1796 appointments for three to 15 year olds and 806 appointments for 16 and 17 year olds. Children's appointments were equivalent to approximately 3% of the hospital's activity.

Most children came into the hospital as outpatients. In 2014, 12 patients who were under 16 stayed overnight as inpatients and 55 had day-case procedures. This was a 52% increase on 2013 activity levels. Many of the day case admissions were for ear, nose and throat (ENT) operations. There were 1313 paediatric outpatient first attendances and 1340 outpatient follow ups.

There were no wards or waiting areas specifically for children. Instead, staff adapted existing adult bedrooms with child or young person friendly duvet covers and books.

We spoke with nine parents, the lead paediatric nurse, three staff nurses, the critical care lead, an anaesthetist, one of the lead paediatric consultants, the matron and deputy matron.

Summary of findings

The children's service had a good track record on safety. The hospital safeguarded children and young people through offering care tailored to their needs. If a child was admitted overnight, a paediatric consultant and a children's nurse stayed on site to look after them. Staff working with children were qualified to 'National Society of Prevention of Cruelty to Children' safeguarding level three, in line with good practice. The children's nurses had specialist training in paediatric life support and the lead nurse promoted skills in nursing children.

The hospital routinely conducted a range of risk assessments and there were procedures to treat children whose health was deteriorating after an operation. However, some of these risk assessments were not signed or fully completed.

The hospital lacked specific waiting areas and consulting rooms for children, but staff minimised the risk of mixing with adults.

The children's services were relatively new and did not have a quality dashboard to monitor their performance over time. They had not developed systems to carry out benchmarking or clinical audits, which limited organisational learning. However, since the inspection we have been informed that a children's quality dashboard has been implemented.

Parents said their children received compassionate care. They said the hospital gave them good information and involved them in decisions about their child's treatment and care. Child friendly information was available for

Good

Services for children and young people

children about their procedures, nurses and consultants encouraged them to ask questions about their care. Nursing staff offered children and parents emotional support when needed. The hospital planned care for children taking into account emotional, spiritual, social, mental and physical needs.

Children's and young people's services were responsive and provided access at times to suit children, young people and their parents.

Nurses encouraged children to keep in touch with friends and family and the hospital provided beds in children's rooms and a meal if a parent wanted to say overnight. The service was sensitive to children who had been inpatients and introduced them to the environment through a visit and a pre-assessment appointment, so that everything would be familiar. Nurses and consultants ensured that children who had behavioural challenges also felt at home and were cared for well.

The service had a vision for expansion in the future. There was a positive culture and staff showed clear motivation to do their best for children and young people. There was a good risk management structure and children's nurses worked well with consultants to develop policies and plan services.

Are services for children and young people safe?

Good

We judged safety as good. Children were protected from avoidable harm and the service had a good safety record. The safety incident record for children and young people was good. The service was very new and had only treated a small number of children and no clinical incidents had occurred at the time of the inspection visit. However, discussions with staff confirmed that they were aware of how to report incidents and would not hesitate to do so.

The hospital safeguarded children and young people through offering care tailored to their needs. If a child was admitted overnight, a paediatric consultant and a children's nurse stayed on site to look after them. Staff were trained to level three in safeguarding, the appropriate level for treating children. Although there were no children only waiting rooms or consulting rooms, staff accompanied children through the process, limiting the risk.

The children's nurses had specialist training and the lead nurse promoted skills in nursing children, training non-specialist nurses in paediatric lifesaving skills. The service had a good safety record and there had been no serious incidents involving children or young people. There were procedures to treat children whose health was deteriorating after an operation. A range of risk assessments were in place. However, these risk assessments were not always fully completed or signed. We also observed information gaps in fluid charts and the absence of consultant signatures on either the preliminary discharge letter or young person's risk assessment. The hospital had not audited medical records for children.

There were no specific protocols for children or young people who had mental health problems or learning disabilities.

Incidents

- The safety incident record for children and young people was good. The service was very new and had only treated a small number of children and no clinical

incidents had occurred at the time of the inspection visit. However, discussions with staff confirmed that they were aware of how to report incidents and would not hesitate to do so.

- Managers could not identify any clinical incident, which had involved a child or young person. The hospital's adverse event reporting system contained one non-clinical concern relating to children. We saw that staff had taken the appropriate action in relation to this incident, which resulted in learning and a change in practice for the x-ray service. The change of practice was to ask patients and parents to leave their mobile phones or cameras outside the x-ray suite. The service implemented this to ensure that children and young people's dignity was respected while they were undergoing procedures.
- The service did not hold children's and young people's mortality and morbidity meetings. This was because the hospital specialised in straightforward procedures and operations for children, such as ear, nose and throat procedures.
- The lead children's nurse received national patient safety alerts for children. So far, they had not received issues of relevance to the hospital. For example, there was an alert regarding coin batteries in children's toys, but the hospital had no toys of this type.
- The hospital held a briefing session on the 'Duty of Candour' and nurses at all levels were clear about this. They told us they would have to explain, and apologise to the patient and their parents if nurses or clinicians made a mistake. They would also have to rectify the mistake if they had not done so previously. However, this situation had not arisen.

Cleanliness, infection control and hygiene

- The outpatient's area and equipment used for children appeared visibly clean; as did the recovery area, ward areas and the children's soft play area in outpatients.
- The hospital's facilities contractor cleaned the toys in outpatients every day, and recorded this. The lead children's nurse cleaned before and after each use, the toys she used with child inpatients. The hospital did not have a cleaning policy specifically for toys, but all toys were cleaned daily in outpatients and between each inpatient use.
- We observed nurses in outpatients and wards using hand gel frequently and washing their hands before and after seeing patients.
- Staff who worked with children had received online infection control training but this was not tailored to the care of children. The lead children's nurse was the link nurse for infection control. She used hand washing colouring packs with the children to encourage them to wash their hands.
- The service worked well with parents on infection control. We saw patient literature tailored to children on aftercare, which explained how to help prevent infections after an operation. We heard from parents that nurses gave them verbal advice on keeping wounds clean.
- When we inspected, the hospital had not audited children's infection control.

Environment and equipment

- The outpatient's service used an environmental checklist. This helped monitor whether toys available for children were compliant with national standards. It also helped ensure that items such as sharps (syringes), medicines and cleaning products were properly stored out of the reach of children.
- Resuscitation trolleys contained specialist equipment for children. We checked all of the resuscitation trolleys, which were located in outpatients, Ward Two and recovery. These included Broselow bags (bags with resuscitation equipment colour coded for children of different sizes.) All items were within their expiry date.

Medicines

- The hospital kept a range of medicines for use with children. We reviewed notes for three inpatient and three day case children. Information on children's allergies and analgesics (medicines to relieve pain) was well completed in patient records. We saw that all children had a good range of post-operative analgesics prescribed so that the nurse could respond quickly if a child was in pain. Allergies were clearly documented in patient notes. Children's weights were clearly documented, which ensured that a child would be prescribed the correct dosage of medication.
- The hospital had procedures to ensure the safety of controlled drugs administration. The use of controlled drugs required two qualified members of staff to check the medication and record this in the controlled drug book. For children's drugs, one member of staff had to be a registered children's nurse. The hospital pharmacist told us that copies of the children's 'British

National Formulae' (BNF) for drugs were available in pharmacy, on the wards and in outpatients. We saw a copy in the outpatients consulting room, which meant staff had access to the BNF for matters related to administration of drugs for children.

Records

- We reviewed 16 sets of children's notes and found that risk assessments such as for moving and handling were sometimes not fully completed or signed. Four records did not have completed fluid charts. Five sets of notes did not have consultant signatures on the young person's risk assessment. The hospital had not audited medical records for children.
- There was a system in place to ensure that medical records generated by staff holding practising privileges were available to staff or other providers who may be required to provide care or treatment to the patient.
- Care plans and nursing assessments were in line with the Nursing and Midwives Council guidance on record keeping. For example, they included notes of conversations and information given to the child's family.

Safeguarding

- The hospital checked in July 2015 whether its consultants had the correct level of safeguarding training to deal with children. Consultants could only be granted practising privileges (contracts enabling consultants working in the NHS to work in private hospitals) if they had correct and up to date training. The hospital confirmed that all 45 consultants who saw children at the hospital were qualified to level three in 'National Society for the Prevention of Cruelty to Children' safeguarding, in line with good practice.
- Children's nurses including the lead children's nurse who was the children's safeguarding lead and the matron, had level three safeguarding training accreditation
- The hospital set safeguarding standards for other clinicians who worked with children. It stipulated that anaesthetists who worked with children at the hospital should have level two safeguarding training, and confirmed that this was the case. The hospital's physiotherapists who worked with children had level three safeguarding training, in line with good practice.
- Staff and managers discussed safeguarding issues at monthly clinical governance and ward staff meetings, six weekly theatre staff meetings and monthly Spire matron cluster meetings. None of the safeguarding events at the hospital involved patients under the age of eighteen years.
- The hospital took measures to safeguard children and young people at risk of female genital mutilation (FGM). Spire Healthcare' s corporate policy , the 'Procedure for the care of Children and Young People in Spire Healthcare' outlined how staff should treat FGM as child abuse and make a safeguarding referral to the local authority.
- The hospital also had a local policy 'Safeguarding Children and Young People' written in June 2015. This clarified local standards and responsibilities, training, information sharing and multidisciplinary team arrangements.
- The hospital had a clear response if a child was abducted. The procedure for the care of children outlined what staff should do if a child was missing. If staff did not find the child within 15 to 30 minutes, the police and the safeguarding team would be alerted. There were also arrangements for children admitted under a Child Protection Plan, which included protocols for safeguarded children. However, there were no electronic alert systems to flag up children on the child protection register. Children on the child protection register are those at risk of abuse or neglect. This meant that this risk may not be immediately apparent to staff.
- Nurses were able to monitor child patients closely. The hospital admitted a limited number of children and young people at one time, usually a maximum of four. The lead children's nurse was able to supervise and care for them personally.

Mandatory training

- The children's nursing team received mandatory training to keep children safe. The hospital training target was to train 95% of staff on each mandatory subject. The training year ran from January to December. The hospital's records showed that the children's nursing team achieved 66.7%During our inspection, nurses told us that they were up to date, apart from one nurse who had not done two on-line modules.
- The children's lead nurse held the European paediatric intensive life support qualification. She was proactive in

training other nurses on basic and intensive life support for children during the monthly training days. She attended Spire Group networking days to further enhance her knowledge.
- Clinical staff treating and caring for children had life support training. Consultants and anaesthetists had European paediatric life support qualifications. Physiotherapists worked with children had European basic life support training.

Assessing and responding to patient risk

- Spire Leicester used the provider's corporate policy setting out criteria for admitting children, either for day case procedures or overnight. This stated that there should be five days' notice to parents of pre-assessment and that pre-assessment should take place at least two weeks before surgery. Clinicians carried out a clinical risk assessment at the same time as the pre-assessment. As far as possible, children had their operations as part of a children only list. The children's recovery area was partitioned off, rather than completely separate.
- The hospital managed the risk of a child's health deteriorating after an operation. They used the paediatric early warning system (PEWS), which was included in the patient's notes. A flowchart and observation guidelines were in use with the PEWs scoring to explain how staff needed to take action at various levels of risk. This ensured that a child was cared for according to their condition, and was monitored more frequently or transferred to another hospital if necessary.
- If a child remained at a high PEWs score, had respiratory or cardiac problems or excessive blood loss, the child would be transferred to the local acute NHS trust for urgent care. The provider detailed in a local procedure on child transfer the circumstances when this would apply, the handover and relevant responsibilities.
- The hospital had risk assessment tools to address frequent child health risks. These were for deterioration of a child patient under 16; chicken pox; child having blood tests; and a child who may hurt themselves. However, there were no specific arrangements outlined in the procedure for children or young people regarding children who had mental health problems or learning disabilities.
- The imaging department had a protocol for children and their level of exposure to magnetic resonance imaging and x- rays and relevant safe dosage levels. The service also maintained safety before x-ray exposure by routinely checking if young female patients might be pregnant.

Nursing staffing

- Staffing arrangements were safe for children and met Royal College of Nursing (RCN) guidelines. The children and young people's service was staffed by a children's lead nurse, and a children's recovery nurse in theatre. Another trained permanent children's nurse was on maternity leave when we visited. In addition, two children's nurses worked flexible hours, on the ward and in the outpatients department.
- The service did not employ agency nurses. If the service could not ensure that staffing was at a safe level, it did not admit children. When we inspected, the lead children's nurse was on holiday and no children were admitted for inpatient treatment that week. If a children's nurse became ill during her duty, the hospital would transfer children out to the local acute NHS trust where safe staffing levels using children's nurses could be assured.
- One parent stated that although the lead children's nurse appeared to be constantly present for the children, she did not have much time for a break. The hospital was in the process of recruiting another children's lead nurse. It recognised that staffing did not allow for an increase in child patient numbers or give flexibility for cover.

