

Spire Healthcare Limited

Spire Thames Valley Hospital

Quality Report

Wexham Street
Wexham
Berkshire, SL3 6NH
Tel: 01753 662 241
Website: www.spirehealthcare.com

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital

Good



Medical care

Requires improvement



Surgery

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Overall summary

Spire Thames Valley Hospital is operated by Spire Healthcare Limited. It opened in the 1960s initially as a nursing home, and its ownership has changed a number of times over the years.

The hospital treats patients from Buckinghamshire, Berkshire and Middlesex. Spire Thames Valley is a two storey Hospital with 37 beds providing inpatient and day case care and a 2 bed High Dependency Unit.

In 2015 the hospital developed its sterile services department. Current facilities include 8 consulting rooms, 2 minor procedures treatment rooms, audiology room, physio gym and treatment room, 2 laminar flow theatres and 1 endoscopy unit, an in-house theatre sterile services department and 3 wards. Diagnostic imaging facilities include a digital mammography, ultrasound and x-ray. 2 days per week, a mobile MRI service is on site.

Specialities at the hospital include: Bariatric (Obesity) surgery, Oncology, Breast surgery, Oral surgery, Cardiology, Orthopaedic surgery, Colorectal (bowel) surgery, Paediatric surgery (age 3 and above), Age 0-3 OPD Consultation only, Cosmetic surgery, Dermatology, Physiotherapy, Dietetics, Plastic & reconstructive surgery, Ear, Nose & Throat (ENT), Psychology, Endocrinology, Renal medicine, Fertility, Respiratory medicine, Foot & ankle surgery, Gastroenterology, General surgery, Hand & wrist surgery, Urology, Immunology & allergy testing, Vascular surgery, X-ray/MRI/Mammography, Gynaecology, Cardiac Stress Echo's, Fertility.

The Spire Healthcare Limited provides surgery, including highly-specialist, complex, gender-reassignment surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery and services for children and young people within the surgical section of the overall report.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 14 and 15 November 2016, with an unannounced visit on 28 November 2016.

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

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

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

Services we rate

We rated this hospital as Good overall.

- We found a good incident reporting culture, staff were trained how to report and there was a willingness to learn from mistakes.
- Equipment was maintained and appropriately checked.
- The hospital had systems in place for reporting abuse and safeguarding patients.
- Staffing levels were sufficient to meet patient needs, and skill mix was planned and reviewed to ensure that patients were safe.
- Medicines were stored safely and checks on emergency resuscitation equipment were performed routinely.

Summary of findings

- Staff treated patients with dignity and respect and patients were kept involved in their care. Patients and their relatives we spoke with told us they were supported by staff. We observed staff deliver care in a caring, compassionate and supportive way.
- The hospital had a national programme of clinical audits in place.
- There were robust systems to ensure that consultants holding practicing privileges were valid to practice. We saw there were procedures in place to ensure all consultant requests to practice were reviewed by the Medical Advisory Committee (MAC).
- Managers were engaged with staff in realising the hospital's ambition of working together to provide excellent care in a highly-saturated local health economy.
- There was an open culture and staff were empowered to make changes and improvements.

However, we found areas of practice that require improvement in both surgery and medicine:

- There was a concern regarding a lack of robust cleanliness and infection control practices within theatres and endoscopy.
- Our inspection of the theatre suite found that some parts including ceilings in the operating theatres were not visibly clean and there were cracked tiles in both scrub rooms which did not allow for effective cleaning.
- Our inspection of the endoscope decontamination room found that the washers and floors were marked following leaks from the washers. The decontamination room was cluttered and we were not assured the room could be cleaned effectively.
- Hand washing facilities in the decontamination room were not accessible to staff due to large items of portable equipment being stored within the room.
- Recording of surgical first assistant competency within theatre was inconsistent.
- The use of the WHO Checklist process was carried out safely, but certain aspects such as team and patient interaction were not fully completed with the patient fully involved.
- The outpatient departments had not completed audits on WHO checklist audits, patient medical notes, waiting times and consent.
- Governance of risk within endoscopy was not sufficiently robust. The hospital had identified risks concerning the flow of decontaminated endoscopes but these had not been addressed or mitigated.

Following this inspection, we told the provider that it should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Requires improvement

Rating



Why have we given this rating?

Medical care services were a small proportion of hospital activity comprising mainly oncology services and endoscopy procedures. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section and referenced them in this section. We rated this service as requires improvement because there were some concerns within safe and well-led, although we rated the service good in effective, caring and responsive. We found a good incident reporting culture, staff were trained how to report appropriately and there was a willingness to learn from mistakes. Staff followed infection control processes and procedures. Hygiene and cleanliness was generally maintained to a high standard. However, there were concerns regarding cleanliness of the endoscopy decontamination room and the procedure for the flow of used or dirty endoscopes. Medicines in oncology and endoscopy were managed and stored in line with guidance. There were sufficient numbers of trained medical and nursing staff to look after the number of patients who attended the hospital. Patients told us that staff were caring and treated them with respect and dignity. The hospital took account of their patients' needs, making adjustments to services where necessary and ensuring flexibility with appointment times. However, There had been several changes in senior management team in the 12 months prior to the inspection. Some appointments had been made only shortly before the inspection. It was therefore too soon to see the benefits of the new management. Staff told us they had seen positive improvements in some areas, which led them to be assured and confident for the future. We were not fully assured there was robust oversight of governance as we found some identified risks had not been addressed or mitigated.

Summary of findings

Surgery

Good



Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section.

We rated this service as good for effective, caring, responsive and well-led and requires improvement for safe

We found that the ceilings in the operating theatres were not visibly clean.

The use of the WHO Checklist process was carried out safely, but certain aspects such as team and patient interaction were not fully completed with the patient fully involved.

However,

There were arrangements in place to keep patients safe. Staff reported incidents that allowed them to be reviewed by managers to identify trends.

Departments undertook audits and acted on the results of these. The leadership team understood risk and took action to address it.

Medicines were stored securely and safely.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005.

Staffing levels and skill mix were planned and reviewed to ensure that patients were safe. Staff were supported with training and development to maintain and develop their skills. Staff we spoke with were positive about working at the hospital. Inpatient wards areas and patient rooms were clean and well maintained.

We found that patients were treated with compassion and respect, privacy and dignity were maintained at all times.

The hospital designed its processes around the needs of patients, both adults and children.

Managers were engaged with staff in realising the hospital's ambition of working together to provide patients with an excellent care environment and high quality care.

There was an open culture and staff were empowered to make changes and improvements.

Summary of findings

Outpatients and diagnostic imaging

Good



Overall, this service was rated as good. We found outpatients and diagnostic imaging (OPD) was good for the key questions of safe, caring, responsive and well-led. We did not rate effective, as we do not currently collate sufficient evidence to rate this. Staff monitored patient safety; they investigated incidents and shared the learning to improve care. Medicines were stored safely and checks on emergency resuscitation equipment were performed routinely. Staff had appropriate safeguarding awareness and people were protected from abuse. There were sufficient staff with the right skills to care for patients and staff had been provided with induction, mandatory and additional training specific for their roles.

The service had policies and guidance to ensure staff provided care and treatment that took account of evidence based standards and procedures, except with the regards ionising radiation regulations. The annual Radiation Protection Audit (RPA) in June 2016 found that the service was partially compliant with the current regulations, standards and guidance relating to the use of ionising radiations in diagnostic imaging.

The hospital had a national programme of clinical audits in place, in which the OPD also took part. However, we found in OPD the departments had not completed audits on WHO checklist audits, patient medical notes, waiting times and consent.

Patient's privacy was always protected in outpatient and diagnostic areas. Staff knocked on doors before entering rooms, used curtains appropriately and were careful to avoid conversations in corridors. Feedback from patients who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

Patients' treatment and care was delivered in accordance with their individual needs. Patients told us they felt involved in decisions about their care and they were treated with dignity and respect. The leadership, governance and culture within the

Summary of findings

departments promoted the delivery of person centred care. Staff were supported by their managers and were encouraged to contribute to the development of the services.

Spire Thames Valley Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Outpatients and diagnostic imaging

Detailed findings

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Background to Spire Thames Valley Hospital

Spire Thames Valley Hospital is operated by Spire Healthcare Limited. It is a private hospital in Wexham, Berkshire. The hospital primarily serves the communities of Buckinghamshire, Berkshire and Middlesex. It also accepts patient referrals from outside this area.

At the time of the inspection, a new manager had recently been appointed and was registered with the CQC on 1 August 2016.

The hospital also offers cosmetic procedures such as dermal fillers and laser hair removal, ophthalmic treatments and cosmetic dentistry. We did not inspect these services.

The hospital has an outreach clinic, called the Spire Windsor Clinic. This clinic provided patients with additional access to minor treatments and outpatient appointments.

Our inspection team

The team that inspected the service comprised a CQC lead inspector supported by two other CQC inspectors, an Inspection Manager, and specialist advisors with expertise in theatre management, surgery, diagnostic imaging and governance.

Facts and data about Spire Thames Valley Hospital

The hospital has one ward and is registered to provide the following regulated activities:

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

During the inspection, we visited outpatients and diagnostic imaging, inpatient ward and theatres. We spoke with 31 staff including; registered nurses, health

care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 14 patients and two relatives. During our inspection, we reviewed 19 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. This was the hospital's first inspection since registration with CQC, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016):

Detailed findings

- In the reporting period July 2015 to June 2016, there were 5,190 inpatient and day case episodes of care recorded at the hospital; of these 8% were NHS-funded and 92% other funded.
- 33% of all NHS-funded patients and 22% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 38,431 outpatient total attendances in the reporting period; of these 94% were other funded and 6% were NHS-funded.

192 surgeons, anaesthetists, physicians and radiologists from local NHS trusts worked at the hospital under practising privileges. Two externally employed, regular resident medical officers (RMO) worked on a weekly rota. The hospital employed 29.2 full-time equivalent registered nurses, 7.5 full-time equivalent operating department practitioners and care assistants, as well as having its own bank of nursing staff. In addition, there were 62.2 full-time equivalent other members of staff employed by the hospital. The accountable officer for controlled drugs (CD's) was the Matron.

Track record on safety (July 2015 to June 2016):

- No Never events.
- Clinical incidents 40 no harm, 143 low harm, 104 moderate harm, 11 severe harm including 6 medical deaths.
- No serious injuries.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).

- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- One incident of hospital acquired Clostridium difficile (c.diff) in the period January 2016 to March 2016.
- No incidences of hospital acquired E-Coli.
- 36 complaints were received by the hospital during the reporting period. No complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.

A mobile MRI service attends the hospital twice weekly. We did not inspect this facility as part of this inspection.

Services accredited by a national body:

- BUPA Approved Breast Care accreditation
- BUPA Approved Bowel Cancer accreditation

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laundry
- Maintenance of medical equipment
- Pathology and histology
- RMO provision
- Specialist blood services






Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Medical care

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

Information about the service

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

The medical service included delivering chemotherapy, oncology care and treatment for patients requiring breast, gynaecology, upper gastrointestinal and colorectal oncology services. It also included endoscopic procedures to insured, NHS funded and self-paying patients.

The endoscopic unit is based in theatre areas and was open for elective procedures (where required) Monday to Friday, Saturday and in some cases, Sunday. Out of hour's emergency cover was able to be provided.

Summary of findings

Medical care

Are medical care services safe?

Requires improvement



We rated safe as requires improvement.

Incidents

- Please see core service report for surgery for further details.
- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospitals electronic reporting system.
- Staff we spoke with in endoscopy and oncology had access to the electronic incident reporting system. Records we reviewed confirmed that staff had received training and were confident with using the incident reporting system. Staff we spoke with were aware of their responsibility to report incidents.
- There were no never events reported during the period July 2015 to June 2016.
- The hospital had reported 314 clinical incidents, and reported 69 non-clinical incidents, from July 2015 to June 2016. The data provided by the hospital was not split by core service. The overall rate of incidents reported during that period was equivalent to that of other independent hospitals for which CQC holds data. We found there was a positive culture of reporting incidents so learning could occur.
- The hospital reported that there had been eight deaths in the reporting period July 2015 to June 2016, of which seven were unexpected. However, CQC had a record that five of these deaths were expected in the oncology service. This was checked with the hospital during the inspection, they reported that there were eight deaths in total. Three deaths occurred in the patient's own home, and were expected. Whilst the hospital data was inconsistent, we found this was due to reporting inaccuracy, which the hospital management team were addressing.

Duty of Candour

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

- Staff in endoscopy and oncology were aware of the duty of candour legislation. If an incident occurred in oncology or endoscopy, nursing staff were open and honest in talking with patients. The matron was aware of the requirement to write to patients providing them with an opportunity or a meeting to discuss serious incidents, investigations and any learning. There was a process in place and we saw a hospital document prepared for staff regarding the implementation of duty of candour.
- Staff in endoscopy and oncology told us no incident had occurred that triggered the duty of candour process, in the period between July 2015 and June 2016.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- Please see core service report for surgery for main details.