Medical staffing

- Medical staffing for children was safe. All children were cared for by a named consultant at all times. A named consultant paediatrician was available for liaison and immediate cover when a child was admitted.
- Staff told us that if a child or young person was admitted for an operation, the paediatrician would stay at the hospital as long as the child did. This meant that if the child stayed overnight, the paediatrician did too, providing out of hours cover. As a result, there was always a paediatrician available for liaison and advice, and who could treat the child within 30 minutes.

Major incident awareness and training

The hospital had a backup electricity generator so that children's services continued running during a power

Good

Services for children and young people

failure. The generator could cover essential services with one or two other functions such as x-ray machines and autoclaves. The generators were tested every month and serviced every six months.

Are services for children and young people effective?

Requires improvement

We judged effectiveness as requiring improvement.

The hospital did not have an identified children's audit plan, which meant that it had not learnt from formal clinical audits, benchmarking or tracking clinical outcomes. The service did not have performance indicators to measure trends in the quality of services for children and young people over time.However, since the inspection we have been informed that a children's quality dashboard had been implemented.

Multi-disciplinary team working resulted in positive outcomes for children. There was good partnership working with other organisations. Parents we spoke with were very pleased with the outcomes for their children. Food for children was appetising and tailored to their needs. The service had access to x-rays and pharmacy for children 24 hours, seven days a week. There were clear arrangements for parents and children to consent to operations and treatment.

The service benefitted from the NHS experience of its consultants and from networking with other Spire hospitals.

Evidence-based care and treatment

- Co-operative working and benchmarking within the Spire group helped to develop procedures and policies for children in Leicester. The lead children's nurse networked regularly with other Spire Hospitals with larger and more established children's services. This networking produced corporate policies such as the 'Procedure for the care of children'. However, because managers agreed these policies shortly before our inspection, the service had not had time to audit compliance.

Pain relief

- The children's lead nurse was responsible for children's post-operative pain relief. She was qualified in palliative care and the training had included several modules on pain control and pain relief. Pain relief training was planned for the other permanent full time children's nurse.
- The hospital had a pain management policy for children. Parents told us that nurses managed their children's pain well.

Nutrition and hydration

- The hospital provided food for children according to their age, height and weight. There was an adapted menu for very small children. At pre-operative assessment stage, the hospital asked the child and parents about dietary needs and preferences. They tailored catering according to the child's needs. Food allergies were marked on a white board in the kitchen.
- After an operation, the child could choose to have a picnic box of easily digestible food. Typically this would contain sandwiches on white or brown bread, a fruit bag, a packet of crispy snacks and a fruit juice. The kitchens made sandwiches more exciting for children by cutting them into dolphin shapes. Parents we spoke with were satisfied that the food for children and young people was attractive and nutritious.
- The hospital had clear pre-operation fasting guidelines which were listed in the 'Procedure for Children and Young People.' Parents told us that consultants gave them clear instructions on their child's fasting at the pre-admission meeting.
- The hospital dietician worked with paediatric patients at the local NHS trust and was available to provide advice on paediatric dietary issues.

Patient outcomes

- The hospital set up the service for children and young people in 2013. It started with small numbers of children and staff. So far it had not had enough nursing staff to carry out formal audits on agreed guidance such as that from the National Institute of Clinical Excellence (NICE) or the Royal College of Surgeons, for example on asthma or diabetes care for children. As a result the service had not been able to learn from these and improve practices.
- The service did not monitor patient outcomes and had not established quality monitoring measures. It lacked performance indicators to measure trends in the quality

of services for children and young people over time.However, since the inspection we have been informed that a children's quality dashboard had been implemented.
- Patients we spoke to were pleased with the outcomes for their children. For example, they told us about a tonsillectomy which resulted in easier breathing, and an operation to correct folded ears, which boosted the child's confidence.

Competent staff

- We were informed there had been no competency issues with regard to any of the consultants working in the hospital. There were processes in place for all staff working for the provider to ensure issues were dealt with appropriately. The responsible person for medical staff at the employing NHS trust would be contacted if concerns regarding a consultant's working practices were raised.
- The provider had put systems in place to ensure qualified doctors and nurses' registration status had been renewed on an annual basis.
- Nurses told us they had appraisals. These meetings took place at the beginning, middle and end of every year. The two permanent nurses at work had their appraisals, and the nurse on maternity leave would have an update and appraisal meeting on her return. When we visited, they had received their January and June 2015 objective setting and follow up. They thought the meetings were useful. They discussed hospital values, personal and organisational objectives and training needs.
- The children's nursing team were experienced registered children's nurses. The children's lead nurse had experience with children with communication and learning difficulties, and skills in paediatric bereavement and palliative care. The children's outpatient's nurse had extensive experience of caring for children in outpatients settings.

Multidisciplinary working

- The service had a policy for the transfer of a sick child to the local NHS trust, written in July 2015. This included briefing parents during pre-assessment about the possibility of transfer. The policy outlined the urgent and non-urgent circumstances under which a child might be transferred and handover arrangements.
- Multidisciplinary teams could be organised for children with complex needs. The hospital had an agreement with an external provider to organise quick assessments involving, for example, paediatricians, occupational and speech therapists.

Seven-day services

- The lead paediatric consultant and lead nurse ensured that if a child was admitted overnight they were well cared for. The clinicians stayed on site overnight, offered reassurance to the children and could respond quickly if needed.
- Diagnostics services such as X rays and pharmacy services for children were available seven days a week. The hospital had agreements with external providers to ensure these were available.

Access to information

- Children's nurses encouraged the use of 'Personal Child Health Records' (Red books) so that parents had a continuous record of their child's growth and development, and could share the information with other health professionals. The lead nurse planned to start their use with parents when the new baby immunisation clinic opened in September 2015.
- We found that discharge forms were informative and timely. Clinicians sent care summaries to a child's GP, usually within two weeks, to ensure that children continued to be cared for in the community.

Consent

- Staff understood arrangements for consent and the relevant legislation. The hospital had different rules for children and young people at different ages. The hospital's 'Procedure for the Care of Children' made the patient's best interests central to the process. If a young person was under 16 and wished to consent to their own treatment, the treating doctor assessed whether the young person would have the maturity and intelligence (known as Gillick Competency) to understand the nature of treatments. They would give the young person time to consider all the options.
- Consent forms were easy for patients for follow. The parental agreement to investigation or treatment was in plain English and explained parental responsibility and who could give consent. The child or young person

could also add their signature to this form. There was also a 'confirmation of consent' box for the clinician to sign. We reviewed these forms, which were correctly completed.

- Nurses told us that if parents were not capable of providing consent, they would act in the child's best interests. They explained that they would refer to the Spire Group's Consent Policy and consult the group's legal team.
- Parents told us the hospital gave them time to make an informed choice about treatment. They could seek further advice if necessary and felt the process included their child's point of view. Clinicians offered parents helpful information about their options. Parents told us that the anaesthetist explained the process to them before the operation.

Are services for children and young people caring?

Good

Parents said their children had received compassionate care and they were fully informed and involved in decisions about their child's treatment and care. Child-friendly information was available for children about their procedures, and nurses and consultants encouraged them to ask questions about their care.

Nursing staff offered children and parents emotional support when needed. The hospital planned care for children taking into account emotional, spiritual, social, mental and physical needs.

Compassionate care

- We spoke with 11 parents and/or guardians who informed us that the lead children's nurse looked after a maximum of four or five children as inpatients; often though there were only two or three children at any one time. The nurse was able to supervise the children, play and sing with them and involve clinicians as needed. Parents told us the children's lead nurse responded quickly if their child was in pain or discomfort.
- We reviewed ten recent patient surveys, which children and young people had completed. Most patients were very pleased with communication before, during and after the treatment. Everyone who responded stated that the nursing care was very good or excellent. However, one young person felt the nurse call button and pre-admission visit were poorly explained.
- We observed the children's nurse and consultant interacted very well with children who had come to the hospital for an operation. Nurses were compassionate and caring with children young people and their relatives.
- Staff respected the privacy and dignity of children and young people. No child was examined without a chaperone present, in addition to the parent or guardian.

Understanding and involvement of patients and those close to them

- Patient and parent feedback showed they were satisfied with communication and care. We heard from parents how paediatric nurses were sympathetic and encouraging towards children and provided play, reassurance and advice.
- Information and support was provided in a child-friendly format to help children make decisions about their own care, including an attractive set of leaflets for children about surgical procedures.
- Children, young people and their parents were involved in care plans. We heard from parents that they discussed the options with clinicians for treatment and care for their children going forward. This enabled them to weigh up the risks and advantages of a given treatment.
- Older children were able to talk to a clinician without their parent(s) present. The hospital had a clear policy on consent at different age ranges, and that 16 to 17 year olds were entitled to withhold consent. The treating doctor would have to decide whether the young person had the competence to make their own decision.

Emotional support

- Staff provided emotional support. Children came to the hospital on pre-operative familiarisation visits where they met nurses, clinicians and the anaesthetist. This was important in reducing their anxiety when they were away from home. One of the paediatric nurses was on hand to play with children who were scared or upset.

Good

Services for children and young people

We heard from parents how the paediatric lead nurse supported and reassured them at sensitive times, for example if their child was slow to recover from anaesthetic.

- Parents told us that consultants tailored services to the child or young person and took a range of emotional, spiritual, mental and physical factors into account. One set of medical records we reviewed included a school report and details of hobbies such as yoga. This ensured that consultants were able to better focus post-operative care.
- Consultants and managers explained the options and possible timescales to parents without exerting any pressure, ensuring that parents could decide about treatment in a measured and unhurried way.
- Staff had not had experience in breaking bad news to parents as the service carried out routine low risk operations. The lead nurse had bereavement and palliative training and the hospital had a psychology team, which could offer additional support.

Are services for children and young people responsive?

Good

Children's and young people's services were responsive and provided access at times to suit children, young people and their parents. Nurses encouraged children to keep in touch with friends and family and the hospital provided beds in children's rooms and a meal if a parent wanted to say overnight.

The service was sensitive to children who had been inpatients and introduced them to the environment through a visit and a pre-assessment appointment, so that everything would be familiar. Nurses and consultants ensured that children who had behavioural challenges also felt at home and were cared for well.

Service planning and delivery to meet the needs of local people

- The hospital was developing its services around children's needs. We heard about the plans for a new baby clinic and immunisation service, starting with meningitis B vaccination in September 2015. Staff had received training to give these vaccinations.
- The hospital had also won an additional contract and it estimated that this would lead to 50 extra child admissions each year. It planned to expand children's day care services, particularly ear nose and throat (ENT) treatment, optometry and squint surgery. We observed that staff offered refreshments to patients and their families. In the main outpatient waiting area, there was a children's soft play area, which was brightly coloured and visibly clean. It also had books and access to a television. Staff provided toys on request.
- Existing facilities were not suitable for children's care at the hospital, given the need to expand due to the new contract. Managers recognised this and planned to convert an area at the back of Ward One to a children's ward with four beds, and to create a children's waiting room in outpatients.
- We saw from medical records that the service worked effectively with other health providers, for example, occupational therapists, schools and speech therapists. This enabled them to provide a holistic treatment, which worked for all aspects of a child's life.
- At Spire Leicester, most of the procedures were routine day casework such as ENT operations, with very few children staying overnight.
- Parents told us that consultants and managers discussed cost issues with them in a sensitive manner, and informed them of their options.

Access and flow

- The hospital offered good access for children's routine operations. Outpatient's clinics were available in the evening as well as during the day. Children could have operations during the school holidays. Consultants could also perform day case procedures at short notice, providing there was sufficient time for the pre-operative assessment.
- The hospital had a policy for admitting children, and the process was different from the adult pathway. Children had an appointment with the consultant, then a further appointment for pre-assessment and familiarisation.
- The paediatric service did not routinely measure how long children waited for their operations. Parents told us that waiting times for operations were tailored to their needs. For example, they would schedule an operation during the school holidays if this was more convenient. If a child needed an urgent operation, the service had

the flexibility to do this. Although the service aimed for children-only theatre lists, the hospital sometimes prioritised children to have their operations first, ahead of an adult theatre list.
- There were no next-day clinics, but parents told us consultants fitted in urgent child outpatient appointments in a few days.