Cleanliness, infection control and hygiene

- Please see core service report for surgery for further details.
- Endoscopy staff decontaminated endoscopes on site. The hospital had looked at the decontamination flow for endoscopes and had identified a number of risks. We saw a draft internal review document, dated 16 March 2015, with actions to be completed by end of March 2015. However this document had not been approved until 24 October 2016 and none of the actions had been started.
- We observed that staff were unable to wash their hands in the decontamination room due to the handwashing sink being inaccessible. Large items of portable equipment were stored in the room that blocked access to the sink. This meant that staff had to pass through a door into the endoscopy treatment room to wash their hands.
- The door from the main theatre corridor to the decontamination room had unrestricted access when staff were cleaning contaminated endoscopes in the

Medical care

sink. There was no signage to alert staff that washing was in progress. As the sink was situated next to the door, this meant there was a risk that staff entering the room could be splashed with contaminated water.

- The review of the decontamination room also identified that the hospital blood storage fridge was located within the endoscopy decontamination room. This was accessed by all members of the hospital team who might not be wearing appropriate protective clothing.
- Staff told us the endoscope washers occasionally leaked. The machines and floor were marked where this had happened and we could not be assured that cleanliness could be maintained.
- The decontamination room was cluttered with items such as stationery supplies. Mobile endoscope equipment stacks were stored in the room when not in use. There were endoscope cases and cardboard boxes stored on the floor behind the endoscope washers. The washers are large and secured to the floor meaning we were not assured that items stored on the floor were moved during cleaning.
- The oncology department was visibly clean and tidy. This included all areas such as patient rooms, the corridor through the department and both the clean and dirty utility rooms.
- Sharps containers were dated and signed when assembled. Purple sharps boxes for cytotoxic waste were available and being used in the oncology department.
- The oncology department had a documented schedule of daily and weekly cleaning, and records were checked which confirmed this had taken place.
- Staff in both oncology and endoscopy adhered to the 'bare below the elbow' uniform policy when providing care and treatment. The hospital assured themselves of compliance with good hand hygiene practice through quarterly observational audits undertaken by the infection control link staff.
- Disposable aprons and gloves were readily available for staff to use when delivering care and treatment to patients, to reduce the risk of cross infection and we observed staff wearing them.

Environment and equipment

- The hospital had five dedicated rooms for the oncology department, all with beds, chairs and en-suite facilities. Pull wands in the patient bathrooms were clearly visible and easily reachable.
- The endoscopy rooms were located entirely within the theatre suite and shared resuscitation equipment from theatres.
- Environmental risks were not all managed appropriately in endoscopy to ensure patient and staff safety was maintained. For example, the room had a single sink for handwashing however, staff could not use it as equipment stored in the room was blocking access.
- Maintenance and repair contracts were in place for endoscopes, the machine that processed the water for rinsing, the washer disinfectant and drying cabinet. We saw that maintenance records were up to date during our inspection.
- Staff told us that if the endoscope washer broke down, the maintenance company were responsive. They would give advice over the telephone or repair the equipment that day or the next.
- Daily checks were carried out on the endoscope washers using a self-check automated system within the washer. Print outs from the washers were checked and filed by the theatre staff.
- Staff told us the endoscope washers were approaching the end of their fiduciary working life and there was a plan for them to be replaced. This was due to happen once plans to redevelop the endoscopy rooms had been finalised and approved by the hospital. Staff told us that they hoped this would be in early 2017.
- The oncology department used resuscitation equipment obtained from the outpatient department. Outpatient staff checked the trolley daily. We checked the trolley and records and found it to be tamper proof, appropriately stocked, checked and ready for use.

Medicines

- Please see core service report for surgery for further details.

Medical care

- There was a medicines management policy dated April 2016 that staff used to guide their practice. Staff also had access to the British National Formulary for guidance on medicines.
- We observed effective systems for the storage and management of medicines in the oncology department. Chemotherapy medicines were delivered to the hospital prepared and ready for administration to patients. These medicines were only transported to the oncology department in suitable containers once they had been checked by an appropriately trained member of the pharmacy team.
- In the oncology unit, emergency medicines, including in-date extravasation kits, were available for use, and staff were aware of the procedure for managing an extravasation. An extravasation kit is equipment used to remove an intravenous (IV) drug or fluid that has leaked from a vein into the surrounding tissue.
- Anaphylaxis kits, for treating a severe allergic reaction to medicines or treatment, were accessible, in-date and clearly marked in both endoscopy and oncology areas.
- Chemotherapy spillage kits were available in the oncology department. These were accessible, in-date and checked by the oncology nurses and an oncology trained pharmacist.
- Medicines were stored in locked cupboards. Medicines that required temperature controlled storage were stored in a locked fridge. We saw minimum and maximum temperatures had been checked and recorded appropriately. Staff we spoke with could describe the actions to take if temperatures were not within the minimum and maximum range, and there was guidance on the record sheets.
- A patient having an endoscopy may have the procedure carried out under sedation. Endoscopy staff ensured medicines were available in case a patient had an adverse reaction to sedation.
- Patient records in oncology were primarily held on paper however the hospital had recently introduced an electronic prescribing system for chemotherapy medicines. This was a new record system and there was an on-going training programme for all staff. Staff reported this was working well however not all staff had yet been trained how to use it. For example, the RMO had not received training so nursing staff produced additional paper records in case the RMO needed access to records out of hours during this period of transition.
- We reviewed five patient records in endoscopy and in oncology. Nursing and medical staff had completed accurate, legible records which were up to date.
- Endoscopy staff maintained manual tracking and traceability records of the endoscopes. Each entry logged the patient details, the procedure carried out and the endoscope used. The entries were clear and legible, with no gaps on the log.
- Staff told us a record was made in the patient notes when there was a chaperone at the appointment.
- Patients were also discharged with advice leaflets about managing common problems after specific procedures.

Safeguarding

- Please see core service report for surgery for main details.
- At the time of the inspection, 100% of staff in the oncology department had completed the safeguarding adults and children level 2 training. Training details for endoscopy staff was covered in the figures for theatre staff.
- The matron was the named lead for safeguarding adults, and the ward manager was safeguarding lead for children. Both members of staff had appropriate level 3 adult and children's safeguarding training. We saw evidence of this during the inspection.

Records

- The oncology department maintained comprehensive patient's records in paper format. These were stored securely in a locked cabinet in the department office. The office was kept locked when not in use.

Mandatory training

- The hospital had a target of 95% for staff to complete mandatory training. The reporting period for training was from January to December each year. Staff in

Medical care

oncology had achieved 100% completion of mandatory training. Figures for endoscopy staff are included in the theatre staff statistics, which is reported in the surgery core service report.

- Staff had access to a range of electronic and face-to-face mandatory training. This included topics such: health & safety, infection control, fire safety, basic life support, manual handling, equality and diversity, safeguarding children level one and level two, safeguarding adults level one and two, compassion in practice and information governance.
- Staff were supported to complete this training and time was given to staff to enable them to complete any required learning.
- Managers told us they received monthly emails from the human resource team informing them of training compliance for each member of staff in their department. They then ensured staff had time to complete training that was about to, or had, expired.

Assessing and responding to patient risk

- Patients attending for an endoscopy were required to complete a pre-assessment health questionnaire. Pre-operative assessment staff checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for the planned procedure. The pre-operative assessment staff advised the consultant of any medical risk factors that they would need to be aware of so they could revise the treatment plan if required.
- The national early warning system (NEWS) is a scoring system that identifies patients at risk of deterioration, or needing urgent review. This included physical observation of patients to detect signs of deterioration. This system was in use for patients admitted to the medical service. Medical and nursing staff had awareness of the appropriate escalation action to take if a score indicated a patient had deteriorated.
- The hospital had an established oncology service which was supported by a multidisciplinary team of four oncologists. All treatments were initiated by an oncologist/haematologist.
- Prior to each treatment, nurses completed a nursing assessment, as part of a specifically designed care

pathway for oncology patients. This incorporated blood tests and sepsis screening to ensure patients were well enough to receive treatment. Patient assessment included information about the risks of chemotherapy, and how these risks were managed.

- Patients were able to contact the hospital out of hours via telephone if they needed to discuss any concerns or report any adverse side effects of chemotherapy. The service used the United Kingdom Oncology Nursing Society (UKONS) triage tool in collaboration with the RMO. Depending on the nature of the telephone call the RMO would contact the treating oncologist. All calls were monitored by the oncology nurses and training was provided to ward nurses where needed. All patients who contacted the out of hours service received a follow up call from the oncology nurses.
- The medical and nursing staff in endoscopy completed a WHO Surgical Safety Checklist in endoscopy. This is an internationally recognised system of checks before, during, and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed staff performing the checklist correctly during our visit. Hospital observational audits were undertaken in endoscopy showed 100% compliance with the WHO Surgical Safety Checklist from June 2015 to July 2016

Nursing staffing

- For our detailed findings on nurse staffing please see this section in the surgery report.
- No bank or agency staff were used in the oncology department during the period July 2015 to June 2016. This provided patients with continuity of staff, with patients often seeing the same nurse on each visit to the hospital.
- The manager in the oncology department confirmed the skill mix and competencies of staff enabled the needs of patients attending the unit to be effectively met.
- The theatre manager, who was also the lead for endoscopy, confirmed the staffing skill mix and

Medical care

competencies were appropriate, and were as planned for the endoscopy procedure lists that were scheduled. No endoscopy lists had been cancelled due to having insufficient appropriately skilled staff.

Medical staffing

- Please see core service report for surgery for main details.
- The hospital had an established oncology service which was supported by a multidisciplinary team of four oncologists.

Are medical care services effective?

Good



We rated effective as good.

Evidence-based care and treatment (medical care specific only)

- Please see core service report for surgery for main details.
- Care and treatment was provided in line with evidence-based practice. The hospital used Spire's group care pathways for surgical inpatient and day cases. These pathways followed evidence based guidance from the National Institute for Health and Care Excellence (NICE) and Royal Colleges. Updates to guidance were issued corporately via a monthly safety bulletin to ensure staff were up to date with best practice.
- The hospital had close links with the local NHS trust and MacMillan Cancer information centre.
- Clinical scorecards were published quarterly that benchmarked the hospital against other hospitals within the Spire group or with national benchmarks, where available. Patient outcomes were monitored and audited quarterly and reported via the clinical scorecard.
- There was a Spire corporate audit calendar that was supplemented by additional local audit activity. An annual review was carried out by Spire's national clinical services team to ensure monitoring and improvement in patient outcomes.

Pain relief (medical care specific only)

- The oncology department had a link to the local NHS trust pain management team who they could contact for advice.
- Nurses in oncology and endoscopy monitored a patient's pain using a numerical pain scale. A patient told us that staff closely monitored their pain level during their procedure and provided appropriate support.
- Endoscopy patients were offered a throat spray to reduce discomfort and / or intravenous sedation, to minimise any discomfort or pain whilst undergoing a gastrointestinal endoscopy. Medical staff also performed gastrointestinal endoscopies under a general anaesthetic where this was clinically indicated. This procedure would always be undertaken in theatre if required.
- Colonoscopies could be performed under intravenous sedation should the patient prefer, to ensure they were relaxed and comfortable during the procedure.

Nutrition and hydration

- The Patient-Led Assessment of the Care Environment (PLACE) in 2016 rated the quality of ward food as 100%; this exceeded the England average of 92%.
- Patients due to undergo a gastrointestinal endoscopy were given detailed advice on how to prepare for the procedure, and advice regarding dietary and fluid intake.
- The hospital advised patients due to undergo an endoscopy they could have clear fluids up to two hours before their admission time. The staff explained how they would liaise with the anaesthetist if there were a delay to the endoscopy list, to ensure patients were not without fluids for several hours.
- Patients were offered a drink and light snack, following a procedure, and swallow assessment should they have had a throat spray, in endoscopy and prior to discharge. There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.

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- The majority of oncology patients were day case patients only. Staff offered patients drinks and light snacks as appropriate during and after their treatment.
- Patients could contact hospitality staff direct from their rooms if they required refreshments and they would be prepared accordingly. This facility came about from direct patient feedback received by the hospital. The hospital had involved patients in the re-design of menus specifically for oncology patients.

Patient outcomes (medical care specific only)

- Please see core service report for surgery for main details.
- The endoscopy service provided at the hospital was not accredited by the Joint Advisory Group on GI Endoscopy (JAG) but they were working towards achieving this. JAG accreditation indicates that the service provides endoscopy in line with the Global Rating Scale Standards. However, it is not an essential requirement for providing the service.
- Oncology patients were discussed at a multidisciplinary team meeting held in a local NHS trust, and this provided opportunities for peer review and benchmarking. Oncology nursing and medical staff at the hospital monitored individual patient outcomes as patients returned for review and further chemotherapy treatment cycles.
- The head of clinical services (matron) informed us that the hospital group was working with the private healthcare information network (PHIN), in relation to the collection and publication of clinical outcomes.

Competent staff

- Please see core service report for surgery for main details.
- Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospitals following approval from the medical advisory committee (MAC). This included the hospital making checks such as disclosure and barring service (DBS) checks, qualifications and experience to practice.
- Medical staff performed endoscopy procedures, and were supported by nurses with specific endoscopy

skills. Staff working in endoscopy had training and were competent in clinical aspects of endoscopy including supporting the patient through a procedure, management of specimens and the decontamination of endoscopes.

- Nurses in the oncology department were assessed against specific competencies for their role. For example, they received training in how to administer chemotherapy medicines safely. We saw training records which showed staff had undertaken training relevant to their role and these were signed off by the manager in oncology. For example, additional training received included the use of devices such infusion pumps and scalp cooling machines.
- The hospital employed a full-time specialist breast-care nurse in addition to the oncology trained nurses.
- Staff told us they had received an annual appraisal from their line manager. They told us the appraisal process was structured and effective. Data provided by the hospital confirmed 100% of staff in oncology and endoscopy had received an appraisal at the time of our inspection (the hospital reporting period for appraisals was January 2016 to December 2016).

Multidisciplinary working

- Please see core service report for surgery for further details.
- The hospital confirmed multidisciplinary team (MDT) meetings took place at the local NHS trust in conjunction with Spire staff, for all oncology patients with decisions recorded within patient records. The hospital reported that they could evidence 90% compliance that the MDT took place, against the target of 80%. They were working with the Cancer MDT to enable improved sharing of information and so they could evidence 100% compliance of MDT going forward.
- MDT meetings for patients with breast cancer were held via teleconference with Spire colleagues across their region. These were attended by all relevant staff groups.

Medical care

- During our inspection, we saw the administrative, pre-assessment, endoscopy and oncology medical and nursing staff worked well together to ensure the patient pathways were effective. This included sending letters to patients GPs.
- The hospital employed breast care specialist nurses that worked closely with the oncology nurses and doctors to ensure effective support for patients.

Seven-day services

- Patients were able to contact the hospital out of hours via telephone if they needed to discuss any concerns or report any adverse side effects of chemotherapy. The service used the United Kingdom Oncology Nursing Society (UKONS) triage tool in collaboration with the RMO. Depending on the nature of the call the RMO would contact the treating oncologist. All calls were monitored by the oncology nurses and training was provided to wards nurses were needed. All patients who used the out of hours service received a follow up call from the oncology nurses.
- Pharmacy services were available Monday to Friday 8.30am to 4.30pm and 9am to 1pm on Saturday. Pharmacy staff provided on-call cover, out of hours, on a rota basis.

Access to information (medical care only)

- Staff were able to access information on the hospital intranet, which included clinical policies and standard operating procedures. There was also patient information such as information leaflets to support a patient giving informed consent. Staff could print these from the intranet to give to patients when required.
- Oncology staff sent a letter to the patient's GP detailing the chemotherapy treatment administered. Staff provided oncology patients with details about their chemotherapy. For example, staff provided leaflets which detailed what to do if they developed a raised temperature.
- Patients received a discharge letter that included the reason for their endoscopy procedure, relevant findings, and if any changes were required to existing medication, potential concerns and details of follow up. A copy of this letter was sent to the patient's GP, and a copy placed in the patient record at the hospital.

This also included the ward telephone number and the number for their patient record, this meant if the patient had a concern, they could contact the ward for advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- The hospital used a Spire group-wide consent policy that included guidelines for those patients who lacked the ability to give consent. All clinical staff had to complete a module on the Mental Capacity Act (MCA), as part of their mandatory training. At the time of inspection, 100% of staff in the oncology department had completed the training. This was above the target for completing 95% of mandatory training. Training figures for endoscopy staff were included in those for the theatre team and are reported in the surgery core service report.
- Staff we spoke with understood the principles of consent and the Mental Capacity Act. Staff gave us examples of times when they had identified that patients had lacked capacity. Staff told us that it was a consultant-led service and if a patient lacked capacity to provide consent for any procedure they would escalate it to the responsible consultant and not continue with the treatment. The consultant would carry out a capacity assessment.
- In oncology, the consultant assessed patient understanding prior to obtaining consent with specifically designed consent forms for systemic anti-cancer therapy. Staff told us this also included a documented discussion of the benefits and risks.
- Patients received information prior to an endoscopy procedure. This allowed patients to review the information and, if understood, give consent when they came for their procedure. Consent forms we reviewed were appropriately completed, signed and detailed the risks and benefits to the procedures.

Are medical care services caring?

Good



We rated caring as good.

Medical care

Compassionate care

- Staff had completed specific modules of compassion in practice and this was reflected in the interactions we saw between staff, patients and relatives at what was often a stressful period of their lives.
- We spoke with three patients who described their experiences and interactions as strongly positive.
- We observed staff in oncology and endoscopy treated patients with dignity and respect, and maintained patient privacy.
- We reviewed 16 items of patient feedback relating to the oncology department. This was positive with comments such as “You all have made it bearable and sometimes enjoyable. Thank you for taking such good care of me, I will never forget any of you.”, “I cannot thank you, and all the team, enough for the really wonderful care I have received from you all.”.
- The hospital collected Friends and Family test (FFT) data for NHS and private patients. The hospitals overall FFT results were above the England average from January 2016 to June 2016.

Understanding and involvement of patients and those close to them

- Oncology patients were usually cared for by the same nurse on each appointment. Patients we spoke with told us this enabled them to build relationships and nurses were more able to recognise how patients were feeling either before, during or after treatment.
- Patients’ undergoing a procedure in endoscopy or treatment in oncology were provided with relevant information by staff, both verbal and written. Patients said there had been sufficient time at their appointment for them to discuss any concerns they had.
- Patients in the oncology unit told us staff kept them informed about their care, involved them in decision-making, and listened to their concerns and worries about treatment.
- Staff also involved patients close relatives, when they wanted to. The relatives we spoke with also felt well informed and cared for by staff, and able to support their family members.

Emotional support

- Patients, particularly in oncology, described how they felt emotionally supported. Breast care specialist nurses were available if needed. These nurses supported a patient from receiving their initial diagnosis and throughout their treatment. They would support patients who had concerns regarding body image and provided links to external services, for example wig makers.
- A charity provided all new oncology patients with a ‘ChemoGift Bag’. A patient we spoke with told us that this was wonderful and unexpected. It contained various items and information that patients would find useful when receiving treatment, for example cosy socks, slippers, soft toothbrushes and a ‘Thinking of You’ card.
- We observed signs prompting patients to request a chaperone if they would like one present when examined.

Are medical care services responsive?

Good



We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Please see core service report for surgery for main details.
- Operational staff from the hospital, including clinical staff, estates and administration, attended regular weekly planning meetings. This ensured patient’s care was planned with sufficient staff, and the correct skill mix.
- Oncologists treated insured and self-pay patients at the hospital on a planned day case basis.
- Patients admitted for an endoscopy procedure went to the inpatient ward prior to their procedure.
- All patients had private rooms with en-suite facilities and there was free car-parking on-site.

Access and flow

Medical care

- Patients told us that appointment times for cancer treatment were available at times that suited their needs. Many of the patients we spoke with told us they had specifically chosen the hospital because of the service access it provided.
- Patients had access to a single room for their cancer treatment. Rooms were usually only used for one patient per day, this meant patients could stay after their treatment had been completed, if they felt unwell or wanted to rest.
- Consultants saw patients referred by their GP as an outpatient before an endoscopy procedure to check that patients met the admission criteria. They then assessed the patient and discussed a plan of treatment. This meant staff could plan the flow of patients. Consultants carried out endoscopy procedures within two to four weeks of referral to the hospital.
- If a patient with medical needs was referred to the hospital, the matron was informed. The matron would then ensure a medical consultant was available to accept responsibility for the care and treatment of any medical patients.

Meeting people's individual needs

- Please see core service report for surgery for further details.
- The hospital used a Spire group-wide equality and diversity policy. All staff in the hospital had to complete equality and diversity training as part of their mandatory training. At the time of the inspection, 100% of staff in oncology had completed the training. Training details for staff in endoscopy is covered by theatres.
- Patients received information relevant to their endoscopy procedure prior to their attendance for treatment. For example, information about gastroscopy included preparation and time to arrive, the two ways the procedure can be performed, the examination process and after care. For a colonoscopy, the information included guidance on preparation, arrival time, the procedure and aftercare.
- Day procedure pre-admission questionnaires included an assessment of people's individual needs, which included a question to check if they needed any

additional support. Pre-assessment staff reviewed the questionnaires and would liaise with the consultant to ensure appropriate adjustments and support were in place for the patient.

- Staff in oncology showed us the chemotherapy pathway, which also included a prompt for staff to ask a patient if they had any special needs or disabilities. They did not have any specific examples but told us they would ensure they would cater a patient's needs as far as they were able.
- Staff in oncology were trained in the use of scalp cooling devices for patients.
- The hospital had a recently appointed dementia lead and staff had received dementia awareness training. However the hospital admission screening meant that very few patients living with dementia had been admitted to the hospital.
- Staff told us there were not many patients that had complex or additional needs. Staff in the medical service had an understanding of the needs of people with dementia. Patients who required additional support were identified during the pre-assessment process. Arrangements for additional support would be made prior to a patient being admitted for example, if a family member needed to accompany the patients or stay overnight.
- The hospital had a chef who prepared meals for patients. If patients had any individual dietary requirements, the hospitality staff would liaise with the chef and patient to ensure that these were accommodated.

Learning from complaints and concerns

- Please see core service report for surgery for main details.
- Information for patients about how to raise a concern or make a complaint was in the patient information brochure.
- The oncology service received very few complaints, this meant the service was currently unable to monitor trends. Patients we spoke with knew what to do if they wanted to make a complaint but none we spoke with had felt the need.

Medical care

- The hospital had received 36 complaints during the period July 2015 to June 2016. CQC have assessed this rate of complaints as similar to other acute independent hospitals for which we hold data. There were no complaints relating specifically to services in the medical service from July 2015 to June 2016.

Are medical care services well-led?

Requires improvement



We rated well-led as requires improvement.

Please see core service report for surgery for main details.

Leadership and culture of service

- Staff told us that there had been a number of significant changes to the senior management within the hospital in the 12 months preceding the inspection. Staff we spoke with were enthusiastic about these appointments and reported seeing some positive changes already.
- Staff reported there was an open culture throughout the hospital and a genuine sense of family with the hospital. Staff told us this meant they worked together and were proud of the standard of patient care they provided.
- Staff we spoke with told us they felt confident to challenge poor behaviour by staff at any level, medical or nursing, if they were concerned about poor practice.
- All staff we spoke with were passionate about the service they provided and the care they offered to patients.
- There was strong local leadership within the oncology service. New management with the department had consolidated previous practice. New governance structures had also been developed and expanded during this period.
- Staff told us, and we saw, senior managers and departmental managers were visible and accessible throughout the hospital.

- Departmental meetings and staff forums were held to provide staff with information about the hospital and its services. The hospital also published newsletters to keep staff informed of developments.

Vision and strategy for this core service

- The oncology service had developed its own vision, using the hospital vision as a template and this was displayed in the department.
- The endoscopy department vision was to attain Joint Advisory Group (JAG) accreditation for its endoscopy services. The hospital supported this vision and plans had been drafted to redevelop the endoscopy rooms. These were due to be submitted for financial approval in early 2017.

Governance, risk management and quality measurement (medical care level only)

- Risk registers were developing across the hospital. Some individual departments did hold local risk registers however, understanding of what constitutes a risk within the hospital was still developing. For example, the identified risks within the endoscopy decontamination room were not yet recorded on the hospital risk register.
- Departmental risk assessments were a more developed process within the hospital. These were carried out however, we were not assured that there was effective audit and governance around some of these assessments. For example, we observed areas where identified risks had not been addressed or mitigated despite action plans having been shared.
- Risk assessments had taken place and action plans had been developed in line with highlighted areas of concern. We were not assured however, that there was effective and robust audit and oversight of these plans. For example, in endoscopy a risk assessment had identified areas of concerns regarding scope decontamination and infection prevention procedures. However at the time of our inspection only some of the mitigations outlined had been put in place.
- The oncology service had a local governance structure led by the oncology manager, which fed into the hospital governance meetings. This structure was relatively new, having been developed since new

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management had taken over the department in the previous 12 months. The endoscopy governance structure was led by the theatre manager and is reported in the surgery core report.

Public and staff engagement







- Oncology staff had engaged with patients regarding the purchase and design of new furniture for the patient rooms. For example, patients were involved in the selection process for chairs so that the hospital would be assured they were purchasing chairs in which patients would be comfortable while receiving their treatment.
- The hospital produced a staff newsletter. The newsletter provided various information including details of charity and fundraising events staff had participated in. It also provided information about available training courses that staff could attend.

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test (FFT). The hospital's FFT scores were above the England average of NHS patients across the period January 2016 to June 2016.
- Staff ran forums and a committee to enable them to engage with hospital management.

Innovation, improvement and sustainability

- The hospital offered Single Dose Intraoperative Radiotherapy for early stage breast surgery. This is where radiation is administered to the breast during surgery while the patient is under anaesthetic.

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

Information about the service

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

Summary of findings

Surgery

Are surgery services safe?

Requires improvement



We rated safe as requires improvement.