Meeting people's individual needs

- The hospital co-ordinated appointments for children with complex needs. There was a multidisciplinary team approach for children who needed to see a number of professionals, for example, a paediatrician, an ENT specialist and a speech therapist.
- Staff responded to a patient's individual needs. We heard from parents that the hospital had planned treatment around their child's emotional, mental physical and spiritual needs. Senior nurses gave us an example of staff planning care for a child with behavioural challenges. They contacted the parents of a child with Asperger's syndrome in advance of their appointment to enquire about the best way to help them prepare for admission and reduce their anxiety.
- The hospital offered outpatients appointments and operation times to suit the individual family. Most parents chose operation times during the school holidays, as this did not disrupt schooling or draw attention to the child's operation.
- The hospital used an interpreting service and asked employees with language skills to interpret. However, we heard that on one occasion, it was difficult to obtain consent for a child's treatment from parents, because they could not understand English well enough. The hospital could not find an interpreter, so the matter was unresolved. They rescheduled the appointment for another day, delaying treatment.
- Nurses encouraged children and young people to keep in touch with friends and family. Parents told us that they helped children plug in their electronic devices and access Wi-Fi. Staff also encouraged parents to stay overnight on a temporary bed in the same room as their child to reduce anxiety, and would provide a meal if needed

Learning from complaints and concerns

- The service used the Spire corporate complaints policy. The complaints process was clear and parents said that they would have no difficulty giving feedback. However, the service had not received any official complaints from parents in relation to their child's care since the service began in 2013.
- Small children received a bright pictorial patient survey which was easy to follow and tailored to them. Older children received the adult survey. Children and young people responded that they were happy with the service.
- The service did not analyse by age group complaints, comments or concerns raised in the patient survey. Therefore, the service was unable to identify any needs or trends pertinent to an age group, so that service could be tailored around this.

Are services for children and young people well-led?

Good

The service had a vision for children's facilities and expansion of services in the future, shared with staff. There was a positive culture and staff showed clear motivation to do their best for children and young people. There was a good risk management structure and children's nurses worked well with consultants to develop policies and plan services. The governance structure helped deliver good quality care.

Senior managers recognised that the lead children's nurse provided good care to children and had represented the service well within the Spire Group.

However, staff and managers recognised that there was a need to strengthen quality and performance management, for example quality monitoring measures, and to introduce learning from audits and benchmarking. They also needed to assess staffing for their expansion plans.

Vision and strategy for this core service

- Hospital managers, paediatric nurses and consultants had a vision for children and young people's services. They had recently introduced a strategy 'Paediatric services for children and young people at Leicester Spire Hospital' which was drafted with children's nurses and other stakeholders in August 2015. They aimed to expand the range of children's services offered.

Good

Services for children and young people

Governance, risk management and quality measurement for this core service

- The matron, who was also the senior safeguarding contact, took the lead at executive level. The two lead paediatric consultants represented the interests of children and young people at the Medical Advisory Committee. They also attended the paediatric steering group which met every two months with a service improvement/development agenda.
- Staff who worked with children and young people were aware of the governance structure. All children's nurses attended the 'Paediatric Steering Group', which was the main meeting for service development and review of adverse events. We saw minutes of this meeting and saw that it had led to positive outcomes such as immunisation training. It was also attended by paediatric consultants, the matron and the training coordinator. This meeting linked with the medical advisory committee.
- The hospital had not assessed staffing needs to meet this increase in demand. They were recruiting an additional children's nurse.
- The additional children's nurse would be responsible for developing audits and quality and performance monitoring. The strategy for children and young people showed the team planned to carry out audits on policies, for example, transfers for children and 'Paediatric Early Warning Scores.' They also planned to set up monitoring and comparison of performance on quality indicators such as unexpected re-admission rate, complication rate and mortality. This would form part of the new lead nurse's role.

Leadership

- There was a 'can-do' culture within the service and staff felt respected and valued. Staff felt that all senior managers were good role models and approachable. They were aware of the hospital's values and there was clear two-way communication between management and staff for example via the staff forum.
- Senior managers recognised that the lead children's nurse provided good care to children and had represented the service well within the Spire group. However, they identified a need to strengthen leadership capacity as a result of a new contract to expand children's services.

Culture within the service

- Staff aimed to give children pleasant memories of the hospital and worked creatively to achieve this. The hospital invited children who had recently had an operation to a 'Tigers Tea Party' earlier in 2015, and four members of Leicester Tigers rugby team attended.
- The culture was centred on the needs of the child using the service. We heard from parents how hospital staff and doctors tailored treatment and hospital stays to the needs of the child.

Public and staff engagement

- The hospital gathered views through patient satisfaction forms and informal parent and patient feedback. It took action on these suggestions, for example through providing multicultural food such as curry. However, it had no formal group for parents to help shape services or future facilities for children.
- Children's nurses were activity engaged in the planning of services. For example, they were provided with immunisation training to prepare for the well-baby clinic and advised on how long a clinic appointment should be. They also suggested a lifestyle clinic to support young people with eating disorders and were arranging to work with a paediatric dietician on developing this.

Innovation, improvement and sustainability

- Spire Group recognised Leicester Spire's paediatric early warning system (PEWS) chart, developed by the lead children's nurse, as good practice. They planned to implement it in all Spire hospitals. The lead children's nurse also represented Leicester Spire on a networking group with other children's leads in the Spire Group, influencing corporate policy and sharing knowledge.
- We saw evidence that staff were focused on continually developing and improving the quality of care. For example, paediatric steering group minutes showed that nurses and other staff designed and printed new patient leaflets with an elephant logo. The paediatric steering group also took action to prevent outpatients' appointments running behind schedule for children.
- Just before our inspection, the hospital won a new contract and had calculated that from January 2016 there would be approximately 50 additional child admissions per year. The service also planned to start corrective squint surgery, optometry and routine immunisation and travel vaccination for children and young people. This would start with meningitis B vaccinations in September 2015. The paediatric nurses

Good

Services for children and young people

and a paediatric consultant received immunisation training in April 2015. This showed that staff competencies improved in anticipation of the new services.

- The service also planned to set up a lifestyle clinic for children with eating disorders and the hospital was assessing the market for these services. The senior management team and the paediatric steering group monitored and reviewed progress against these plans.

The hospital ensured that there would be better facilities for children and young people in future. It had committed capital funds for building outpatient's consulting rooms and an inpatient's ward specifically for children. It planned to start survey work in September 2015, consult with parents and child patients in November 2015 and complete building work in May 2016.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

The outpatient and diagnostic imaging department at Spire Leicester Hospital provide outpatient clinics and diagnostic imaging services to self-fund and NHS patients.

The outpatient and imaging services had 72,022 attendances between April 2014 and March 2015, 13% of these were attendances by NHS patients. Services were provided predominantly to adults, the department saw a small number of children equating to 4% of the attendances.

The outpatient department held clinics for a range of different specialities including orthopaedics, ophthalmology, cosmetic surgery, gastroenterology, ENT, gynaecology, general surgery, cardiology, dermatology, rheumatology and oral surgery. The diagnostic and imaging services offer Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), X-Ray and Ultrasound. Physiotherapy was also contained in the outpatients department and provided a range of treatments including acupuncture, sports rehabilitation and pain management.

As part of this inspection we visited all outpatient locations and diagnostic areas. We spoke with 15 patients and four relatives, 18 staff and departmental managers. We observed care and treatment and looked at patient records. Information provided by the hospital before the inspection was also reviewed.

Summary of findings

Emergency equipment was not immediately available within the department. However, since the inspection the provider has confirmed that the resuscitation trolley has been re-sited. Staff in outpatients department had limited knowledge in regards to decontamination following patients with suspected communicable diseases.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates, whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Safety concerns were identified and addressed in a timely manner. All staff were aware of responsibilities in relation to reporting incidents and the duty of candour. There were effective systems in place to protect people

Requires improvement

Outpatients and diagnostic imaging

from avoidable harm and lessons were learnt from any incidents within the department. We found that equipment was appropriately serviced and calibrated. Staff received training in mandatory and role specific areas. Patient risk was assessed and responded to appropriately.

We saw that staff were caring towards patients and respected their privacy and dignity. Patients understood options available to them and were able to choose appointments to suit their needs. Information was available for patients throughout the department and staff had the appropriate skills and knowledge to seek consent from patients throughout their care.

Waiting times and attendances were not always monitored and collated effectively; this was not recognised as an issue within the hospital. Patient outcomes were not looked alongside cancelled clinics to ensure there was not a negative effect. People could access the right care at the right time and patient needs were taken into account. Signage was not always clear to patients visiting the outpatient and imaging department. Consideration was not always given to those with cultural needs and staff said they would benefit from further training in this area.

Complaints were investigated and where necessary clinical and administrative practice had changed to prevent recurrence. Radiation regulations were followed and staff received the necessary training and competency assessment to ensure patient safety.

Staff felt valued and were positive about their roles. There was a shared vision throughout the hospital and safe patient care was paramount. Innovation and improvement was encouraged in outpatient and imaging areas, with evidence to support this. Feedback was a valued tool and the department strived to improve following any negative comments from patients or relatives.

Are outpatients and diagnostic imaging services safe?

Requires improvement

The outpatient and diagnostic imaging services required improvement.

The hospital's risk register identified that not all areas of outpatients and imaging, including sinks and carpeted areas, were compliant with Department of Health guidelines.

The hospitals risk register identified the access and exit to the minor operations room as a risk. The doorway was small and in a narrow corridor, this meant that if a patient became unwell in the room it might be problematic when moving them out, potentially delaying treatment.

Staff in outpatients department had limited knowledge in regards to decontamination following patients with suspected communicable diseases.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks and General Medical Council registration expiry dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Medicines were stored securely and monitored appropriately. Prescription pads were signed out to consulting rooms when they were in use. However, no records were kept to show how many were used or the prescription number. We were advised during our inspection that this would be rectified with a new system to

ensure all prescriptions could be tracked and volumes monitored. We saw this system in place during a follow up inspection to the hospital and were satisfied that this enabled prescriptions to be tracked and monitored.

Equipment was appropriately serviced and calibrated. Resuscitation equipment was in place to deal with emergencies; however, this was not immediately available as it was kept in a key code locked room.However, since the inspection the provider has confirmed that the resuscitation trolley has been re-sited.

Staff adhered to infection prevention and control policies and procedures. There were facilities available in all areas for staff to maintain appropriate hand hygiene practices. Environmental audits were completed regularly in outpatients and imaging.

Staff were aware of responsibilities in relation to reporting incidents and the duty of candour. There were effective systems in place to protect patients from harm and lessons were learnt from any incidents in the department.

Effective systems were in place for managing medical records and less than 1% of patients were seen without their records since January 2015.

Staff were aware of procedures when a patient deteriorated and could give a recent example of when this had happened in the imaging department. Feedback was given to staff to advise they had followed procedures correctly.

Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with described or demonstrated how to report incidents using the system. All staff gave examples of incidents such as medication errors and injuries in the department. Acknowledgements were sent to the staff member after reporting an incident to confirm the incident was being investigated.
- Staff in outpatients confirmed all incidents had a root cause analysis completed. We were told of a variety of clinical and non-clinical incidents that had occurred in the department in the last six months.
- We saw examples of learning and action plans being implemented following incidents. Staff told us that incidents were taken seriously by management teams and feedback was provided in a timely way.
- Weekly rapid response meetings took place where incidents in the department were reviewed. The investigation process was discussed along with any action plans. Shared learning and feedback following incidents was shared with the relevant department.
- Following an investigation of a serious incident involving a medication error in outpatients we saw changes had been made, which included medication checks in a quiet area and with another member of staff. This meant the hospital had taken steps to improve patient safety and avoid harm.
- The service had not reported any Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) or magnet related events in the last 12 months.
- Staff were aware of the duty of candour. The duty of candour regulation requires providers of health services to be open and transparent when things go wrong. This includes some specific requirements, such as providing truthful information and an apology. The outpatient department senior sister was able to provide an example of this in relation to a medication administration error. Following the error the patient was informed immediately and it was escalated to the deputy matron. The senior sister told us support was provided to the patient and staff member throughout the process.
- We saw leaflets available in all staff areas advising on the duty of candour. This meant we were assured that staff were aware of the new regulation regarding being open and honest.

Cleanliness, infection control and hygiene

- The hospital risk register identified some areas in the outpatient department were non-compliant with Department of Health guidance (Health Building note 00-09). A refurbishment plan was in place to rectify the areas including carpeted rooms and sinks.
- The majority of consulting rooms had carpeted floors, which were deep cleaned twice yearly. Staff told us that carpeted rooms were deep cleaned twice yearly, when they appeared dirty or when a spillage occurred.
- There were disposable curtains in all the treatment and consulting rooms with a date on when they were put up and when they were due to be changed.
- Equipment and patient furniture in consulting rooms and storerooms had green stickers to confirm it was clean and ready for use.

Requires improvement

Outpatients and diagnostic imaging

- We found outpatient and imaging waiting areas, consultation rooms and treatment rooms to be visibly clean and tidy.
- Staff were observed and noted to be 'bare below the elbow' in line with the hospitals infection control policy.
- Staff working in the outpatients and diagnostic imaging department understood their responsibilities in relation to cleaning and infection prevention and control.
- There were enough hand washing facilities including hand washbasins and hand gel sanitizers within all areas of outpatients and imaging. We observed staff practising appropriate hand hygiene routines between patients.
- We inspected six consulting rooms and noted all had gloves available. Although aprons were not readily available we were told they could be acquired where needed.
- We saw all rooms had appropriate facilities for disposal of clinical waste and sharps.
- Spillage kits were available as required. Staff were not able to tell us what they would do in regards to decontamination following patients with suspected communicable diseases.
- Environmental audits in relation to cleanliness and infection control were conducted regularly. Action plans demonstrated the changes that had been made following the audits, staff in the departments were aware if anything from their area was on this action plan. Within the physiotherapy area staff told us it had been identified that some items of equipment were being stored on the floor, to rectify this racking had been ordered.
- Imaging rooms were cleaned daily with only radiology staff cleaning the equipment. This was to ensure staff that were aware of radiology risks and were kept safe.

Environment and equipment

- We inspected resuscitation equipment for outpatients and radiology. The equipment was located in-between the two departments in a key code locked room with a self-closing door. This was not in line with the Resuscitation Council's guidance. We spoke to the resuscitation officer for the hospital who advised us this had not been risk assessed and had not previously been thought of as an issue. Since the inspection the provider has confirmed that the resuscitation trolley has been re-sited.
- We were not assured that staff could access resuscitation and emergency equipment promptly due to its location and therefore could delay care to a patient in a medical emergency.
- Equipment in the resuscitation trolley was appropriate and checked daily to ensure that it was ready for use. We saw evidence of weekly checks that were thorough and meant drugs and equipment were monitored for expiration dates. Policies related to resuscitation and equipment checks were visible and all staff we spoke to were aware of these policies.
- The access and exit to the minor operations room was documented in the hospitals risk register. The door way was small and in a narrow corridor, this meant that if a patient became unwell in the room it may be problematic when moving them out. Regular scenarios were carried out by staff to ensure this risk was minimised.
- The outpatients and diagnostic imaging department was uncluttered, and well maintained. All patient waiting areas were visibly clean with sufficient seating for patients and their relatives.
- All equipment had been appropriately maintained and serviced; we were shown evidence of service records that were clear and up to date.
- Within all rooms and in waiting areas there was a colour coded alarm system that allowed staff or patients to alert others to a medical emergency. Within the consulting rooms there was also a button to request assistance or a chaperone.
- Daily self-checks and calibrations were performed when MRI and CT scans were active, this further ensured the equipment was safe to use.
- All rooms had warning signs in relation to radiation at the entry point.
- Imaging staff told us that appropriate protective equipment, such as lead coats, was available and that it was checked yearly to ensure it could provide sufficient protection.

Medicines

- We looked at storage of medicines throughout the outpatients and imaging department and found them all to be in date and stored appropriately.
- We saw a safe system in place for transferring drugs to treatment and consulting rooms where required by consultants. High cost medicines had a register that staff signed once administered or removed.

- Prescription pads were signed out to consulting rooms when they were in use; however no records were kept to show how many had been used or the prescription number. This meant that there was no audit trail and discrepancies in volume of prescriptions would be difficult to identify.
- We were advised during our inspection that this would be rectified with a new system to ensure all prescriptions could be tracked and volumes monitored. We saw this system in place during a follow up inspection to the hospital and were satisfied that this enabled prescriptions to be tracked and monitored.

Records

- We found gaps in some of the patient records we reviewed. We were told that some consultants used their own notes rather than Spire medical records in which to record the patient's outpatient consultation and not all those notes were retained within the Spire medical record. Patient records that weren't retained within the Spire medical records were available on request from the Consultant or their secretary in line with hospital policy.
- Staff we spoke with could not recall an occasion where medical records had not been available for a clinic, or when a patient could not be seen because their records were not available. Data we received prior to inspection informed us that the number of records which were unavailable was less than 1% (20 patients since January 2015.)
- Imaging requests were handwritten and then scanned onto the computer system by imaging administrative staff. We were shown five patient records and the imaging requests that had been scanned; all were legible and had been double checked with the patient as they booked in.
- Records were held at the hospital for six months and then transferred to another Spire site for storage. We were advised that notes can be requested to be sent back should a patient return for further treatment, staff told us this was a 24 hour service.
- Medical records were audited monthly to ensure all relevant information regarding the patients care was documented. We saw evidence of one month's audit which showed staff not signing in all required areas of documentation. Any recommendations following the audit would be circulated to the relevant areas.

Safeguarding

- We saw systems in place to ensure the right person received the right radiological scan at the right time. Reception staff told us they confirmed patient details including the area they were expecting the imaging on. If the area of the body differed they would look back to the referral and establish if it was a clerical error or a referral error. We saw radiology staff check details of the areas of the body they expected to be imaged to ensure that they had the correct information before commencing the imaging process. This confirmed that safe systems were in place to protect patients from unnecessary radiation through referral and clerical errors.
- All staff we spoke with informed us they had received safeguarding training for both adults and children in the last year. We checked eight staff files across outpatients and imaging and saw evidence of this.
- A senior physiotherapist provided us an example of when staff had followed the hospital's safeguarding policy and made an appropriate referral to the hospital safeguarding lead. Feedback was given to the reporting staff member and to the rest of the department following the referral.
- All staff were aware of what action to take if they felt a patient required safeguarding. This meant we were assured that training was adequate and staff would be able to protect vulnerable patients.
- The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on medical indemnity, disclosure and barring checks, General Medical Council registration expiry dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the

collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Mandatory training

- Managers in all areas of outpatients and imaging told us their staff had all completed mandatory training. Staff also supported this and told us they had completed all required learning. Staff told us that training included subjects such as manual handling, infection control, safeguarding, basic and intermediate life support and fire safety.
- We checked nine staff records in outpatients and imaging and saw that all had up to date training records that documented mandatory training had been carried out in the last year.
- We were informed that monitoring of mandatory training levels was carried out by a different department and that managers of outpatients and imaging were not involved in this.

Assessing and responding to patient risk

- Staff informed us that if a patient deteriorated in the department the resident medical officer (RMO) would assess the patient. Radiology staff were able to provide us of an example of where a patient became unwell prior to imaging, the emergency button within the room was pressed and the RMO attended. Following assessment the patient was transferred to the accident and emergency department of a local NHS hospital by ambulance. Feedback was given to staff involved, confirming that correct procedures had been followed and this was shared with the rest of the department.
- Administrative staff told us that if a patient collapsed in the waiting area they would press the emergency button to alert other staff. This meant that in the event of a medical emergency appropriate action would be taken to assess and respond to the patients' needs without putting them at risk of deterioration.
- Radiography staff informed us they were aware of contrast-inducted reactions and that they could easily locate the anaphylaxis kit to use should these reactions occur. Staff told us that if anaphylaxis was suspected they would contact the RMO who would treat the patient appropriately.
- Signs in relation to radiation exposure and pregnancy were seen throughout the imaging department.
- Radiographers conducted a check on the pregnancy status of all women of childbearing potential prior to imaging in line with national guidance. Pregnancy status checks were audited by the radiation protection advisor (RPA) to ensure that these were conducted and patients were kept safe.

Nursing staffing

- The hospital used an adapted version of the Shelford acuity and dependency tool to establish their staffing levels.
- Records provided to us prior to inspection showed use of agency staff varied throughout outpatient and imaging areas. The imaging department had no use of agency staff. Outpatients had minimal use of agency staff, while physiotherapy were currently using agency staff to cover due to a vacancy and staff sickness. Physiotherapy staff told us that the hospital tried to use the same agency staff where possible to enable continuity.
- We were advised that if agency staff were used in any areas that they were given sufficient information and the hospitals procedures discussed with them along with an induction checklist. This meant that patients could be assured that staff were familiar with the service provided and the needs of the patients.

Medical staffing

- Resident medical officer (RMO) cover was provided throughout the 24-hour period, RMOs had been employed through an agency that ensured necessary employment and registration checks had taken place for all RMOs that work in the hospital.
- Staff told us that consultants were generally on time for their clinics. However, some consultants came from local NHS hospitals and if their lists overran or had a complication this meant there would be an impact on their clinics. This information was not collated or monitored and therefore we were unable to see how often this occurred or the impact it had.
- Radiologists did not provide cover over evenings and weekends. There was no procedure in place should one be required urgently other than calling each one individually to see if they could attend the hospital. Staff within the department felt this was an issue but stated there had never been an incident where a radiologist could not be contacted. There was no plan to alter this practice.

Requires improvement

Outpatients and diagnostic imaging

Major incident awareness and training

- We were informed prior to inspection that the hospital would provide support should there be a major incident within the area. We spoke to the leads of both outpatients and imaging who were not able to tell us the role of the department should there be a major incident. However both members of staff informed us there was a policy and they would be able to access this to establish their roles.
- Post inspection we were provided with information to show that major incident plans were currently being discussed with the head of emergency preparedness, resilience and response for the Central Midlands. The matron informed us that once plans had been developed further then staff would receive information and training.

Are outpatients and diagnostic imaging services effective?

Pain relief was assessed and patients were supported with pain management, through medication and/or complimentary therapies. We saw evidence of patient outcomes being measured in some areas of the department.

Staff received appropriate training for their roles and were encouraged to develop further through external training. Appraisals were carried out yearly with a six month review. Staff felt these were meaningful and were clear of any actions required by them afterwards.

The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.

Services were not available seven days a week, but the majority of areas provided an on call service should staff be required.

Staff had an understanding of consent, Mental Capacity Act and Deprivation of Liberty Safeguards and were able to provide examples of where they had experienced these in practice.

Evidence-based care and treatment

- Staff told us they worked to local policies that were reviewed regularly as part of the governance arrangements for the service.
- National Institute for Health and Care Excellence (NICE) guidance was being used in medical and surgical clinics as part of patient care and treatment.
- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. DRLs were cross referenced to national audit levels and if they were found to be high a report to the radiation protection advisor (RPA) would be made.
- A folder was kept in the staff office with relevant local policies and procedures; these were all up to date and had been reviewed within the necessary timescale. Policies and procedures followed national guidelines for outpatients and diagnostic imaging.
- Staff we spoke with were aware of how to access the policies and procedures folder. Staff could also locate further guidance on the hospitals computer system which was demonstrated to us.
- The hospitals clinical audit schedule outlined when, how often and who would conduct audits in the various areas. These audits included quarterly medication and resuscitation equipment audits along with annual laser safety audits to ensure national guidelines had been followed.

Pain relief

- Patients were assessed for pain relief during assessments and supported in managing pain through prescriptions with the appropriate medication.
- Complimentary pain relief therapies were available such as acupuncture and massage. These therapies were provided by physiotherapists. Pilates was previously

offered to patients but was stopped due to staff sickness. The physiotherapy team felt this treatment was very beneficial and were therefore undertaking training to be able to provide it again.
- We spoke with one patient who had used the physiotherapy service for pain relief, they felt positive about the services offered and said their pain had improved following treatment.

Patient outcomes

- Staff in the physiotherapy department informed us they measured outcomes and told us that this was through a patient self-assessment questionnaire. Staff showed us evidence of these questionnaires and were able to describe how these were audited and treatments adjusted based on the findings.
- There was no evidence of outpatients and imaging taking part in national audits.
- The 'United Kingdom Accreditation Service' had awarded the hospital pathology services clinical pathology accreditation. The most recent documented assessment of clinical pathology services was dated the 5 February 2013.

Competent staff

- Shortfalls were found in hospital wide consultants' information with the exception of consultant staff working with children and young people and termination of pregnancy services. Information received from the provider relating to required documentation for hospital wide consultants, showed that on 11 August 2015, 84% of consultants had received a practice appraisal and 71% of consultants had received a biennial review. Although the percentages of compliance had increased since 15 April 2015, the provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of actions that would be put in place immediately to achieve compliance and mitigate risk. The Consultant's Handbook stated that consultants were at risk of suspension if they did not provide up-to-date documents.
- The Spire Leicester Hospital weekly compliance report dated the 7 and 11 August 2015 showed shortfalls in the receipt of medical staff information on whole practice appraisals and biennial review dates. The provider acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of the actions in place to achieve compliance and mitigate risk. By 20 August 2015, 312 consultants had provided all the required documentation. The suspension of practising privileges for thirty-four consultants took place until all documentation was submitted to the hospital. Since 20 August 2015, the provider confirmed that compliance has remained at 100% at all times in relation to the collection of this information and that all medical staff were fully insured during the CQC inspection, despite shortfalls having been observed in the collection of this data.
- Managers and staff told us performance and practice was continually assessed during mid-year reviews and at the end of year appraisal. Staff we spoke with confirmed they received regular appraisals and we saw evidence that the appraisal completion rate for outpatients and diagnostic imaging staff was 100%.
- Staff told us they were encouraged to undertake continuous professional development and were given opportunities to develop their skills and knowledge through training relevant to their role. Examples of training courses attended included Master's degrees which had been partially funded by the hospital.
- Medical consultants with NHS contracts had their appraisals and revalidation done at their employing trust and a copy had been provided to the hospital. Following our inspection we were provided with evidence to show 100% of consultants had completed revalidation and had current Disclosure and Barring Service (DBS) checks.