Incidents

- There had been no never events reported in the period July to June 2016. A Never Event is defined as: 'A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'.
- The hospital reported no serious injuries in the period July 2015 to June 2016.
- Staff reported incidents on the hospital's electronic reporting system. This allowed incidents to be reviewed by managers to identify trends. Staff could tell us what kinds of incidents they would report on the system, such as sharps left on trays in theatre. Staff told us that they received feedback from reported incidents as part of team meetings.
- Of the 314 clinical incidents reported by the hospital, 89% (272 incidents) occurred in surgery or the inpatient unit. Of the reported incidents 104 were moderate and 11 severe harm, 183 were low or no harm.
- The rate of clinical incidents was higher than for other independent hospitals that CQC holds such information for in the reporting period July 2015 to July 2016. However, this was attributed to the way in which incidents were classified on the electronic system. One of the incidents classified as severe harm required a duty of candour response. This was where an endoscopy needed to be repeated due to a technical failure.
- There were 69 non-clinical incidents reported in the period July 2015 to June 2016. Thirty percent of non-clinical incidents occurred in the surgery or inpatient service.
- Mortality and morbidity meetings were held at a local NHS trust and were attended by the chair of the medical advisory committee. Learning from these were shared at medical advisory group meetings and cascaded to staff through team meetings.

Safety Thermometer

- The hospital collected patient safety thermometer information about falls, pressure ulcers and catheter related urinary tract infections. Data from the hospital showed that there was 100% harm free care, with no falls or pressure ulcers recorded. Patients were also assessed for risk of venous thromboembolism (VTE) and bleeding. This assessment was rechecked after surgery.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital used the Spire Healthcare Clinical scorecard to benchmark the hospital for its key performance indicators. Performance was reviewed at the clinical governance committee meeting and the MAC meeting. The score card was RAG rated, anything with an amber or red rating had an action plan devised to address performance.
- In addition there was a monthly clinical governance and quality report. This clearly displayed compliance against hospital policies. This quality report was available for staff to be discussed at team and heads of department meetings. It contained comprehensive information about complaints, clinical incidents, patient safety and drug and medical device alerts. For example, it showed quarterly audit results showing 98-100% (Quarter 2) compliance with NEWS scoring, pain management, venous thromboembolism risk assessment and temperature recording.

Cleanliness, infection control and hygiene

- We reviewed the hospital infection control policy and this provided clear guidelines about preventing the spread of infection. The infection prevention and control (IPC) policy was in date and checks were carried out against it.
- The ward and operating theatre suite had cleaning schedules for all areas. However, we found that these were not always fully completed by domestic staff.
- Personal protective equipment (PPE) was worn during clinical procedures.
- Staff we observed undertaking patient care were "bare below the elbows" and complied with the hospital's uniform policy. We saw staff washing their hands in between patient contacts and after carrying out

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procedures. The ward had sufficient supplies of personal protective equipment for staff to use, such as disposable aprons and gloves. We saw that these were used correctly and appropriately by staff.

- Hand hygiene audits showed a 95% compliance with the policy.
- Hand gel and sanitisers were readily available on entry to clinical areas and on entering the ward. There were audit checks on hand sanitiser units.
- In theatres staff followed appropriate dress codes, clean theatre 'scrubs' were available to all staff that worked in the theatre suite. There was footwear that remained within the clean area. If theatre staff needed to leave the theatre suite in order to see a patient, there were over garments and overshoes available to cover the theatre attire.
- In theatres there were some omissions with the cleaning checklist, with some elements not being documented as completed each day.
- Our inspection of the theatre suite found that ceilings in the operating theatres were not clean. They had been subject to a "deep clean" on the weekend before the inspection, but this had not been checked before being signed off as completed satisfactorily. There was a signed and dated certificate; this stated the methods and cleaning chemicals that were used by the contractor.
- We found that there were gaps around ceiling tiles in the theatres. These had been disturbed during the deep clean and there was visible dust. There were also gaps in sealing at the edges of flooring and doorframes in scrub and anaesthetic rooms which would impede effective cleaning. There were also a number of cracked tiles in both scrub rooms which would also not allow the area to be cleaned properly.
- The flooring in both operating theatres was stained. This made it difficult to assess that it was clean. There was a plan in place to replace the flooring in both theatres as it had been recognised that this required refurbishment.
- Inpatient ward areas and patient rooms that we saw were clean and well maintained. Patients told us that they found the ward to be very clean.
- We found that the cleaning log for the inpatient ward was not consistently completed to provide assurance that all areas were cleaned regularly with housekeeping staff.
- Patient led assessments of the care environment (PLACE) scores indicated that the cleanliness of the hospital was rated at 100% in 2016. Apart from the operating theatre ceilings we also observed this.
- There were no incidents of hospital acquired infections such as, , Meticillin sensitive (MSSA) in the reporting period July 2015 to June 2016. In the same period no incidents of E-Coli were reported. There was a single incident of **Clostridium difficile** (C.diff) in the same period, reported January to March 2016.
- Observational hand hygiene audits were undertaken by infection control link staff in order to support the hospital's lead for infection control and prevention, environmental checks were also carried out using an improvement tool.
- We observed staff on the ward washing their hands between procedures and after carrying out patient care. Staff we saw all followed the hospital's uniform policy and were 'bare below elbows' and did not wear jewellery
- There were four surgical site infections reported at the hospital between July 2015 and June 2016. However, there were no surgical site infections reported for orthopaedic surgery during the same period.
- There were protocols for the decontamination of reusable medical devices that were in line with national guidance. We saw evidence of this during the inspection.

Environment and equipment

- The main ward had 37 separate ensuite rooms. There was secure access to the theatre suite; this had two theatres, each with a dedicated anaesthetic room. The endoscopy unit (reported under medicine) was located in the theatre suite. There was a recovery room with four bays.
- Both theatres were equipped with laminar flow clean air systems, suitable for performing orthopaedic surgery. These systems had been certified as checked by an independent engineer. We saw records that this check was carried out annually.

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- The theatre suite was secure and required a key code to gain entry. This helped ensure the safety of vulnerable patients, and prevented unauthorised access to theatres and endoscopy.
- The hospital had a theatre sterile supply unit (TSSU) for the decontamination and sterilisation of surgical instruments and equipment. New cleaning and sterilisation equipment had been fitted in TSSU two years previously however, due to a lack of external auditors the facility had not been subject to a compliance inspection. This meant that the hospital were only permitted to sterilise reusable surgical equipment that was for use on-site.
- There were “difficult airway” trolleys for adults located in each anaesthetic room. These were found to be appropriate, but not all the recommended equipment was located on each trolley. This meant that in an emergency staff would have to leave the room to locate other items of equipment.
- There was resuscitation equipment in the theatre suite that was checked daily, we saw records to demonstrate this. There was a ‘difficult airway’ trolley for children. This did not have a checklist against which the contents could be checked. Although staff told us this trolley was checked regularly there was no evidence to demonstrate this. There was no clear signage to show staff where the difficult airway trolley for children could be found. Some of the sterile supplies in the difficult airway trolley for children were open and therefore not suitable for use. This was escalated during the inspection and signage was put in place, and a checklist devised. Non-sterile items of emergency equipment were also replaced.
- Theatres had appropriate trolleys for a wide range of sizes and weights of patients; we saw that these were clean, well maintained and were safe to use.
- Anaesthetic equipment was checked before each patient by the operating department practitioner and the anaesthetist. There was a daily check book to evidence that these had been carried out. There were no omissions in these records of checks.
- The recovery area had been recently refurbished with new floor and wall coverings and ceiling. There was a monitoring system in place that matched that in use on the ward to ensure that all equipment was fully compatible and the staff trained to use it.
- There was a bay in recovery that was equipped and dedicated for use by children. This had a foldable screen decorated for use with children that were recovering from surgery. When there was a children’s surgical list running, adults would not be operated on at the same time.
- There was a mobile hoist available for staff to use if required on the ward. This was kept on charge in a dedicated store, and was in date for regular six-monthly inspections. An appropriate range of slings was available for staff to use with the hoist. These were single patient use slings that were disposed of after use to reduce the risk of cross infection.
- Patient rooms were equipped with electrically operated profiling beds. There were bed rails if these were required, for a post-operative patient that was not fully recovered for example. Each room had its own shower room and toilet. The pull cords for lighting and nurse call were made of ridged plastic. This made them easy for patients to see, and possible to be cleaned thoroughly.
- The ward and high dependency unit used a monitoring system that could be viewed remotely. For example, there was a display in the ward office to allow staff to see patient observations and monitoring during handovers. There was a plan to further extend this system to include all inpatient rooms.

Medicines

- There was a medicines management policy dated April 2016 that staff used to guide their practice. Staff also had access to the British National Formulary for guidance on medicines.
- Supplies of controlled drugs on the ward were found to be secure and managed correctly. We saw evidence of daily checks of controlled drugs. A check found them to be in date, and these were consistently carried out to ensure that stock balances were correct.
- Other medicines were stored securely on the ward in a temperature controlled room, with an access code. This included supplies of sterile infusion fluids and

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irrigation. The medicines we checked were all in date and ready for use. We saw evidence of a system to highlight to staff when medicines were approaching their use-by date. We saw that stocks of medicines were checked and managed by a pharmacy technician.

- We checked supplies of medicines in theatres including the management and storage of controlled drugs. These were found to be secure and managed correctly. We saw evidence of daily checks of controlled drugs. A check of the controlled drugs found them to be in date, and checks were consistently carried out to ensure that stock balances were correct.
- There was a system in place to ensure that other medicines stored in theatres and on the ward were in date.
- There were emergency drug boxes in the recovery unit for adult and child anaphylaxis (a severe and life threatening allergic reaction) that were sealed and were in date. There was a Malignant Hypothermia (a serious reaction to anaesthetic agents) box, this was in date but was not sealed. This was escalated during the inspection and pharmacy was contacted to check and seal the box.
- The malignant hypothermia emergency drug box contained a copy of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) relevant clinical guidelines for immediate reference. Other emergency boxes also contained relevant guidance.
- There were emergency drugs available in security tag sealed boxes for adult and paediatric resuscitation, anaesthetic toxicity and anaphylaxis (a life threatening allergic reaction). These boxes were all stored safely in view for quick access, each was sealed and in date. The paediatric emergency drugs had clear guidelines on dosages required for different weights of children.
- Medicines that required temperature controlled storage were held in lockable refrigerators. There were daily record checks of minimum and maximum temperatures and ambient room temperatures. Staff could tell us what they would do in the event of a refrigerator being found out of temperature parameters.

Records

- Medical and nursing records in the surgical department were paper based; these were bound and maintained in

good order. All of the seven records we reviewed were legible, signed and dated. Records contained all the relevant information including allergies, diagnosis, patient management plan and discharge plans.

- Patient care records were paper based and stored securely on the ward in locked cupboards behind the nurses' station. Risk assessments and observation charts were held in the patient's rooms.
- Pre-operative assessments were completed at a pre-assessment clinic that patients would attend before the day of their admission.
- We saw that staff followed standardised pathway documentation for patients, such as total hip or knee replacement. These documents were personalised to specific patient needs and preferences through individual risk assessments and care plans.
- We saw evidence in the seven sets of patient records that we reviewed that pre-operative assessments were completed for all patients that had undergone a surgical procedure. This included the WHO surgical safety checklist template. We saw that this was fully completed in all cases.
- We saw evidence of traceability in all supplies used during surgical procedure recorded in the patient care record, this included implants.
- When patients were discharged their medical records were stored securely off-site.
- There were recording systems for implants used in surgery. This ensured that each implant was fully traceable. A record of all supplies and implants was stored in the patient's care record.

Safeguarding

- The hospital had safeguarding policies for adults and children. Staff were aware of their responsibilities with safeguarding and had received training.
- The hospital had reported no safeguarding concerns, and none had been reported to CQC in the period July 2015 to June 2016.
- We reviewed the systems, policies and procedures for safeguarding children and vulnerable adults and found these were robust, well understood and supported by staff training.

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- The matron was the named lead for safeguarding adults, and the ward manager was safeguarding lead for children. Both members of staff had appropriate level 3 adult and children's safeguarding training. We saw evidence of this during the inspection.
- Staff had completed level 1 and 2 training in safeguarding adults and children. Information received from the service showed 100% of inpatient, and 80% of theatre staff had up to date training in safeguarding, the corporate provider requirement was 95% target by the end of the year. Thirteen ward staff had attended level 3 safeguarding children training at the time of inspection.
- Staff were able to tell us what constituted abuse and said they would report to the senior staff in charge.
- Staff we spoke with had an understanding of female genital mutilation (FGM) and knew where they could find information on the statutory actions they would need to take to protect these patients.

Mandatory training

- The hospital ensured that staff were committed to completing their mandatory training on an annual basis. The hospital's target for staff completion of mandatory training was 95%.
- The managers in Theatres had been encouraged to complete their mandatory training in the previous two months. At the time of inspection mandatory training for theatre staff had achieved 94%. This was a significant improvement on previous compliance, which had been previously been less than 60%.
- There were systems in place that allowed senior managers to identify which staff had not completed their training and identify those who were due for updates.
- Staff on the ward were 96% compliant with mandatory training.
- The registered medical officer's [RMO's] were employed via an external agency, prior to commencing work at the hospital. As part of the recruitment process they were asked to demonstrate evidence of mandatory training, all documents were stored on the individual doctor's electronic file. Renewal/update of the mandatory training was organised by the external agency, who updated the hospital with the required information. Hospital specific mandatory training was also undertaken by the RMOs. This included participation in resuscitation scenario training.