Nutrition and hydration

- There was a drinks machine available in the department for patients to access, and food could be acquired on request.

Multidisciplinary working

- Staff told us that communication and working relationships were good throughout the department and with the rest of the hospital. We observed staff worked together as a team and provided support to ensure that care and treatment was managed effectively.

Requires improvement

Outpatients and diagnostic imaging

- There were no multidisciplinary clinics available however staff told us that access to different disciplines was very easy.

Seven-day services

- Radiologists did not have rotas for weekend working or an on call rota. We were told that if a radiologist was needed at the weekend then staff would have to phone around to try and reach one of them.
- Radiographers were available during evening and weekends on an on-call basis. Staff told us they were all flexible and would help cover the department where needed.

Access to information

- All staff had access to policies, procedures, and e-learning on the hospital's intranet. All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the electronic system.
- Radiologists were now able to use voice recognition for reporting, this meant reports were available sooner and more time effective for radiologists.
- There was a secure image exchange portal transfer of information between local NHS trusts and the hospital. This meant that images were shared between providers to prevent unjustified re-imaging of patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any procedure.
- All staff we spoke with were aware of the Mental Capacity Act (MCA) and were aware of implications it may have in practice. Staff were able to tell us what they would do if they felt a patient lacked capacity and we were given two examples of where this had previously occurred in the department.
- We saw evidence of staff completing MCA and Deprivation of Liberty Safeguards training in outpatients and imaging.

Are outpatients and diagnostic imaging services caring?

Good

Staff were respectful and polite towards patients and care was good throughout the department. Patients understood options available to them and were able to choose appointments to suit their needs.

Patients and their relatives we spoke with were pleased with the care they had received. Survey results showed the majority of patients would recommend the outpatients department to their family and friends for similar treatment.

Information was available for patients throughout the department and staff had the appropriate skills and knowledge to seek consent from patients throughout their care. Psychological support was available for patients and those that had received it felt it was very useful and tailored to their needs.

Compassionate care

- Reception staff were very respectful and polite to patients, assisting them with enquiries.
- We spoke with 15 patients who were very happy with the care that they had received. One patient told us they had received treatment at the hospital over several years, stating they would, "Always come here," and "The physio staff are really good." Another patient who told us it was their first visit to the radiology department said, "It met expectations and staff are welcoming and friendly."
- Feedback from NHS patients over July 2015 stated that 77% would recommend the outpatient department to friends or family. One patient stated, "All aspects of what I experienced were first rate."
- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, staff offered patients with reduced mobility assistance to move to the reception desk and seating area.
- Patients' privacy was respected and they were addressed and treated respectfully by all staff. Staff were

Requires improvement

Outpatients and diagnostic imaging

observed to knock on consulting and treatment room doors before entering. Curtains were drawn and doors closed when patients were having their consultation or treatment.
- We spoke to six family members of patients who had received treatment. They all stated they were pleased with the care provided to their relative.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they fully understood their care and were informed of risks and benefits during consultations. Patients were given written information throughout care and treatment which ensured they knew who to contact for advice or support.
- Patients were given advice regarding how long results from blood tests would take. This information was easily accessible to staff to make sure patients received the correct information prior to leaving the hospital.

Emotional support

- We spoke to a family who had all received treatment in outpatients. They felt involved in all aspects of care and were offered psychological services that they felt were tailored well to their needs following treatment.
- We were informed during the inspection that various avenues of support, including in the community, were being discussed by the leadership team to ensure patients were well supported during and after treatment.
- We saw clear signs in all consulting rooms and waiting areas advising patients they could request a chaperone. We were told that if a patient requested a chaperone the member of staff pressed the chaperone button in the room to request another member of staff.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

The responsiveness of the outpatients and diagnostic service required improvement.

Delays, cancellations and attendances rates were not always responded to within the department. Data was collected but not audited or actioned further to prevent or reduce these events in future.

Staff informed us that if a patient could not speak English then they would either allow the family to translate or see if another staff member spoke the necessary language. Staff did not receive training to perform this role.

Patients had easy access to services and appointments were given in a timely manner, with referral to treatment times for NHS patients being met. Radiology services did not always run on time. Patients were informed if a clinic or appointment was delayed or cancelled and most patients felt this was done in a timely way.

Complaints were discussed openly in the department and learning shared following them.

Service planning and delivery to meet the needs of local people

- The outpatient and imaging departments were sign posted from the entrance of the hospital and all areas were within a short walking distance. Signage around the outpatient and diagnostic imaging department was in English only. We saw staff stopping to ask patients and visitors if they required assistance or directions if they saw them appearing to be lost.
- We were told by staff and patients that was some confusion over one of the imaging receptions as they dealt with MRI bookings only, but the sign stated CT and MRI. This was confusing for patients and meant they had to go to a separate area to book CT scans.
- We saw various information leaflets throughout outpatients and imaging including CT scanning, MRI scanning and information from the British Heart Foundation. Leaflets in the department were all in English. Different languages were available on request but this was not clear to patients.
- Some patients told us car parking was problematic, meaning that they sometimes had to park on the pavements on the entrance and exit of the hospital site.
- Waiting areas and consulting rooms were appropriate and patients told us they felt the department was 'open and airy 'and they liked the brightness of the department. Toilet facilities, drinks machines and magazines were available in all waiting rooms which patients told us was beneficial.

Requires improvement

Outpatients and diagnostic imaging

- Evening and Saturday clinics were available to patients, dependant on consultant specialty.

Access and flow

- We spoke with administrative staff in all areas of outpatients and imaging.
- In radiology appointment availability depended on the type of imaging required. Patients who required plain film imaging generally had them done on a 'walk in 'basis which followed their consultant appointment. For other imaging such as MRI and CT we were told patients could normally be given an appointment within a week.
- Patients told us they were normally seen on time in the imaging department but there were sometimes delays which they had subsequently been informed of. Administrative staff confirmed that delays in appointments happened on average once per week and this was usually due to patients arriving late or moving during imaging meaning the procedure had to be repeated. These waiting times were not collected, audited or monitored regularly for review.
- During our inspection the MRI scanner was not working which meant patients had appointments cancelled at short notice. It was the administrative staff's responsibility to call patients and inform them of the need to cancel their appointment; they were offered another appointment within 48 hours. We asked how often this occurred and were told it had begun happening more often with the MRI scanner and staff estimated it had happened once a month.
- Prior to inspection, we were informed that in the outpatients department the monthly average of patients that do not attend (DNA) appointments between January 2015 and July 2015 was 358 patients (6%). We asked what the process was to follow these patients up and there was no set procedure in place. Some staff told us that if they were NHS patients then they would complete a form so that it was documented; other staff told us they would call patients depending on the nature of the consultation. Although DNA rates were collated each month we saw no evidence that they were assessed or audited to attempt to improve them.
- We were provided with outpatient clinic cancellations between January 2015 and June 2015, on average 222 clinics were cancelled per month (156 had no patients booked), resulting in 166 patients having their appointment times changed. We discussed this, along with DNA rates, with departmental managers who could not advise us why they were not acted upon.
- We were advised that consultants were required to give six weeks' notice before cancelling a clinic, unless there was an exceptional circumstance, for example family bereavement. We saw a spreadsheet which detailed which consultants cancelled clinics, but there were no other systems in place to ensure the movement of patient appointments was kept to a minimum.
- Referral to treatment time of 18 weeks for NHS patients attending outpatients and imaging department were consistently met.

Meeting people's individual needs

- The outpatient reception area allowed patients to speak to a receptionist without being overheard and signs requested that further patients wait to be called forward to allow this.
- The CT/MRI reception areas did not allow for privacy during busy times. The area was small in size and the reception window located in the centre.
- The hospital had access to an interpretation and translation service in the event that a patient required assistance.
- Staff informed us that if a patient could not speak English then they would either allow the family to translate or see if another staff member spoke the necessary language. Staff did not receive training to perform this role. The use of family and carers is not considered good practice.
- Staff told us their yearly training included equality and diversity and 91% of staff in outpatients and imaging had recently completed the training. Two members of staff told us that they would like to know more and felt it could be more in depth.
- Appointments in the radiology department were booked by the estimated time the imaging would take; this meant that appointment lengths were tailored to patient needs. However there was no time allowance for errors or mistakes and therefore occasionally led to delays if one imaging procedure over ran.
- The outpatient department was located on the ground floor and had accessible toilet facilities for disabled patients. We observed that there was a wheelchair located by the entrance should it be required.

Requires improvement

Outpatients and diagnostic imaging

- Relatives we spoke to told us they felt fully involved in their family's care where necessary. A child with learning disabilities received treatment at the hospital and the family were very positive about how staff interacted with their child and the care they received.
- Staff told us that if a patient had any additional needs this could be communicated through the hospital easily to ensure those involved in the patients care were informed.
- The imaging department had several individual changing cubicles for patients to use; they were not separated into male and female. There were small sub-waiting areas for patients once they had changed, however patients could be seen from the main waiting areas. Staff advised us that the majority of the time patients remained in the changing room until they went into the imaging suite. During the inspection, we saw four patients sitting in the sub-waiting area in gowns.
- Information related to fees for self-funded patients was readily available and given prior to any treatment or care.

Learning from complaints and concerns

- The majority of patients we spoke with were unsure of the complaints process. However, they did tell us that they believed this information had been given to them by the hospital but they had not read the documentation. We saw patient leaflets in all areas of the department detailing the complaints process so that patients had access to information to support them in raising complaints or concerns.
- No accessible feedback forms were seen in the department for patients to access, however there were leaflets explaining the complaints process.
- Staff told us that if a patient complained directly to them they would enter it on the electronic incident reporting system so it could be dealt with. We were also told that any complaints were discussed at the rapid response meetings to ensure they were dealt with quickly and learnt from as a department.
- We saw that there had been one complaint related to histology results not being available for a patient's consultation two weeks after a biopsy had been taken. Changes had been made to practice including the use of a whiteboard in the department. To ensure that this change in practice had been effective, plans were in place to audit the use of the whiteboard and sample turnaround times.
- Complaints and comments were reviewed and discussed by teams at monthly staff meetings. We saw minutes of meetings which demonstrated that complaint themes and learning were shared with staff. Complaints made included delays in diagnostic results and unexpected payment fees.

Are outpatients and diagnostic imaging services well-led?

Good

Leadership in outpatients and diagnostic imaging was good.

Effective governance and risk management systems were in place and quality was measured regularly in a variety of areas. Risks were shared in the department and staff knew of action plans in place to rectify them.

Feedback was sought within the departments but action plans were not always put in place to rectify negative experiences.

Shortfalls in the receipt of medical staff information were monitored by the hospital. We escalated these findings to the provider who acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. Immediate actions were implemented by a senior manager to achieve compliance and mitigate risk. By the 20 August 2015, 84% of consultants had provided all the required documentation.

Staff were aware of departmental and hospital wide leadership teams and felt they were visible and approachable. Improvements and innovations were encouraged within the department.

Vision and strategy for this service

- All staff were aware of the corporate provider's vision and values that included a passion for caring, success and driving excellence. Staff stated patient safety was a key priority for the hospital.
- Staff told us of plans to improve facilities in outpatients and imaging with plans being discussed with them locally. However within the overall hospitals strategy there were no specific areas documented relation to outpatients and imaging.

Requires improvement

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- Shortfalls in the receipt of medical staff information were monitored by the hospital. These shortfalls included up to date information on whole practice appraisals, medical indemnity, disclosure and barring checks, biennial review and General Medical Council registration expiry dates. We escalated these findings to the provider who acknowledged that further work was required to ensure all consultants provided evidence of all the required documentation. We spoke with a senior manager who informed us of actions that would be put in place immediately to achieve compliance and mitigate risk. By the 20 August 2015, 84% of consultants had provided all the required documentation. Thirty-four consultants practicing privileges were suspended until they had submitted their documents to the hospital.
- The hospitals live risk register identified some areas in outpatients were non-compliant with Department of Health guidance (Health Building note 00-09), this included sinks and carpeted rooms. A refurbishment plan was in place to rectify this but changes had not yet been made.
- Effective governance was in place to support the delivery of quality care and regular reviews and improvements were made. When we asked staff if they would change anything in their area the responses we received aligned with what was on the hospitals risk register. This included refurbishment of rooms to make the areas more patient friendly. This demonstrated risks and necessary improvements were shared amongst all staff levels and areas.
- There were regular team meetings to discuss issues, concerns and complaints. Staff were given feedback at these meetings about incidents and lessons learnt.
- The hospitals clinical audit schedule outlined when, how often and who would conduct audits in the various areas such as quarterly medication and resuscitation equipment audits along with annual laser safety audits. We saw evidence of resuscitation audits which showed high levels of compliance consistently.
- Representatives from outpatients and imaging attended monthly clinical governance meetings so that any problems within the department could be raised for discussion amongst other hospital staff. We saw evidence of meeting minutes which included areas such as radiation protection and training updates.
- We reviewed a number of policies and procedures in the department and found that they were up to date and relevant to practice. They all had review dates documented and who was responsible for this. We saw staff were able to locate local and corporate policies electronically.

Leadership of the service

- There were clear lines of accountability and responsibility in the outpatients and diagnostic imaging department. Staff in all areas stated that they were well supported by their managers, that their managers were visible and provided clear leadership.
- All staff we spoke with described the leadership team in the hospital as having an 'open door' policy and that they were accessible.
- Managers in outpatients and imaging were also involved in direct clinical patient care. This meant their skills and knowledge were maintained to be able to provide the necessary support to other staff working in the department.
- Leaders in outpatients and imaging demonstrated to us that they encouraged staff to take on additional responsibilities based in their interests. This could be through leading a change in the department or developing areas of patient care.

Culture within the service

- Staff told us that the leadership team were approachable, supportive and made them feel valued.
- All staff we spoke with felt that there were good working relationships between clinical and non-clinical staff, they felt that staff could contribute from any area and there was no divide.
- There was clear collaborative working in the department and openness and honesty was encouraged. Staff felt did not feel a blame culture existed and told us of incidents that had occurred and the support they had been given.

Requires improvement

Outpatients and diagnostic imaging

- We saw examples where staff had put forward improvement ideas and they had been supported by the management teams in the department. There was a strong emphasis on including staff on improvements and changes within the department.
- Action was taken where necessary to ensure staff performance was satisfactory and consistent; we saw this recorded in staff appraisals. Action was taken to encourage staff to improve and assistance was provided until performance was met.

Public and staff engagement

- The hospital collected patient views using a patient satisfaction questionnaire. Questionnaires were completed twice a year for the majority of patients. NHS outpatient feedback was collated monthly. Over the past six months four comments related to a lack of seating, delayed appointments and poor signage in the department. All other comments were positive. We saw no action plans to improve any of the negative issues raised by patients.
- Staff informed us that they felt able to share their ideas and opinions to develop and improve the outpatient services. Regular team meetings were held as a forum to facilitate this.
- The hospital had a patient steering group that enabled patients who had used the service to provide feedback to the leadership team. We saw there had been no particular feedback recently in regards to outpatient or imaging services.
- It was clear that patient feedback was valued by the hospital and this was discussed at a variety of meetings to establish whether changes could be made to avoid similar feedback in future and improve patient experiences. Positive feedback was passed onto appropriate departments and staff members.

Innovation, improvement and sustainability

- In the physiotherapy area staff had plans to create wall art to make the environment brighter following patient feedback. A box was located in the department for patients and staff to provide input to influence the wall art. This showed innovation in the department and staff told us they felt it was important to act on feedback to make the department as pleasant as possible for patients.
- Staff told us of the refurbishment plan for the outpatient and imaging areas.

Good

Termination of pregnancy

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

Information about the service

Spire Healthcare provided a termination of pregnancy service at Spire Hospital Leicester.

The hospital offered early medical abortion procedures for patients with a gestational age up to nine weeks and surgical abortion procedures for patients with a gestational age up to 12 weeks. The medical termination of pregnancy service was a new service which commenced in August 2014. Termination of pregnancy was only provided to women over 18 years of age.

The medical termination service was provided on a Monday and Friday evening and was led by an NHS consultant obstetrician/gynaecologist who was based at the local NHS hospital. Surgical termination of pregnancy was offered as a day case procedure under general anaesthetic. From August 2014 to 2015 a total of 84 termination of pregnancy procedures were carried out at this hospital, out of which 75 procedures were early medical abortions and nine were surgical abortions.

The termination of pregnancy service was delivered in accordance with the Royal College of Obstetrics and Gynaecology (RCOG) Guidance in Relation to Requirements of the Abortion Act and the Department of Health (DH) guidelines Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy which includes the Required Standard Operating Procedures (RSOP).

Summary of findings

The termination of pregnancy service at Spire Leicester Hospital offered safe care to the patients.

There were sufficient numbers of suitably trained staff available to care for patients. The environment and equipment was visibly clean and infection control procedures were followed. Staff were aware of safeguarding procedures and had received training in safeguarding adults, the Mental Capacity Act (2005) and Deprivation of Liberties (DOLs.)

Medicines management was safe and there was a clear audit trail for the request and receipt of the medication.

There were appropriate procedures to provide effective care. Care was provided in line with national best practice guidance. Arrangements were in place to ensure that staff had the necessary skills and competence to look after patients. Patients had access to Spire Leicester Hospital out of hour's aftercare 24 hours a day, seven days a week. Patients were cared for by a multidisciplinary team working in a coordinated way.

Patients received compassionate care that respected their privacy and dignity. All the patients considering termination of pregnancy had access to pre-termination counselling. Patient's wishes were respected and their beliefs and faith were taken into consideration regarding the sensitive disposal arrangements for pregnancy remains.

Good

Termination of pregnancy

The hospital was responsive to patient needs. Professional interpretation service was available to enable staff to communicate with patients for whom English was not their first language.

The service was compliant with the guidance from the Royal College of Obstetrics and Gynaecology (RCOG) Guidance in Relation to Requirements of the Abortion Act and the Department of Health guidelines Procedures for the Approval of Independent Sector Places for the Termination of Pregnancy Required Standard Operating Procedures (RSOP). The hospital monitored its performance against the RSOPs.

There were effective governance arrangements in place and staff felt supported by the senior management team. The culture in the hospital was caring and supportive. Staff said that the leadership and visibility of the hospital director, matron and senior managers was good. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for Spire Leicester Hospital.

Are termination of pregnancy services safe?

Good

Termination of pregnancy service provision for both medical and surgical procedures were safe and in line with the guidance from the Department of Health (DH) Required Standard Operating Procedures.

Staff were encouraged to report incidents through the recently introduced electronic reporting system and had received feedback on the incidents they had reported. Spire has introduced a Sign up to Safety Action Plan dated 11 September 2014 to learn and take action to improve patient safety. Learning and actions as a result of incidents within the hospital were shared with the staff in team meetings.

The environment was visibly clean. We observed that all the clinical staff regularly washed their hands in between patients, used personal protective equipment (PPE) such as gloves and aprons and observed the 'bare below the elbow' guidance.

Equipment had been maintained and checked regularly to ensure it continued to be safe to use. Portable Appliance Testing (PAT) testing stickers were visible on the equipment and equipment maintenance records confirmed an ongoing maintenance programme. Resuscitation equipment was available in case of an emergency and had been checked daily. We saw documentation which confirmed these checks had been completed daily.

There was an established system for the management of medicines to ensure they were safe to use and there was a clear audit trail for the request and receipt of medication. Only a consultant for patients undergoing early medical abortion prescribed abortifacient medication (the medication used to induce abortion).

Patient records for termination of pregnancy had a unique identifier identified by a red star. When patient records were completed, we saw they had been stored separately and securely.

Good

Termination of pregnancy

There were sufficient numbers of suitably trained staff available to care for patients. Staff had undertaken competency based training for the medical termination of pregnancy and were up to date with mandatory training as of August 2015.

Clinical and non-clinical staff were aware of safeguarding procedures and had received training in safeguarding adults at either level 1 through e-learning or level 2.

All the patients undergoing surgical abortion had undergone a venous thromboembolism (VTE) risk assessment in accordance with the recommendations from the National Institute for Health and Care Excellence (NICE). During surgical procedures, staff used the World Health Organisation's (WHO) pre-operative checklist incorporating the National Patient Safety Agency surgical safety checklist, which is designed to prevent avoidable mistakes. These were completed appropriately in the patient records we reviewed.

Incidents

- Staff were encouraged to report incidents through the incident reporting system and received feedback on the incidents they had reported. Spire had introduced a 'Sign up to Safety Action Plan' dated 11 September 2014 to learn and take action to improve patient safety. An example of this was a commitment to reduce avoidable harm in the hospital by 50% and to ensure key patient safety priorities were reported and monitored. Local actions included publishing audits and adverse events in the monthly Clinical Governance and Quality reports and feeding back to the Medical Advisory Committee.
- All staff we spoke with were familiar with how to report incidents and gave us examples of incidents they had reported.
- Clinical incidents were reviewed and it was clearly demonstrated that investigations and root cause analysis had taken place. Action plans had been developed to reduce the risk of a similar incident reoccurring. There had been no serious incidents reported in relation to termination of pregnancy service provision.
- A clinical practice and governance manager - reviews and monitors the incident reporting forms. The lead for clinical audits is the deputy matron.
- Clinical governance meetings were held monthly and rapid response meetings were held weekly to discuss complaints and any adverse incidents. The learning and actions required were cascaded to clinical staff at team meetings. The clinical governance report was submitted to the hospital Medical Advisory Committee for comment.
- The Spire Board of Directors received a report from all the Spire hospitals through the Incident Review Committee and weekly reports from the central Governance team.

Cleanliness, infection control and hygiene

- All the clinical and non-clinical areas we visited were visibly clean.
- In all areas, we observed staff to be complying with best practice with regard to infection prevention and control policies. Medical and nursing staff in the clinical areas were observed to be adhering with the bare below the elbow policy to enable good hand washing and reduce the risk of infection. There was access to hand washing facilities and a supply of personal protective equipment, which included gloves and aprons. Staff washed or applied hand gel to their hands between patients. Handwashing audits had been completed by the infection control lead nurse and showed 100% staff compliance.
- The hospital had reported no incidence of Methicillin resistant Staphylococcus Aureus (MRSA) and clostridium difficile in the reporting period to June 2015. The results of MRSA audits were displayed on the website and in the clinical areas.
- Audits and checks were in place to monitor standards of cleanliness. Staff told us that infection control audits were completed by the infection control lead. The results of the infection control audits were reported through clinical governance.
- The hospital had recently appointed a new infection control nurse who had developed an infection control annual plan to monitor and control infection and to maintain a clean and appropriate environment.
- The hospital had a service level agreement with a local NHS Trust. This was for infection control support and advice in relation to antimicrobial prescribing from an NHS Consultant Microbiologist who had practising privileges with the hospital. The Infection Control meetings are held on a quarterly basis and attended by the consultant microbiologist. Minutes of meetings were available.

Environment and equipment

- Patients were seen on the ward area in one of the private rooms.
- We observed all patient-care equipment to be visibly clean and ready for use. Patient equipment had been routinely checked for safety and was clearly labelled stating the date when the next service was due. The equipment was also labelled to indicate that portable appliance testing had been carried out to ensure it was fit to use. The annual contract service report and certificate for the medical device ultrasound scanner (Phillips Scanner) dated 2 September 2014 was seen. Resuscitation equipment was available in all clinical areas. Single-use items were sealed and in date, and emergency equipment had been serviced.

Medicines

- We observed that there was an established system for the management of medicines to ensure they were safe to use. This included clear monitoring of the stock levels, stock rotation and the expiry dates of medication. The minimum and maximum temperature of fridges where medication was stored was monitored to ensure that medication was stored at the correct temperature.
- There was a clear audit trail for the request and receipt of medication for the anti-abortifacient medication and the Anti D injections.
- The audit review of the management of controlled drugs for the hospital dated April and May 2014 had identified some issues and an action plan had been completed. We observed that medicines were securely stored, kept in locked cupboards and fridges.
- There was system in place for the safe disposal medication. This was to place the medication into a dedicated disposal bin that could be tracked to the place of origin.
- Patients were asked if they had any known allergies and it was seen to be clearly recorded in the five pre-assessment forms we reviewed.
- Following a face to face consultation with a member of the nursing team a consultant prescribed the required medication for patients undergoing early medical abortion.
- Anti-microbial drugs were prescribed to all patients having medical termination of pregnancy. To reduce the risk of infection and the local trust antimicrobial prescribing protocols for the administration of antibiotics were used. There were clear guidelines on when these were to be used.
- Anti-sickness drugs were prescribed for the women as part of the patient pathway for early medical abortions to reduce the side effect of vomiting.

Records

- Patient records were paper based .Patient information and records were kept separately and were held securely in a lockable cabinet in matron's office.
- Patient records were well maintained and documented with clear dates, times and designation of the person documenting. We reviewed five sets of patient records. These records were written legibly and assessments were comprehensive and complete, with associated action plans and dates. Comprehensive pre-operative assessments as part of the pathway were undertaken and recorded where patients under went surgical abortion.
- The record keeping audit undertaken for early medical termination pathways in quarter two dated 10 August 2015 was 100% compliant. An audit for the completion of the legal documentation dated 12 September 2014 to 31 December 2014 which included (the HSA1 forms) checking the grounds for carrying out an abortion and that two medical practitioner signatures were on the forms was 100% compliant.