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

- We observed the use of the WHO surgical safety checklist and this was carried out safely and involved all members of staff and the patient. The sign in part of the process should be a fully interactive process with confirmation between the patient, anaesthetist and the operating department practitioner. However, we observed that there was no formal sign-in performed as recommended in the national guidance in the use of the WHO checklist.
- The hospital had an admission policy that included criteria to ensure that patients with complex or high risk conditions did not undergo surgery at the hospital. Patients were admitted by consultants with practising privileges and admitting rights.
- Nursing staff used risk assessment tools to support safe care was undertaken. They gave us examples of risk assessments they used including the Waterlow score, the malnutrition universal screening tool (MUST), falls prevention, pressure ulcer risk and pain assessment. This was confirmed by records we reviewed.
- The hospital used the national early warning score (NEWS). We found that patients had observations recorded on NEWS charts. Staff knew what to do in the event of observations being recorded that indicated a patient was deteriorating. The use of NEWS was subject to an audit and results showed 100% compliance for the period April 2016 to June 2016.
- For children and young people the hospital used the Paediatric Early Warning Score (PEWS).
- There was a policy for the management of deteriorating patients. The hospital used NEWS to detect changes in a patient's condition. If the patient showed signs of deterioration post-operatively staff escalated this to the resident medical officer (RMO). The resident medical officer would liaise with the patient's consultant. In an emergency situation the RMO would act independently to provide a review, and have the patient transferred by emergency ambulance to the nearby NHS trust.

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- The hospital had an agreed emergency transfer policy with a nearby NHS acute hospital.
- The resident medical officer was available 24 hours per day seven days a week. Consultants were accessible to the RMO and nursing staff. It was the consultants responsibility to provide cover if they would be unavailable to see their patients. This was agreed as part of the consultants practicing privileges.
- The hospital did not have a written escalation policy for a patient with suspected sepsis who required immediate review. However, staff had a high awareness of sepsis and could explain actions they would take if this was suspected in a post-operative patient.
- There is a briefing each day for theatre staff to discuss the day's operating lists and any particular risks, equipment issues or special requirements for any patients that day. This involved all appropriate staff.
- There was a similar heads of department meeting held each day with the matron to discuss any concerns or potential clinical risks on the ward or in theatres.
- The hospital audited the rate of assessment of patient risk of venous thromboembolism (VTE). In the reporting period July 2015 to June 2016 results varied from 90 – 100%. However, this was 90% in the period January to March 2016 and greater than 98% for the remaining period covered. There was a single incident of hospital acquired VTE or pulmonary embolism (PE) in the period July 2015 to June 2016.

Nursing and support staffing

- Although the hospital did not use an acuity tool, staffing was planned based on the predicted dependency of patients at booking, and the skill and competency mix of available staff.
- Daily bed meetings were held to discuss current patients and planning for patients being admitted the next day. Staffing requirements were also discussed. Patients that required the high dependency unit (HDU) were planned a week in advance. There was a seven day admission rule for HDU and paediatric patients.
- The ratio of staff required to care for children was higher than for adults. When children were booked as inpatients the rota was planned to include sufficient paediatric trained nurses such as one on each shift. Any

patients that had additional needs highlighted at booking were discussed with the ward manager so that effective staffing levels could be planned prior to the patient's admission. We reviewed staffing rotas from May, June and July 2016, Staffing levels met the planned required level in wards and theatres. There were always registered nurses on duty on the ward, including nights and weekends, to enable suitably skilled staff were available to respond to emergencies.

- Handovers were conducted in the nurse's office. We observed these were carried out sensitively and private information could not be overheard.

Medical staffing

- There was a registered medical officer in the hospital 24 hours a day, seven days a week, working one week rotation with another RMO, they were both employed by an agency
- The RMO provided daily medical services and dealt with routine and also emergency situations with the support from the named consultant.
- If a patient required medical assessment out of hours, the admitting consultant would be contacted. Details of consultants cover arrangements are recorded at the hospital and this is available for staff to access.
- Consultants provided patients with either telephone advice or attended in person.
- Out of Hours cover (weekend and nights) was provided by the RMO. However, practising privileges determined that consultants needed to reside a distance from the hospital not exceeding a journey time of 45 minutes. If this journey time was in excess of 45 minutes the MAC was required to perform a documented assessment of the journey time.
- There was a structured handover between RMOs, and an appropriate overlap in shift times to allow a thorough handover of responsibility between staff.
- There was a consultant microbiologist available to support the hospital's IPC lead. Minutes of infection control meetings indicated that they attended these in addition to other key staff.

Emergency awareness and training

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- The hospital had business continuity plans in place. There were action cards stored at reception to be used in the event of a disaster, such as fire, flood or loss of power that would affect the hospital's ability to safely accommodate patients.
- There was an emergency bleep system that was tested daily. Staff that carried emergency bleeps had training in paediatric and adult resuscitation. Resuscitation scenarios were carried out, and learning shared from these. For example, staff had participated in a major haemorrhage scenario in June 2016.

Are surgery services effective?

Good



We rated effective as good.

Evidence-based care and treatment

- The hospital staff used evidence based care pathways, policies and guidelines which were developed corporately by Spire,
 - Staff used this combination of guidelines as a basis to determine the treatment they provided. For example, staff assessed patients for the risk of venous thromboembolism (VTE) and took steps to minimise the risk where appropriate, in line with "venous thromboembolism: reducing the risk for patients in hospital NICE Guideline [CG92]". This meant that there was clear evidence-based guidance for staff for the care and treatment of patients with specific clinical complaints
 - The hospital followed NICE guidance for preventing and treating surgical site infections as in NICE Guideline CG74.
 - The hospital used the national early warning system (NEWS) to assess and respond to any change in a patients' condition post operatively. This was in line with NICE guidance CG50. In patient records we reviewed this was used effectively.
 - We observed care that was given in line with local policies and procedures, such as privacy and dignity, consent and infection control.
- The hospital carried out quarterly audits of the use of the NEWS system to detect deterioration of patients. Compliance against the audit of NEWS was reported by the hospital as 100% across the reporting period July 2015 to June 2016.
 - There were quarterly local audits of pain management undertaken. Hospital data showed that these demonstrated 100% compliance across the reporting period July 2015 to June 2016.
 - Quarterly audit of VTE risk assessment was carried out, hospital data showed that it achieved compliance from 90% - 100%, across the reporting period July 2015 to June 2016 against a 95% target.
 - The hospital participated in the National Joint Registry and submitted data for all patients undergoing hip and knee replacements.
 - A summary of care and treatment was sent to patients' own GP within 48 hours of a patient being discharged from the hospital. This detailed the reason for admission and any investigation results, treatment and discharge medication. A copy of the discharge summary was given to all patients.

Pain relief

- There was no dedicated pain team at the hospital, but staff had access to the pain team at a local NHS trust for advice.
- Patients' pre and post-operative pain was discussed with them as part of the surgical pathway. An assessment for pain was carried out as part of the national early warning score. Patients that had pain that was not under control would be escalated to the RMO or the anaesthetist.
- Pain scores were documented in 9 of the patient notes we reviewed. Staff asked patients to describe their pain on a scale of 0-4, this formed part of the NEWS score. A consistently high pain score would be escalated. There were audits of patient's pain scores, these consistently reported greater than 100% compliance with the reporting of pain scores April to September 2016.
- Patients we spoke with told us they had adequate pain control and pain relief was available to them when

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needed. The management of pain was audited each quarter, and data from the hospital showed that this was 100% compliant across the reporting period June 2015 to July 2016.

Nutrition and hydration

- Patients were given advice on starving prior to surgery. The hospital's policy stated that if patients were to go without clear fluids for longer than three hours an intravenous infusion would be commenced. There was an audit of this quarterly; it reported that compliance with this standard was met between 15% and 85% in the reporting period June 2015 to July 2016. The hospital's most recent data suggested that they were making improvements with compliance against the standards for pre-operative starving.
- Food and fluid intake was monitored using food charts and fluid balance charts. Patients were screened for malnutrition on admission with use of the MUST tool.
- Staff used fluid balance charts for surgical patients; we saw examples of correct completion these including the administration of intravenous fluids.
- Menus for patients were delivered daily by the hostess team. We observed lunch options were discussed with patients. If there were any special requirements identified this would be communicated with the catering staff.
- Patient led assessments of the care environment (PLACE) scores for ward food were 100% for 2016.

Patient outcomes

- The hospital participated in national audits. Patient safety thermometer data was completed monthly. There was an annual audit of blood management in adults undergoing elective surgical procedures for the NHS blood and transplant service.
- Patients that had undergone joint replacement surgery were added to the Public Health England surgical site infection surveillance database. Patients were asked to complete a questionnaire 30 days after their surgery for the monitoring of wound infections.
- The hospital also collected patient reported outcome measures (PROMS) data from patients that had undergone joint replacements to enable them to demonstrate good outcomes from surgery.

- The hospital submitted data to the National Joint Registry with the patients consent, to be able to collect long term results on implants.
- The hospital had reported 13 unplanned readmissions in the surgical service, from July 2015 to June 2016.
- The Spire group of hospitals were engaged with the Private Healthcare Information Network (PHIN). There was a bi-monthly steering group meeting attended by senior managers from the group. Hospital directors across the Spire group have been provided with presentation materials and had been kept up to date with PHIN briefings. The hospital reported that through Spire's national programme of work, it was on-track to meet its obligations. The hospital was working with consultants to ensure their data is verified and complete as per the national PHIN timetable.
- There was a Spire corporate audit calendar that was supplemented by additional local audits. Spire's national clinical services team carried out an annual review to ensure that monitoring led to improvement in patient outcomes.

Competent staff

- All staff received an induction when commencing employment, which included basic life support, health and safety, and fire training. Staff were familiar with the corporate and hospital induction programme, and developed and maintained competencies specific to their role
- Competency assessments were included as part of the induction system within the hospital. This meant that staff were observed to be competent before carrying out procedures or using equipment unsupervised. We spoke with a new member of nursing staff in theatres who told us that they were not permitted to practise until this was completed.
- Nurses we spoke with were aware of the requirements of the Royal College of Nursing (RCN) revalidation scheme, and were being supported to work towards this.
- Consultants wanting to work at the hospital had to apply for practising privileges. This was done by completing the consultants handbook and application form as well as submitting the relevant documents such as disclosure and barring service checks, appraisal, GMC

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registration information and evidence of Medical Indemnity Insurance. This information was collated and the medical advisory committee reviewed and approved accordingly. Practising privileges for consultants were granted by the medical advisory committee. This met quarterly and discussed applications for the granting of practicing privileges. Practising privileges were reviewed for each consultant by the hospital director and matron every two years. They also reviewed activity reports for individual consultants. If concerns were raised regarding individual consultants practice, this would be reviewed urgently, with the involvement of the chair of the MAC if necessary.

- The medical advisory committee (MAC) monitored consultants' practice to ensure consistency with their specialty and compliance with the Spire consultants' handbook. This included assessment of reports relating to clinical performance of individual consultants at the request of the Clinical Governance Committee or the Hospital Director.
- The hospital used a training system that assisted staff to record their training. This system also produced reports for managers on staff training and development.
- In theatre there was a new system of personal development folders, these contained individual staff members job description, competency documents and records of training. This system had been recently introduced to replace incomplete records of staff training, so folders were not yet complete for all staff. There was a similar system being introduced on the ward.
- Staff had appraisals carried out annually on the ward and in theatres. The rate of appraisals was reported by the hospital as 100% across both areas, during the reporting period January 2016 to December 2016. As we inspected in November, this meant the hospital had already completed their appraisals ahead of schedule.
- The hospital had link nurses in place for infection control. Link nurses are provided with additional training to enable them to support ward staff with implementing best practice. The link nurses supported education and carried out the observational hand hygiene audits with the infection prevention and control lead.

- Staff described excellent working relationships and were complimentary about their colleagues. We found that there was evidence of effective internal multidisciplinary working between medical, nursing staff and associated healthcare practitioners, such as physiotherapists, pharmacists and radiographers. For example, patients that had questions about medicines or aftercare were put in touch with the relevant professional.
- The hospital had a transfer policy in place to allow patients to be admitted to a nearby NHS acute trust if their condition deteriorated. The RMO had told us that this had been used and had been effective when it was needed.
- Patients had access to medical and nursing staff at all times during their admission. There was access to diagnostic imaging facilities, an on call theatre team and pharmacy support across 24 hours if needed.
- Consultants remained responsible for the care of their patients during their entire stay. This was recorded as part of consultants practising privileges. The RMO provided medical cover 24 hours a day seven days a week.
- The hospital had a member of the senior management team on call 24 hours a day seven days a week.

Access to information

- Key policies were listed on the hospital's intranet, for example, infection prevention and control and medicines management. This gave staff access to local and corporate policies to guide and inform practice. In the event of the failure of the intranet system, printed version controlled copies of policies were available for staff to refer to.
- Patient notes were always accessible to staff that needed them. They were kept securely at all times to maintain the confidentiality of patients' information
- There was printed safety guidance available for all staff to refer to in each anaesthetic room. For example, the safety guidelines produced by the Association of Anaesthetists of Great Britain and Ireland (AAGBI) was laminated and held in a folder in each anaesthetic room.