Safeguarding

- Trained staff and non-clinical staff we spoke with knew who the safeguarding adult lead was and where to seek advice.
- Spire safeguarding policies and procedures were in place which linked into the local authority.
- The information provided by the organisation demonstrated that all the clinical staff were trained in safeguarding adults - to level two. We were informed that level three training had been undertaken by the safeguarding lead for adults and the paediatric nurse lead.
- All staff we spoke with had received safeguarding training through e-learning at Level 1 or at Level 2 about safeguarding children and adults. They were clear about their responsibilities and how to report concerns.
- The service was not provided for any woman under the age of 18 years and patients signed a form declaring their date of birth. If there were any cause for concern we were informed that this would be escalated to the matron.

- Safeguarding risk assessments were carried out appropriately when there was a suspected case of abuse and safeguarding referrals were made to local safeguarding team when appropriate. There had been no reported safeguarding events for the termination of pregnancy service.

Mandatory training

- Mandatory training covered a range of topics including fire safety, health and safety, basic life support, safeguarding, manual handling, infection control and information governance training, Mental Capacity Act and DOLs. Staff told us they were up to date with their mandatory training. The senior sister on Ward 2 informed us that she had recently attended Mental Capacity Act training at level 2.
- Data provided by the organisation showed that staff in the department were up to date with mandatory training as of August 2015.There were systems in place to remind staff if they were due for the mandatory training.

Assessing and responding to patient risk

- Patients who had undergone a termination of pregnancy underwent a venous thromboembolism (VTE) risk assessment. These were documented in the patient's records and included actions to mitigate the risks identified. The risk assessments informed staff if prophylactic treatments were required. An audits of the surgical termination of pregnancy care pathway showed that VTE assessments were routinely completed.
- Prior to termination procedures all patients should have a blood test to identify their blood group. It is important that any patient who has a rhesus negative blood group receives treatment with an injection of anti-D. This treatment protects against complications should the patient have future pregnancies. The records that we reviewed demonstrated that all the patients underwent a series of blood tests prior to the termination procedure, which included blood group, haemoglobin and Rhesus factor. Those patients who had a rhesus negative blood group received an anti-D injection within 72 hours of the procedure.
- During surgical procedures, staff used the World Health Organisation's (WHO) pre-operative checklist incorporating the National Patient Safety Agency surgical safety checklist', which is designed to prevent avoidable mistakes. These were completed appropriately in the patient records we reviewed. The hospital had also undertaken a surgical safety checklist audit. The audit performed in August 2014 showed that the compliance was 100% for surgical termination of pregnancies.
- Nursing staff had good access to medical support in the event of a patient's condition deteriorating. There was a resident medical officer (RMO) on site 24 hours a day who was trained to registrar level.

Nursing staffing

- The medical termination of pregnancy service was led by the matron and supported by the senior sister in outpatients who has a background in gynaecology. The senior sister was supported by two other registered general nurses who had completed - competency based training. The surgical termination of pregnancy service is based on the wards as a short stay day case and was supported by the senior sister who also has a background in gynaecology.
- A minimal staffing policy was followed in determining the staffing level which was reflected by the staffing rotas which we saw for the previous four months. For pre and post-surgical care, there were sufficient staff on duty to care for patients. When there had been staffing shortfalls due to holiday or sickness these had been covered by internal arrangements.
- Nurses demonstrated their clinical competencies for termination of pregnancy and this was recorded in their personal files.

Medical staffing

- The medical termination service was led by an NHS consultant obstetrician / gynaecologist based at a local NHS Trust The consultant was a Member of the Royal College of Obstetricians and Gynaecologists (MRCOG) and was on the specialist register. He was the lead for the service at the local NHS trust. There were other two consultant gynaecologists involved in the Early Medical Abortions who would cover for the holiday or sickness period.
- Consultations and treatments for Early Medical Abortions were held every Monday and Friday evening. Surgical abortions had been carried out by obstetric and gynaecology consultants as day case procedures.

Good

Termination of pregnancy

- Counselling was undertaken by the lead consultant and there was also a service level agreement in place for patients to be referred for independent counselling if requested.
- The staff told us that the consultants were always available and accessible when they needed support.
- The patients were seen at a second appointment by a private GP at the hospital for the second signature to be signed on the grounds for carrying out an abortion (HSA1 forms) for an opinion in good faith.
- The consultants at the hospital worked under practicing privileges. There was a robust process in place to ensure that suitable checks were carried out to enable staff to practice and have practising privileges with the hospital. The range of checks were undertaken by the hospital managers personal assistant which included qualification, insurance, registration, references, appraisals from the NHS trust, Disclosure and Barring Service checks (DBS) and revalidation reports. Following these checks, the hospital manager and the medical advisory committee (MAC) granted the practicing privileges.
- We reviewed the personnel files for the lead consultant gynaecologist for the service and the consultant microbiologist. The files contained the relevant documentation to enable them to have ongoing practising privileges with the hospital.
- The resident medical officers were trained in advanced life support (ALS).

Major incident awareness and training

- Emergency plans and evacuation procedures were in place.

Are termination of pregnancy services effective?

Good

Care was provided in line with national best practice guidelines. Patients were offered appropriate pain relief, anti-emetics, prophylactic antibiotic treatments and post-surgical contraceptives. The hospital performed audits recommended by Royal College of Obstetricians and Gynaecology (RCOG). These audits included, infection control, consenting for treatment, discussions related to different options of abortion, contraception discussion, confirmation of gestation and medical assessments audits. The outcomes of these audits reflected patient safety and patient choice. Compliance was 100%.

Staff told us they had annual appraisals and had also received clinical supervision. Staff had access to specific training to ensure they were able to meet the needs of the patients. Medical staff, nursing staff and other non-clinical staff worked well together as a team.

Advice was accessible 24 hours per day, seven days a week. Patients were consented appropriately and correctly. Staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty (DOLs) Safeguards. The MCA forms part of the care pathways and when patients did not have the capacity to give consent to their treatment, the Mental Capacity Act 2005 was implemented. Senior nurses had received training at level two for MCA and also for DOLs. This training was in the process of being rolled out to other staff.

Evidence-based care and treatment

- The Royal College of Obstetricians and Gynaecology (RCOG) guidelines for the treatment of patients such as termination of pregnancy for foetal anomaly and ectopic pregnancy were adhered to and were part of patients care pathways.
- Policies were accessible for staff and were developed in line with the updated Department of Health Required Standard Operating Procedures (RSOPs) and guidance.
- A referral pathway was followed by clinical staff in a suspected case of ectopic pregnancy.
- All patients underwent an ultra sound scan by the consultant at consultation to determine gestation of the pregnancy. This was in line with the RCOG clinical guideline for all abortions.
- RCOG guidance 'the care of women requesting induced abortion' suggest that services should make available information about the prevention of sexually transmitted infections (STI).It also suggests that all methods of contraception should be discussed with women at the initial assessment and a plan should be agreed for contraception after the abortion. All the patients attending for consultation for termination of pregnancy were offered screening for chlamydia prior to any treatment. Patients with positive test results would be referred to the sexual health services at the NHS trust.

- Contraceptive options were discussed with patients at the initial consultation and a plan was agreed for contraception after abortion. The patients had been advised about the different contraceptive options and referred to the local NHS clinic. These included Long Acting Reversible methods (LARC) which are considered to be most effective.
- Records audits showed that the centre was 100% compliant in following the discussion around contraceptive advice.

Pain relief

- Pre and post procedural pain relief was prescribed on medication records. Best practice was followed as non-steroidal anti-inflammatory drugs (NSAIDs) were usually prescribed. These are recognised as being effective for the pain experienced during terminations of pregnancy. Feedback from patients at follow-up was recorded in the patient records.
- Staff we spoke with were clear about which medication would be offered to patients for both surgical and early medical procedures and staff followed the recommended guidance as part of the pathway.
- The pain score was recorded on the pain tool in the patient records

Patient outcomes

- The organisation performed various audits recommended by RCOG such as audits related to infection control, consenting for treatment-retained products of conception and failed procedures. An example of a change to clinical practice was that patients at the second visit are routinely given a second dose of the abortion medication to take at home two hours later.
- Patients who had undergone a medical abortion were asked to return for a follow up scan two weeks post procedure to ensure that the procedure has been successful.
- Women who had undergone a surgical procedure were also offered a follow up appointment but we were told by nursing staff that women did not tend to take up this option routinely.
- We saw on the register that there had been one retained products of conception which required a surgical evaluation and two patients who required further oral termination medication in the last 12 months.

Competent staff

- We reviewed the personnel files for the lead consultant gynaecologist for the service and the consultant microbiologist. The files contained the relevant documentation to enable them to have ongoing practising privileges with the hospital. The files confirmed that both consultants had received appraisals from the local NHS trust where they were employed and had undergone revalidation with the GMC. To maintain and update competencies we saw that staff had attended relevant training for their speciality.
- Staff told us they had annual appraisals and had received clinical supervision.
- Information provided by the hospital showed that 100% of staff working in this service had completed an appraisal in the time period to July 2015.
- There was an induction programme for all new staff, which covered a variety of topics, and training and staff who had attended this programme felt it met their needs.
- Staff were supported through an induction process and competence based training relevant to this role.
- The 'Required Standard Operating Procedures' (RSOP) set by the Department of Health required that staff involved in pre assessment counselling be trained to diploma level in counselling.
- All the patients were offered counselling prior to the treatment by the consultant lead at first visit. Counselling was also available pre and post termination procedure if required through a service level agreement with an independent counsellor with an accredited diploma in counselling. Referrals would be made if a patient required further support and counselling.

Multidisciplinary working

- Medical staff, nursing staff and other non-clinical staff worked well together as a team. There were clear lines of accountability that contributed to the effective planning and delivery of patient care.
- The service had close working relationships with the sexual health team based at the NHS trust as part of the patient pathway.

Good

Termination of pregnancy

- The staff told us that they had close links with other agencies and services such as the local safeguarding team and the early pregnancy unit at the local NHS trust. This had helped to improve the patient care pathway.
- Spire Leicester Hospital had a service level agreement with the local NHS Trust which allowed them to transfer a patient to the hospital in case of medical or surgical emergency.

Seven day services

- Termination of pregnancy procedures were carried out as either surgical short stay day procedures or outpatient early medical procedures.
- Patients were phoned the day following the procedure by the trained nurses.
- There was an expectation that patients had access to a 24-hour emergency number should they be worried and require advice.
- There was a resident medical officer available 24 hours at the hospital.
- The consultants and the senior nurse for the service were available for advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- As part of the patient's pathway during the consultation with the consultant consent for the procedure had been obtained and documented. It was explained that if a patient expressed any doubts, efforts were made, by the staff to carefully discuss any sensitive information. Patients were offered a second consultation if they were not entirely sure about their decision to terminate the pregnancy.
- Patients were asked if they wanted their GP to be informed by letter about the care and treatment they received. Patient's decisions were recorded and their wishes were respected. Confidentiality was paramount and no correspondence or billing was sent to the patient.
- The five care records we reviewed contained signed consent from patients. Possible side effects and complications were recorded and had been explained to patients.
- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLs). The ward sister described a recent DOLs referral she reported which involved a patient who became confused and agitated who required one to one support to prevent harm from falling until the prescribed antibiotics took effect. She explained that all the pathways have an element relating to MCA.
- Patients signed a consent form for the sensitive disposal of pregnancy remains and this was recorded in the patient records. We were shown a completed form.

Are termination of pregnancy services caring?

Good

Patients were treated by staff with compassion, dignity and respect. The staff focused on the needs of patients and were caring, compassionate and responded quickly to their needs. Patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care.

The staff explained the different methods and options available for abortion. If patients needed time to make a decision, this was supported by the staff. All the patients considering termination of pregnancy had access to pre-termination counselling. Appropriate support was given where a patient underwent termination of pregnancy due to foetal anomaly.

Patient's wishes were respected and their beliefs and faith were taken into consideration regarding the disposal arrangements for foetal tissue.

The results of the hospital BUPA Customer Satisfaction Results 2014 Friends and Family element demonstrated that 98 % of patients were 'extremely likely' to recommend the service to family and friends.

Compassionate care

- Throughout our inspection, we observed patients were treated with compassion, dignity and respect.
- We observed positive interactions between patients and staff. Patients were introduced to all healthcare professionals involved in their care, and were made aware of the roles and responsibilities of the members of the healthcare team.

Good

Termination of pregnancy

- Patients' preferences for sharing information with their partner or family members were established, respected and reviewed throughout their care.
- Staff had a non-directive and non-judgemental approach to patients who had or were to receive treatment for a termination of pregnancy. Staff were responsive to the individual needs of patients undergoing medical or surgical termination.

Understanding and involvement of patients and those close to them

- The initial consultation by the consultant and nursing staff explained all the available methods for termination of pregnancy that were appropriate and safe to patients. The staff considered gestational age and other clinical needs whilst suggesting these options.
- Patients were given leaflets, which had information regarding different methods and options available for abortion.
- A nurse chaperone was present during consultations and examinations.
- Patients had been involved in their care.
- The five records we reviewed considered and recorded the post discharge support available for patients at home. Women were given written information about accessing a 24 hour emergency number for support following abortion procedure.
- Patients were contacted the day following the procedure to reassure them and to check if they had any concerns and this was documented in their records.

Emotional support

- Patients considering termination of pregnancy should have access to pre-termination counselling. All the patients who attended for consultation were offered counselling either with the consultant or referred to an independent counsellor if required.
- At initial consultation a discussion is held with patients regarding the disposal arrangements for pregnancy remains. Patient's wishes were respected and their beliefs and faith were taken into consideration. The service supported if the patients had specific wishes about burial or sensitive disposal of pregnancy remains. Staff provided women with specific information about how this could be managed and arranged.

Are termination of pregnancy services responsive?

Good

Patients could access the services telephone number through the website and book for a consultation with the specialist customer services team. Confidentiality is paramount and no correspondence or billing is sent to the patient.

'Department of Health Required Standard Operating Procedures' indicate that there should be a 10 working day referral to procedure process time. The timescales from referral to treatment were within those timeframes.

A professional interpreter service was available to enable staff to communicate with patients for whom English was not their first language. There was a clearly defined specialist referral process for women who required a specialist service.

Formal complaints were managed by matron. There had been no complaints for termination of pregnancy.

Service planning and delivery to meet the needs of local people

- The service is advertised on the Spire Leicester website and patients can either self-refer or go to their GP for referral. A specialist team within customer services can arrange an appointment for initial consultation with the consultant. Patients were offered a choice of appointment to the Monday or the Friday evening clinic to access treatment as early as possible.
- There was a service level agreement with the local NHS trust and sensitive clinical waste was collected and taken to the trust and then to the local crematorium. A full audit trail was maintained at the trust.
- Patients had been signposted to either a local support centre or an independent counsellor who support women with post-termination counselling sessions if required.

Access and flow

- Patients were referred from a variety of sources such as GPs or self-referrals through the website number to a specialist team in customer services. The hospital

undertook all aspects of pre assessment care pathway including counselling, date checking scans to confirm pregnancy and to determine gestational age and other pre-termination assessments.
- Department of Health guidelines state the total time from access to procedure should not exceed ten working days in order that patients get timely access to terminations. We were informed that patients were seen at initial consultation and treated within that time frame. This was corroborated when checking the records.
- If there were a foetal abnormality, the patient would be was seen and treated in the NHS trust by the consultant as genetic follow up screening would be required. For those women having difficulty coping due to special circumstances such as foetal abnormality, referrals were made to specialist organisations.

Meeting people's individual needs

- The hospital was accessible to wheelchairs users and disabled toilets were available.
- A professional interpreter service was available to enable staff to communicate with patients for whom English was not their first language.
- Consent forms were based on the Department of Health consent forms and were used as part of the patient pathway for short stay surgical termination of pregnancy and early medical abortions. Staff told us that they could use the interpreter service to ensure the patient understood and could weigh up the decision to continue the treatment.
- Support was available for patients with a learning disability or other complex needs to ensure they were able to make an informed choice.
- There was a clearly defined specialist referral process for women who required a specialist service for foetal abnormality or if the gestation of the pregnancy was over 12 weeks.
- Patient information leaflets included both surgical and early medical termination of pregnancy procedures. This explained about different options available for termination of pregnancy including what to expect when undergoing a surgical termination. This also included any potential risks.
- Leaflets were given to patients to inform them what to expect after the procedure. This included a 24-hour emergency telephone number of where patients could seek advice if they were worried.
- The Early Medical Termination of Pregnancy register showed that there was an occasion when the patient changed their mind about terminating their pregnancy. The sister informed us that under these circumstances the consultant would refer them to the antenatal clinic for a booking scan or back to their own GP to access a midwife.
- The hospital adhered to the management of clinical waste policy specifically for the sensitive disposal of pregnancy remains. Patients were given information leaflets, which detailed the options available for the sensitive disposal of the pregnancy loss. Where a patient wished to dispose of the pregnancy remains privately, staff provided them with a specific information sheet, which laid out how the arrangements should be managed, and a pregnancy loss authorisation for release of pregnancy remains was signed. Where women did not have specific wishes with regard to disposal, the pregnancy remains were stored in accordance with the hospital policy for the storage and sensitive disposal of pregnancy remains.

Learning from complaints and concerns

- Patients were encouraged to raise a concern or make a complaint and staff were positive about learning from complaints.
- Literature and posters were displayed advising patients how they could raise a concern or complaint formally or informally. A separate leaflet was also available.
- We were told by staff that the management of complaints was discussed as part of the corporate induction days.
- We were informed that there had been no complaints relating to the service for either medical or surgical TOPs. However, the policy should there be a complaint was that it would be managed by the matron. Weekly rapid response meetings were held where any complaints would be discussed. A full investigation of a complaint would be undertaken and feedback was given to the staff. Complaints form part of the clinical governance report.

Good

Termination of pregnancy

Are termination of pregnancy services well-led?

Good

Staff could tell us about the hospital's value to treat all patients with dignity and respect and provide a confidential, non-judgmental service.

There was a robust governance structure to manage risk and quality. Staff told us they felt supported by the senior managers and that the leadership and visibility of senior managers was good.

The culture within the service was caring and supportive. Staff were actively engaged. Innovative ideas and approaches to care were encouraged and supported. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the Spire Leicester Hospital.

Patients were engaged through feedback at follow up consultation and by means of a patient satisfaction form. Staff however, told us that due to the sensitivity of the procedure and the procedures being potentially emotional experience for the patients it was challenging to engage with the patients.

The certificate of approval for carrying out termination of pregnancy (issued by the Department of Health) was displayed.

Vision, strategy, innovation and sustainability and strategy for this this core service

- Staff were positive and focused on how to improve the services for patients and about providing a high quality service.
- There was a vision and strategy in place dated 6 August 2015 to develop the early medical termination of pregnancy service and to ensure that the service advertised on the website was accessible, offered informed choice and a seamless service. To treat all the patients with dignity and respect and provide a confidential, non-judgmental services.
- The certificate of approval for carrying out termination of pregnancy (issued by the Department of Health) was displayed and dated 17 July 2014 valid until 31 July 2018.

Governance, risk management and quality measurement for this core service

- There was a robust governance structure to manage risk and quality. Staff felt supported by the hospital director, the matron and senior managers. Staff said that the leadership and visibility of senior managers was good.
- The early medical abortion service and the surgical termination of pregnancy service staff told us that due to the sensitivity of the procedure and the procedures being a potentially emotional experience for the patients it was challenging to engage with the patients. They were in the process of developing a specific questionnaire, which could be completed following the treatment to capture the patient views.
- There is a general risk register with various areas of risk identified. The register included review dates, current ratings and target ratings based on the traffic light system and a record of the action being taken to reduce the level of risk was maintained.
- A risk assessment has been undertaken for both surgical and medical termination of pregnancy. The termination of pregnancy core service was not identified as a risk to the hospital.
- A team brief was circulated to all staff and included generic, financial marketing and clinical elements.
- The consultant leading the early medical abortion service took a lead role in ensuring that the hospital was working in line with current national guidance.
- The assessment process for termination of pregnancy legally requires that two doctors agree with the reason for the termination and sign a form to indicate their agreement (the HSA1 Form). We looked at five patient records and found that all forms included two signatures and the reason for the termination based on the DH opinion in good faith.
- Spire Leicester had completed an HSA1 audit to ensure and evidence compliance. The audit 'Completion of Legal Documentation' was carried out between August and December 2014 and demonstrated 100% compliance.
- The Department of Health (DH) required every provider undertaking termination of pregnancy to submit demographical data following every termination of pregnancy procedure performed. These contribute to a national report on the termination of pregnancy (HSA4 forms). Patients were made aware that information is reported to and used statistically by the DH. The HSA4

forms were signed within 14 days on the completion of the abortion by the consultant who terminated the pregnancy. The forms were then submitted to DH by the outpatient senior sister following the medical termination procedure and the ward coordinator sister following the surgical procedure. It was discussed that it may be more appropriate for the outpatient senior sister to collate the HSA4 forms as part of the pathway and submit to DH.

- The Early Medical Abortion service maintained a register of patients undergoing a termination of pregnancy, which was completed in respect of each person at the time the termination was undertaken and was retained for a period of not less than three years beginning on the date of the last entry.
- The surgical termination of pregnancy procedures were identified in the theatre register with a unique identifier of a red star.

Leadership/culture of service

- The senior sisters involved in the service felt very well supported by the matron and felt there was clear leadership.
- The culture within the hospital was caring and supportive. Staff were actively engaged. Innovative ideas and approaches to care were encouraged and supported particularly since the appointment of the new matron. Staff spoke positively about the high quality care and services they provided for patients and were proud to work for Spire Leicester.
- Staff displayed an enthusiastic, compassionate and caring manner to the care they delivered. They recognised that it was a difficult decision for patients to seek and undergo a termination of pregnancy.
- Staff spoke positively about the high quality care and services they provided for patients. They described Spire Leicester Hospital as a good place to work and they felt empowered to be innovative particularly since the new Matron had been in post.
- Staff told us they were comfortable reporting incidents and raising concerns. They told us they were encouraged to learn from incidents. Staff felt they could openly approach senior managers if they felt the need to seek advice and support.

Public and staff engagement

- Patients had been given feedback forms which asked for their opinion of the service. Staff however, told us that due to the sensitivity of the procedure and the procedures being potentially emotional experience for the patients it was challenging to engage with the patients.
- The results of the BUPA Customer Satisfaction Results 2014 Friends and Family element demonstrated that 98 % of patients were 'extremely likely' to recommend the service to family and friends.
- Staff surveys were completed to gain staff opinion of working at the hospital. The staff survey results for 2014 were generally positive.
- The service facilitated wherever possible and legal, any request made by a patient concerning management of the pregnancy remains, and provided relevant training to staff to enable them to meet those needs. Staff followed the policy 'Consent for Disposal Pregnancy Loss (2014)' in accordance with 'Human Tissue Authority, Code of Practice 5, and Disposal of Human Tissue (2009)'. All patients signed a consent form for the disposal of pregnancy remains. Following a surgical procedure the pregnancy loss is stored sensitively and separately in an opaque container and kept for six weeks.
- Where a patient wished to dispose of the pregnancy remains privately, staff provided them with a specific information sheet which laid out how this process should be managed and how the patient would make their own arrangements. We were informed that this had recently happened as a patient had requested the pregnancy remains on religious grounds. This had been dealt with sensitively and with dignity.

Innovation, improvement and sustainability

- Medical termination of pregnancy was an example of an innovative service as it enabled women to have choice other than a surgical procedure within an independent hospital setting. It was driven in response to patient demand and offered women choice.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Ensure that you maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. There was no audit system for ensuring that medical notes were fully completed within the children's and young people's service.
- Ensure arrangements are put in place to monitor outpatient appointment cancellations and delays.

Action the provider SHOULD take to improve

- Ensure paediatric and adult drug boxes for resuscitation are not of a similar colour to aid quick identification in an emergency.
- Ensure appropriate interpreting services following best practice are always available for those whose first language is not English.
- Ensure auditing samples for compliance with the five safer steps to surgery are more representative of the number of patients undergoing surgical procedures.
- Ensure that there is an effective system in place for contacting a radiologist urgently.
- Ensure that the minor operations room has a plan in place for ensuring patient safety and that treatment can be provided rapidly without delay.
- Ensure that the privacy and dignity of patients using the imaging department is maintained.
- Ensure that all staff working with oncology patients in the chemotherapy unit are aware of the gold standards framework.
- Ensure practice is reviewed around the use of the malnutrition universal screening tool.
- Ensure a protocol for children with learning difficulties is developed.
- Ensure that staffing and workforce development plans are developed in parallel with the paediatric strategy
- Ensure the areas where children are cared for are appropriate for the needs of the child.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance** How the regulation was not being met: Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – ‘’Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.’’ We found gaps in some of the patient records we reviewed. We were told that some consultants used their own notes rather than Spire medical records in which to record the patient’s outpatient consultation and not all those notes were retained within the Spire medical record.

This section is primarily information for the provider

Requirement notices

There was no audit system for ensuring that medical notes were fully completed within the children's and young people's service.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance** How the regulation was not being met: The provider did not ensure that cancellations and delays with patient appointments are monitored. Data was collected but not audited or actioned further to prevent or reduce these events in future.