Multidisciplinary working

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- There was a 'stop before you block' safety poster displayed in anaesthetic rooms. This was to ensure checks were carried out before an anaesthetic nerve block was carried out.
- Discharge letters were sent to GP's with follow up information, a copy of this was given to the patient on discharge from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Staff were able to discuss with us their responsibilities in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).
- Records reviewed showed discussions with patients and verbal consent was documented.
- The hospital had a separate consent form for children and young people, which they were encouraged to sign if assessed as able to make an informed decision to give consent for surgery.
- The hospital provides cosmetic surgery, however the consent policy does not make explicit reference to the two week cooling off period as recommended by the GMC guidance.
- The hospital had access to a clinical psychologist that would see referred patients undergoing andrology (gender reassignment) surgery.
- We observed that surgeons followed the hospital consent policy in gaining consent from patients prior to surgery. However, we found through looking at records and discussions with staff that consent forms for operations were often signed on the day of surgery. The hospital policy states that, patients receiving elective treatment for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the page documenting the decision-making process.
- Guidance about obtaining informed consent of parent or carer and a child were included in Spire's consent policy published in January 2016. The policy covered that a child under the age of 16 can consent to

treatment if the healthcare professional responsible for the child's care has assessed him/her as being 'Gillick' competent. This means that they have sufficient maturity and understanding to make the decision in question. Where a child is not Gillick competent, consent can be given by someone on their behalf who has 'parental responsibility', this was also defined in the policy. The policy also covered consent in young children. Staff we spoke with, that were qualified to care for children were aware of the issues around consent.

Are surgery services caring?

Good



We rated caring as good

Compassionate care

- Staff recognised the importance of delivering good patient care those close to them. They were welcoming and were seen to treat patients and relatives with care and compassion.
- The hospital collected Friends and Family test (FFT) data for NHS and private patients. The hospitals overall FFT results were better than the England average from January 2016 to June 2016. The response rate was mostly around 25%, this was below the England average for NHS patients except in February 2016.
- All patients admitted to the hospital were asked to complete a patient satisfaction questionnaire. Results of this were tracked and reported on at monthly senior management team and quarterly clinical governance committee meetings. The governance committee discussed the results from the patient experience survey.
- Hospital visiting hours were flexible which allowed relatives to support patients. Relatives also commented to us that the staff were very caring and that "nothing was too much trouble".
- Patients anxious about their operation or procedure were given time and information to help to reduce natural anxiety. Staff worked together to help patients with any concerns they expressed.

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- Patients told us call bells were answered promptly and that nursing staff had developed good relationships with them and their relatives. They also told us they were treated in a caring and respectful way. Another patient commented that the hospital staff ensured their privacy and dignity was preserved at all times. Staff were observed to knock before entering patients' rooms on several occasions.

Understanding and involvement of patients and those close to them

- Patients we spoke with were aware of the name of the nurse looking after them and that was responsible for their care.
- Patients and those close to them told us they were involved on decision making about their care and treatment as much as they wanted to be. Patients were consulted on all aspects of their care and treatment. Relatives were involved in care if this was the patients wish.
- Staff gave patients information about their procedure at their pre-assessment appointment. This included procedure specific information leaflets and a patient information booklet about their stay in hospital. Patients confirmed they had received an excellent standard of pre-operative information, and had the opportunity to ask staff questions. A discharge letter was provided to the patients GP within 48 hours of discharge.
- Staff discussed care and treatment in detail with patients, including what to expect post-operatively including length of stay, and involved patients in their plans for discharge
- We observed staff in the theatre suite and on the ward explaining care and treatment to patients to reduce any potential anxiety.
- Patients completed feedback questionnaires, the results of which were fed back to allow for continuous improvement and also benchmarked the hospital against other Spire hospitals. The feedback from the questionnaires was reviewed each month to identify trends, and was shared with staff at team meetings as well as being discussed at the clinical governance meetings.

Emotional support

- We observed staff in theatres providing emotional support to patients that were worried or anxious. For example, we saw a member of staff holding a patients hand in the anaesthetic room to provide reassurance.
- Visiting hours were very flexible, ensuring that patients were able to see their friends and family. Patients had telephones in their bedrooms to allow them contact and obtain emotional support from their family and friends during their recovery.
- We observed staff explaining procedures to surgical patients before and after operations in a way they could understand.

Are surgery services responsive?

Good



We rated responsive as good

Service planning and delivery to meet the needs of local people

- Spire Thames Valley hospital provided elective surgery to NHS and private patients for a variety of specialities, which included orthopaedics, ophthalmology, general surgery, gynaecology and urology. The CCGs checked the hospital provided NHS patients with services in line with agreed quality criteria at quarterly contract meetings. Spire Thames Valley hospital was commissioned by the local clinical commissioning groups (CCGs) to provide NHS choose & book services, and was funded centrally by NHS England to provide gender reassignment services.
- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments whose post-operative needs were met through ward based nursing care or for a short post-operative stay within the level 2 high dependency unit. Post-operative patients cared for in the high dependency unit were most often level 1. The hospital routinely planned surgical lists between Monday and Friday, with occasional lists running on Saturdays to meet demand. The hospital offered patients a choice of admission dates to best suit their needs.

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- The hospital had a regular weekly planning meeting to look at the staffing skill mix and patients planned for admission. Operational staff attended this in order that the patients care was planned for appropriately.

Access and flow

- The hospital accepted referrals from local NHS trusts. Referral to treatment times (RTT) were still measured for NHS patients (despite this measure having been abolished). The percentage of patients on incomplete pathways waiting 18 weeks or less from referral was above 92% in the reporting period July 2015 to June 2016.
- There were 3,949 visits to theatre and 4,087 day case attendances in the reporting period July 2015 to June 2016. The majority of surgical procedures were orthopaedic.
- The hospital had cancelled six procedures for non-clinical reasons in the past 12 months. Of these 83% (five patients) were offered another appointment within 28 days of the cancelled appointment.
- There were 13 unplanned patient readmissions in the period July 2015 to June 2016. This rate was not high when compared to a group of independent acute hospitals which submitted performance data to CQC. During the same time period, there were 11 unplanned returns to the operating theatre. On investigation no common themes were identified for this number.
- From July 2015 to June 2016, seven patients had unplanned transfers to another hospital. This was not high compared to other independent hospitals.
- The hospital did not admit patients routinely the day before surgery unless clinically indicated. If the patient's home location was a problem for early morning admission, then hotel facilities would be used overnight.
- There were single rooms available for patients within en-suite facilities, a few areas such as recovery or the day surgery ward had larger bays. Staff we spoke with were aware of the need for segregation to preserve single sex accommodation.
- Patients were given an information leaflet and checklist for discharge on admission to help them prepare for

their discharge. The hospital planned to discharge patients before 11am; this was monitored by the hospital. The target of 55% was achieved or exceeded in nine months out of 12 from July 2015 to July 2016.

- The ward had a discharge resource folder containing referral numbers for both NHS and private patients. The ward staff discussed patients' discharge progress daily, via the patient status boards to identify any issues
- Theatre staff worked flexibly to ensure that scheduled operations went ahead where possible. 7pm was the latest permitted time to call for a patient, after this time there was an on-call theatre team that were available for emergencies.
- Patients discharge was planned from admission. This included post-operative physiotherapy and equipment for orthopaedic patients, and discharge summaries were sent to the patient's GP within 48 hours.

Meeting people's individual needs

- Staff knew how to support people with complex or additional needs and made adjustments wherever possible. Pre-assessment identified patient's individual needs in relation to communication, dementia or learning disability so that arrangements for additional support could be made. There were patient leaflets about how to prepare for their procedure, before and after the operation and about discharge. Staff told us there were not many patients that had complex or additional needs.
- All areas we visited had good access for people with physical disabilities, including wheelchair users. Pull wands in the patient bathrooms were clearly visible and easily reachable.
- All written information, including pre-appointment information and signs were in English. These were available on request in other formats, such as other languages, pictorial or braille, through a national contract. Staff told us there were low numbers of patients whose first language was not English. Staff could organise face to face or telephone translation as necessary if the patient had a specified communication need.
- The 2016 PLACE score for the hospital for dementia was 87%, this was higher than the England average of 80%. The hospital had identified dementia care as an area for

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improvement and had a hospital dementia lead, champions and a dementia strategy. This described improvements in quality of care for people living with dementia, by identifying leadership and defining the care pathway. The dementia champion had undergone additional training to facilitate this role.

- The chef catered for the needs of patients with specific dietary needs for religious, cultural or medical reasons.
- There were arrangements in place for the parents of children admitted for surgery to stay with them in their room.

Learning from complaints and concerns

- Information for patients about how to raise a concern or make a complaint was in the patient information brochure
- Complaints were responded to within 20 working days from the date the complaint was received. Complaints received by the hospital were acknowledged within 48 hours by the personal assistant to the matron. The complainant received updates regarding the progress of investigations. Senior managers who investigated complaints were trained in the investigation process.
- The hospital received 36 complaints from July 2016 to June 2016. None of these were referred to the ombudsman.
- All learning from complaints were discussed at the senior management team meeting that occurred bi-weekly, also at heads of departments and MAC meetings. Learning and recommendations from complaints received was then cascaded to individual departments and teams.
- There were 'you said, we did' posters displayed on the ward that demonstrated actions that have been taken as a result of complaints. For example, an information leaflet was produced by pharmacy to give to patients discharged with medicines, this was in response to complaints from patients that were unsure about the medicines they had been given.
- The hospital offered complainants the opportunity to meet and discuss their concerns further in their final response letter.

Are surgery services well-led?

Good



We rated well-led as good

Leadership / culture of service related to this core service

- The hospital director had been in post for four months, and there had been significant other changes within the management team over the previous eighteen months. Despite this being potentially a period of instability, staff assured us they were confident in the actions, interactions and acts of the management team, to support safe care and staff.
- Ward staff told us that the senior management team were regularly visible on the wards. The hospital director had weekly walk arounds of ward and departments. The matron visited the ward at least daily.
- Staff we spoke with felt there was 'open door' access to managers at the hospital. There were staff forums, staff questions, newsletters and the departmental meetings for dissemination of information.
- Ward staff we spoke with were proud to work at the hospital and proud of the standard of patient care they delivered. Staff meetings and handover periods provided opportunity for senior nurses to engage with their staff and ensured that key information was given to staff. Staff were actively encouraged to develop themselves, and there were examples of opportunities on notice boards.
- We observed that ward and departmental managers were visible and accessible, and were discernibly proud of their areas.
- The hospital supported leaders to improve services by working with others outside of the hospital. For example, the new theatre manager had been to visit other services within the Spire group, and was encouraged to do so.
- The MAC chair told us that the medical advisory committee was a useful link between consultants and the hospital management team. He described a positive

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reporting culture that worked well and open communication between the MAC, hospital director and matron. The MAC was reported to be committed to its responsibilities and provided constructive challenge.

Vision and strategy for this core service

- The hospital displayed its vision, values and mission statement for the staff and public to see. The mission statement was “to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care.” The vision was “to be recognised as a world class health care business”. The values were; “Caring is our passion. Succeeding together, driving excellence, doing the right thing, delivering our promises and keeping it simple.”
- Staff we spoke with were aware of the mission, vision and values of the hospital and Spire. They demonstrated a commitment to them in their care practices and personal development plans within their appraisals. Staff spoke passionately about the service they provided and the care offered to their patients.
- The hospital recognised that patients in the area had a wide choice of private hospitals, so were striving for recommendation as a place where care was excellent. The hospital aimed to provide a high quality patient experience and acknowledged their need for services to run efficiently and on time.
- The hospital had agreed a three-year business and clinical strategy, which included six areas of focus. This included, the need to increase self-paying private patients, to develop off-site diagnostics, and improve patient satisfaction.
- There was a culture of mutual respect and teamwork, and staff told us they were encouraged to develop skills and expertise.
- In addition to the strategy, there was a clear vision for the development of the hospital over the next 3 years which included expansion of services both on and offsite. The longer term vision was to develop the site, this had been in the planning phase for a number of years, and teams were aware of this potential expansion.

- The hospital strategy was visible in the surgical service. Each department provided inputs to assist with the delivery of the hospital strategy.

Governance, risk management and quality measurement

- Robust arrangements were in place to monitor the quality of care, risk management and any concerns about patient safety. The hospital had clear governance meeting structures, including committees such as the patient and safety quality group, which fed into the senior management team.
- There was a governance structure that was designed to provide assurance at all levels there was a committee structure that comprised; head of departments, clinical governance, health and safety, paediatrics and infection prevention and control. The clinical governance committee minutes showed detailed discussion, names and actions against each of the CQC key quality domains. The clinical effectiveness group (this was a sub-group from the clinical governance and health and safety committees) met regularly and identified if any actions were arising from incidents.
- The hospital completed an annual review of practising privileges which included the review of a consultant's General Medical Council registration, appraisal, data protection registration and medical indemnity insurance. The Medical Advisory Committee representative then reviewed the practising privileges. Any concerns about a consultant would be shared with their responsible officer within their NHS employment.
- The hospital had a quality and risk manager in post. Risk registers had recently been implemented at the hospital. These were at both hospital and departmental level.
- Risks were tracked and managed through the risk assessment register; this was supported by the hospital wide risk register. The ward and departments had local risk assessments, to manage risks within each department. The health and safety coordinator, who collated all risk assessments to monitor their compliance actions, managed these. There were folders for staff to look at as a priority which included learning from incidents or alerts for dissemination.

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- Consultants represented specialities at the quarterly medical advisory committee (MAC). All the consultants received the minutes of each MAC to ensure they were updated with issues. The minutes of the MAC showed discussions included key governance issues such as incidents, complaints and practising privileges.
- Team meeting agendas and reports were standardised and included a review of risks, team leads presented monthly governance templates and quarterly reports at governance meetings.
- Senior staff attended the clinical effectiveness meeting; the minutes showed that incidents, risk register and policy changes or updates were discussed. The senior staff also attended the quarterly governance meeting. Items discussed included action plans, incidents, unplanned patient readmissions or transfers, unplanned patient theatre revisits and day case conversions to overnight stays. There were local morbidity and mortality meetings held in the local NHS trust, to discuss specific hospital patient cases.
- There was a daily morning meeting led by the hospital matron that was attended by heads of department. The purpose of this meeting was for departments to update each other about workload and risks. There was also a clinical meeting to identify staffing and any particular clinical needs or risks of patients. Daily bed meetings were also held to discuss current patients and planning for patients being admitted the next day.
- There was an infection control committee that met each quarter; this was supported by a consultant microbiologist that attended. We saw minutes of these meetings.

- There were scenario tests carried out across the surgical department, such as fire drills and resuscitation scenarios. There had been a recent major haemorrhage scenario training conducted in theatres for learning.







Public and staff engagement

- Staff encouraged patients and relatives to stay engaged with the hospital and share information about their experience. These experiences were shared with staff for active learning.
- There was a staff newsletter produced by the hospital. This gave information about upcoming education sessions which staff could attend for learning. The newsletter also reported on charity events and fund raising that hospital staff had been involved in. Staff awards were also reported
- The hospital ran staff forums and had a committee for staff to engage with management.
- The Hospital Director held regular staff forums that discussed the hospital strategy. This communication was underpinned through communication at senior management team, heads of department and team leader level.

Innovation, improvement and sustainability

- The service had implemented the NHS Accessible Information Standard. This states that from 31 July 2016, all organisations that provide NHS care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss have information that they can easily read or understand with support so they can communicate effectively with health and social care services.

Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Good	
Well-led	Good	
Overall	Good	

Information about the service

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

Summary of findings

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good



We rated safe as Good

Incidents

- The hospital had a policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the hospital's electronic reporting system. The staff we spoke with were able to describe the process of incident reporting and understood their responsibilities to report safety incidents.
- The hospital reported 20 clinical and two non-clinical incidents in the outpatient and diagnostic imaging departments between July 2015 and June 2016. The incidents had been graded as low risk harm. The rate of both clinical and non-clinical incidents in the outpatient departments was lower than the rate of other independent acute hospitals we hold this type of data for.
- No radiation incidents were reported between July 2015 and June 2016. These are incidents where patients had received more radiation than they should. Staff told us they would report these incidents using the computer system and also inform the manager of the diagnostic imaging department. The manager would then, where appropriate to do so, notify the Care Quality Commission (CQC).
- The hospital reported there were no serious incidents requiring investigation in outpatients during period July 2015 to June 2016. In same period, there were no deaths.
- Any lessons learnt from incidents were shared via clinical governance meetings and team meetings. We saw evidence of this in individual department meeting minutes. All meeting minutes were saved on the internal computer system, and could be easily accessed by staff.

Duty of Candour

- The duty of candour is a regulatory duty relating to openness and transparency and requires providers of

health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

- Staff told us no incident had occurred that triggered the duty of candour process, in the period between July 2015 and June 2016.
- Staff we spoke with had a good understanding of the principles of being open and honest with patients when things went wrong and senior staff understood the steps they needed to take if there was an incident which triggered the duty of candour.

Cleanliness, infection control and hygiene

- The hospital used a Spire group-wide infection prevention and control manual. The policy provided information and advice to staff on different areas such as personal protective equipment, hand hygiene and isolation precautions.
- The outpatient, physiotherapy and diagnostic imaging departments were visibly clean and tidy.
- The hospital had an infection prevention and control lead, who chaired an infection prevention and control committee, which was attended by representatives of the outpatient, physiotherapy and diagnostic imaging departments. There was therefore a clear route for infection prevention and control issues to be escalated.
- Hand sanitisers were widely available throughout the outpatient, physiotherapy and diagnostic imaging departments. We saw instructions on hand washing at sinks in clinic rooms, posters about the five moments of hand hygiene on staff notice boards and hand hygiene posters for patients and visitors throughout the hospital.
- We saw that all clinical staff in the departments followed the 'bare below the elbow' guidance to allow thorough hand washing and reduce the risk of cross infection.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We observed staff using them appropriately.
- Patient led assessments of the care environment (PLACE) scores indicated that the cleanliness of the hospital was rated at 100% in 2016.

Outpatients and diagnostic imaging

Environment and equipment

- The outpatient patient department had eight consulting rooms, two minor procedures treatment rooms, and an audiology room. The physiotherapy department had a treatment room and a gym with a range of rehabilitation equipment.
- In all of the diagnostic imaging rooms, the treatment rooms, the physiotherapy gym and the main outpatient reception, there were call buzzers which would notify the emergency on-call team if pressed. If a button was pressed, members of the emergency on-call team would be alerted of the location of the call. Staff told us that each week a different call button in the hospital was tested.
- Equipment we checked across the outpatient and diagnostic imaging departments was appropriately safety tested. We found labels on each piece of equipment saying when the next check was due.
- Resuscitation equipment was clean, well maintained and ready for use in an emergency. Trolleys were checked daily, logs were checked and confirmed daily review. A checklist was used and disposable items due to expire were disposed of and replaced.
- We saw evidence that waste was properly separated and managed. In all of the clinical rooms we saw pedal operated bins for clinical and non-clinical waste, in addition to separate sharps bins which had been signed and dated when assembled.
- Appropriate personal radiation protective equipment was available for staff and patients in the diagnostic imaging department. We saw a range of lead gowns and glasses for staff and patients. Staff in the diagnostic imaging department wore personal dose meters and there were fixed dose meters in the fluoroscopy room.
- Patient led assessments of the care environment (PLACE) assessed how the environment supported patient's privacy and dignity, food, cleanliness and general building maintenance. The hospital scored lower than England average for appearance and maintenance but above the average for all other measures, including 100% for cleanliness. The PLACE audits were not specific to outpatient and diagnostic services.
- Medicines in the outpatient department were stored and monitored appropriately. Medicines were kept in a locked cabinet in a room with key code access. The keys were held by the nurse in charge. Staff told us that the medicines were reviewed monthly to check they were within their expiry date. We checked the drugs and consumables (single use items such as bandages or plasters) and found all were within their expiry date. We also reviewed the oxygen cylinder in the minor procedures unit, which was full and within its expiry date and stored securely.
- Medicines in the outpatient department that needed to be stored at a lower temperature were stored in a locked fridge in one of the minor procedures rooms. We saw that the temperature of the fridge and the ambient temperature of the room was checked and recorded daily. This meant that the service could be assured that the drugs were stored at the correct temperature, so they were effective when they were used.
- In the diagnostic imaging department, drugs and contrast media were stored in a locked cabinet in a locked room.
- Consultants in the outpatient department provided private prescriptions to patients. The private prescription pad was stored in a locked cabinet at the reception. Prescription sheets were numbered and logged out to show which consultant had made the prescription.

Records

- We reviewed the relevant medical records of five patients across the outpatient and diagnostic imaging departments and found that the records were completed, legible and signed. However, we found the outpatient and diagnostic departments did not carry out any patient medical note audits. This meant the hospital did not have mechanisms in place to identify patient areas of improvement, which would lead to improvement in patient outcomes.
- Medical records were only permitted to be taken off site by consultants, who were registered as data controllers with the Information Commissioner's Office. This is a requirement of their practising privileges agreement.

Medicines

Outpatients and diagnostic imaging

- Over the past three months the hospital reported that all patients were seen in outpatients with all relevant medical records being available.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.
- Image transfers to other hospitals was managed electronically.
- The hospital's mandatory training cycle ran from January to December each year. The hospital's target was to complete 95% of mandatory training courses.
- Mandatory training was made up of a mixture of computer based modules and practical modules. Mandatory training included fire safety, health and safety, basic life support, infection control, safeguarding children level one and level two, safeguarding adults level one and two, manual handling, compassion in practice, equality and diversity, managing violence and aggression, and information governance.

Safeguarding

- The hospital used a group wide policy for the safeguarding of vulnerable adults. We reviewed the policy, which sets out the roles and responsibilities of staff if they needed to escalate concerns about the safety and welfare of patients.
- All staff were required to complete level one and level two Safeguarding adults and children training, as part of the mandatory training requirements for 2016.
- At the time of the inspection, 100% of staff in the outpatient department had completed the safeguarding adults and children training and 100% of staff in the diagnostic imaging department had completed the safeguarding adults and children training.
- Staff we spoke with had a good understanding of what should be reported as a safeguarding concern. Staff knew who the safeguarding leads were in the hospital and said they would raise a concern with them and also with their manager. One member staff talked through an example of safeguarding concern they had escalated to the safeguarding lead where they had been concerned about the welfare of a patient.
- Each head of department confirmed they received a training matrix monthly via an email from the Human Resource team. They would use this to notify staff that they were out of date with any mandatory training

Assessing and responding to patient risk

- Staff in the departments knew how to respond to patients who became unwell and how to obtain help from colleagues. The hospital used a group-wide Spire resuscitation policy. We reviewed the policy which set out the steps staff should take if someone suffered either respiratory or cardiac arrest. Staff told us that if a patient became unwell they would call the emergency on-call team or bleep the resident medical officer (RMO), depending on the severity of the patient's illness. We were told that it would be the emergency on-call team or RMO's decision whether to transfer a patient by ambulance to the local acute NHS trust.
- Patients who were having a scan involving contrast media were given a questionnaire to complete in the diagnostic imaging department. This was used to identify and assess any risks, such as previous reaction to contrast, allergies, renal or heart complications or pregnancy. The purpose of this questionnaire was to reduce the risk of any adverse reactions or harm to patients.
- The diagnostic imaging department had local rules and risk assessments for each of the rooms. We reviewed the local rules and risk assessments and found they were relevant to the equipment in the room and up to date
- The diagnostic imaging department used for interventional radiology procedures the World Health Organisation (WHO) Surgical Safety Checklist for Radiological Interventions, which aims to reduce harm during operative procedures, by using consistently applied evidence-based practice and safety checks to all patients.
- Staff in the diagnostic imaging department told us that they had a protocol for a radiographer to review every request for imaging before proceeding to ensure the right patient received the correct scan at the right time.

Mandatory training

Outpatients and diagnostic imaging

- The diagnostic imaging department had a process for alerting a clinician if there were abnormal findings on a scan. If a radiologist found abnormal findings, they completed an alert notification, which the manager would send to the relevant consultant for urgent action to be taken. On the inspection we saw evidence of urgent action being taken as a result of an alert that had been raised.
- Patients who had been given a contrast agent were given advice to hydrate and remain in the department for 20 minutes after the procedure was completed. This was in line with Royal College of Radiation guidelines and reduced the risk of a patient having a reaction to a contrast agent, without medical staff nearby to help.
- We saw signs outside the areas where radiological exposures were taking place in line with Ionising Radiation (Medical Exposure) Regulations (IRMER) 2000. This ensured visitors or staff could not accidentally enter a controlled area.
- We saw signs on the doors in the diagnostic imaging department and in reception warning female patients of the risks of being exposed to radiation if they were pregnant or might be pregnant. Female patients were asked about pregnancy before a scan took place.

Nursing staffing

- There was no set guidance for safe staffing levels in the outpatient department. The outpatient manager set the staffing rota two weeks in advance and based the levels of staffing and the skill mix on the clinics scheduled for that week. The staffing levels were reviewed and staff told us that there was flexibility amongst staff to increase the staffing levels on shifts if it was needed.
- The hospital provided us with information, which showed that between April and June 2016, there were no unfilled shifts.
- Between July 2015 and June 2016, no agency staff were used in the outpatient department or within diagnostic imaging. This was lower than the average of other independent acute hospitals.
- The hospital used dedicated bank staff as and when required from the hospital's own pool of bank staff. Bank

staff told us they completed a local induction and completed competencies. They were invited to department meetings and had completed annual appraisals.

- There were no staff vacancies within the outpatient and diagnostic imaging services.

Medical staffing

- There were 192 doctors with practising privileges at the hospital. 5 of the 192 had not carried out any episodes of care between July 2015 and June 2016. In the outpatient department, consultants with practising privileges (permission to practise as a medical practitioner in that hospital) used the department's clinic rooms to hold their clinic. We were told that consultants held a clinic every two weeks or more frequently, as and when needed by patient demand.
- The hospital used an external company to provide resident medical officers (RMO). The RMO was on site 24 hours a day, seven days a week. The RMO was employed to provide medical cover when the named consultant was not on-site.
- Staff said there were sufficient consultant staff to cover outpatient clinics and that medical staff were supportive and advice could be sought when needed. Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital and there was an arrangement in place for consultants to provide cover for each other if required.

Emergency awareness and training

- The hospital had its own business continuity plan, which covered a number of major potential incidents, such as bomb explosion, fire, flood, loss of power, communication or water. The plan included action cards to follow for each emergency and specific instruction for the diagnostic imaging and outpatient departments for the continuity of services, and staff were aware of this.
- The hospital had a back-up generator to maintain an uninterruptable power. This meant that if a procedure was in progress, it could be safely concluded if there was a loss of power.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

Evidence-based care and treatment

- Within outpatients and diagnostic imaging, policies and procedures had been developed and referenced to National Institute for Health and Care Excellence (NICE) and national guidance. This included policies such as privacy and dignity, safeguarding, medicines, incident reporting, consent and clinical supervision. These were accessible to all staff on the hospital's intranet. In the outpatient department, we saw signature sheets to show that staff had read policies relevant to their job roles.
- The hospital had a national programme of clinical audits in place, which the OPD also took part in. This included audits in infection control, pharmacy, anti-prescribing, Imaging Dosing Reference Levels and PLACE. However, we found in OPD the departments had not completed audits on: WHO checklist audits, patient medical notes, waiting times and consent. This meant the hospital did not have mechanisms in place to identify patient areas of improvement, which would lead to improvement in patient outcomes.
- We found although the WHO checklist was completed by the radiology department for patients, regular audits on this process was not being completed.
- The annual Radiation Protection Audit (RPA) in June 2016 found that the service was partially compliant with the current regulations, standards and guidance relating to the use of ionising radiations in diagnostic imaging. This audit reported the service was not compliant in a number of areas including: not meeting the national guidance of diagnostic reference levels, lack of incident reporting and concerns had been raised with the quality of a fluoroscopy machine. We saw evidence that the RPA had provided several recommendations and areas of improvement, which were required to be achieved

within specific timelines. We saw evidence an action plan was in place for each RPA recommendation, and the provider was working within the agreed timelines to achieve full compliance.

- The radiology manager told us that, the service had sought advice from a local NHS Trust to support them with the issues raised by the RPA audit, and had access to experienced radiologists for advice as and when required. The radiology lead was happy with the progress made on the recommendations, and was confident full compliance will be achieved within the agreed timelines.

Pain relief

- In the outpatient department, consultants were able to provide private prescriptions to patients who required pain relief. Patients could collect medications from the on-site pharmacy.
- In the diagnostic imaging department, local anaesthetic was used in preparation for the injection of a contrast agent before MRI scans.
- Patients were given written advice on any pain relief medications they may need to use at home, during their recovery from their outpatient procedure.

Patient outcomes

- The diagnostic imaging department collected information on images which were rejected, because the image quality meant they could not be used. We were told that this information was available to the radiation protection adviser, who could review trends in the number of images rejected and, if deemed appropriate, put in place actions to reduce the number.

Competent staff

- All new staff completed a corporate induction programme. Staff told us the induction process was comprehensive and enjoyable.
- Data provided by the hospital showed that 100% of outpatient nurses and health care assistants had received an appraisal in the current appraisal year (January 2016 to December 2016).

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- Staff described the appraisal process as a valuable experience and felt that their learning needs were addressed; they were also given the opportunity to attend courses to further their development.
- Staff described being supported in undertaking further learning to develop their skills and knowledge. For example a staff member told us they had been supported by the hospital to complete relevant qualifications to qualify as a registered nurse. They told us they were given the time to study and their shifts had been adjusted to enable this.
- The radiology manager was the qualified Radiation Protection Supervisor (RPS) within the hospital. We saw evidence of their most recent update training and evidence of a competence update for their role.

Multidisciplinary working

- The diagnostic imaging and outpatient departments were staffed by a range of professionals working together as a multidisciplinary team to provide comprehensive service to patients.
- The hospital employed specialist breast care nurses in the breast clinic. They worked as part of a multidisciplinary team, which offered a 'one stop shop' clinic for patients who could have a mammogram and see the consultant or breast care nurse during the same visit to the hospital.
- The hospital employed specialist bariatric nurses in the weight loss service, as part of a multidisciplinary team, in addition to the bariatric surgeon and dietician.
- We observed close working relations between clinical and non-clinical staff within the outpatient department. Staff told us that everyone worked together well as a team.
- Within diagnostic imaging, staff worked closely with the local NHS provider to make use of previous images. If a patient had any previous images, they would be sent via a secure portal and the images could be uploaded to the hospital system for the consultant to review.
- There were arrangements in place to transfer patients' care to the local trust in emergencies.
- We saw evidence of communication to GPs informing them of treatments provided, follow up appointments and medications to be taken on discharge.

Access to information

- All images and reports in the diagnostic imaging department were stored on an electronic system, which was accessible by radiographers, radiologists and relevant consultants.
- The diagnostic imaging department had access to an image exchange portal, which enabled the service to securely access and share images with NHS or other independent hospitals. We observed staff using the system to access a previous radiological image for a patient.
- Consultants who worked in the outpatient department had access to the computer programme which scheduled their clinics. This meant that they and their secretaries were able to review the clinic times and patients scheduled for that clinic.
- All of the hospital policies and procedures were stored on the intranet, which was accessible to all staff and procedures specific to the diagnostic imaging department were stored on a shared folder, which was accessible to relevant staff.
- All appointment letters sent to private patients included a charging sheet so they were fully aware of any charges before attending their appointment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All clinical staff had to complete a module on the Mental Capacity Act (MCA) as part of their mandatory training. At the time of the inspection 100% of staff in the outpatient department and 100% of staff in the diagnostic imaging and physiotherapy department had completed the training. This was above the target for completing 95% of mandatory training.
- The hospital used a Spire group-wide consent policy which we saw addressed situations where patients lacked the ability to give consent.
- Staff we spoke with understood the principles of consent and the Mental Capacity Act. Staff gave us examples of times when they had identified that patients had lacked capacity. Staff told us that it was a consultant-led service and if a patient lacked capacity to

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provide consent for any procedure they would escalate it to the responsible consultant and not continue with the treatment. The consultants carried out a capacity assessment.

- Verbal consent was given for most general x-ray and OPD procedures carried out. The consultants sought written consent for some of the procedures.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as Good

Compassionate care

- We spoke with five patients in the outpatient and diagnostic imaging waiting area. All patients spoke positively about their experience and told us that staff had respected their privacy and dignity.
- We observed staff interacted with patients and their families in a compassionate and respectful manner. This included staff who visited the waiting area to check on the status of patients waiting for appointments.
- All staff in OPD had completed the mandatory training module in 'Compassion in Practice'.
- Within the outpatient department and physiotherapy there were individual consulting rooms. The rooms displayed 'free/engaged' signs on the door. This provided privacy and dignity to patients during their consultation.
- We observed staff in the outpatient department knocking on clinic rooms before entering.
- The reception desks in all the departments were far enough from the nearest seating, so that staff were able to maintain privacy and dignity when speaking with patients. Staff said they would use a private room if they needed to have confidential discussions with patients.
- The hospital used a Spire group-wide policy for using chaperones for appointments. We reviewed the policy, which listed the types of procedures which a chaperone must be offered for. We saw posters in every clinic room and imaging room which informed patients that they

could ask for a chaperone for any appointment. We saw the hospital's training document for chaperones and completed competency forms in staff files. Staff we spoke with said they acted as chaperones, in particular for clinics which involved intimate examinations. They said a record was made when there was a chaperone at the appointment.

Understanding and involvement of patients and those close to them

- Patients we spoke with during the inspection told us they were given appropriate information by clinicians about their care and treatment. Patients explained to us that they were told about different treatment options available and what these would involve.
- We observed staff in the diagnostic imaging department clearly explaining why radiological procedures were being carried out and what they would involve.
- Patients we spoke with told us they were given information about who to contact if they were worried about their condition or treatment after they left the hospital.
- In the reception areas, we saw there was information on TV screen and leaflets informing private patients that they would be responsible for the cost of their treatment, including any additional tests or minor procedures which they might need.
- Patients said they were seen in a timely manner and they did not encounter lengthy waits in clinic.

Emotional support

- Staff we spoke with had an understanding of the emotional impact care and treatment could have on patients. In the outpatient department, a member of staff we spoke with gave us an example of when they supported a patient who was nervous about a procedure they had undergone before. They reassured the patient, discussed the process and offered the patient further time with the clinician before the procedure, to enable them to ask any additional questions.

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- Within diagnostic imaging, families and carers were invited to stay with patients during scans if a patient was particularly anxious and the patient agreed. The family member or carer had to complete a safety questionnaire prior to being allowed to stay.
- We observed caring interactions between staff, patients and relatives. Staff reassured patients and relatives about the care and treatment they received. The majority of people we spoke with said they felt they received emotional support from staff, or this would be available if needed.

Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as Good

Service planning and delivery to meet the needs of local people

- The hospital offered a range of 23 outpatient department specialities to meet the needs of the local people. Between July 2015 and June 2016, 16% of appointments were for orthopaedic surgery; 11% for plastic surgery, 9% for gynaecology, 8% for general surgery, 7% for cardiology, 6% for dermatology, 5% for ear, nose and throat and urology, 4% for ; and less than 3% or fewer for the other specialities offered.
- Managers in the outpatient department told us that they reviewed the number of patients at every clinic, every three months, and gave consultants more or less clinic time depending on how many patients they had. This showed that the department was being responsive to the demand of patients using the hospital.
- The departments were all open between 8am and 8pm on weekdays and clinics were held on Saturday mornings from 8am-1pm, giving people of working age the flexibility to attend before or after work.
- We saw magazines and newspapers readily available in waiting areas and there was information displayed about how to connect to the hospital's internet.
- Between July 2015 and June 2016, the hospital saw 38,431 outpatients in clinics of which, 14,053 were first appointments and 24,378 were follow up appointments.
- The hospital treated NHS and other funded patients and received the NHS referrals through NHS Choose and Book. Out of the 38,431 attendees, 2,339 were NHS funded and 36,092 were other funded appointments.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the NHS in England. This system enabled patients to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- The hospital had no patients who waited for six weeks or longer from referral for magnetic resonance imaging (MRI) and non-obstetric ultrasound diagnostic tests in the reporting period (July 2015 to June 2016).
- The provider consistently achieved the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral during from July 2015 to June 2016.
- Patients had a choice for booking the dates and times of appointments. Patients we spoke with confirmed appointments were offered that suited their needs. None of the patients we spoke with raised any concerns about being able to access appointments in a timely manner. We heard reception staff booking patients for future appointments; patients were all offered a choice of times and dates.
- Staff in the outpatient department told us that if a patient was waiting for an appointment for longer than 15 minutes, they would speak to them, apologise and tell them how long they were likely to wait so they could leave the reception area if they chose to. Patients we spoke with said that appointments usually ran on time.
- The hospital did not audit specific waiting times for patients to receive an appointment, or the length of wait when they attended for their appointment.
- The hospital had very low 'Did not attend' (DNA) rates. All patients who missed their appointment were followed up by telephone and audited. Subsequently, the referrer was notified of the non-attendance.

Meeting people's individual needs

Access and flow

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- The hospital used a Spire group-wide equality and diversity policy. All staff in the hospital had to complete equality and diversity training as part of their mandatory training. At the time of the inspection a 100% of staff in OPD had completed the training.
- Appropriate seating was available in both the outpatient and diagnostic imaging waiting areas. A raised-height chair was provided in each of the waiting areas for patients who had difficulty standing from low heights.
- Private changing facilities were available for patients in the physiotherapy and diagnostic imaging department. Rooms contained lockers where patients could safely store belongings.
- The 2016 PLACE score for the hospital for dementia care was 87%; this was higher than the England average of 80%. The hospital had identified dementia care as an area for improvement and had a hospital dementia lead, champions and a dementia action plan.
- All written information, including pre-appointment information and signs were in English. Staff told us these were available on request in other formats, such as other languages, pictorial or braille, through a national contract. Staff told us there were low numbers of patients whose first language was not English. Staff could organise face to face or telephone translation as necessary if the patient had a specified communication need.
- In the OPD there were leaflets about procedures carried out in the hospital and other topics, such as knee arthroscopy and tonsillectomy. We saw that the leaflets gave relevant information about the procedures and advice for patients about aftercare.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation.
- We noted in the radiology waiting area there was a 'Pregnancy Safety Poster' displayed, to further alert patients to notify the radiographer if they are or may be pregnant.
- There was a small children's play and toy box in the waiting area of the outpatient department.

- Free car parking was available with disabled spaces allocated close to the entrance of the hospital.

Learning from complaints and concerns

- The hospital used a Spire group-wide complaints policy. We reviewed the policy, which sets out the two stage procedure for complaints from NHS patients and three stage procedure for complaints from private patients. Stage one involved an investigation and response by the hospital. If a complaint went to stage two, it was reviewed by Spire Group's Medical Director for private patients or an independent investigation by the Parliamentary and Health Service Ombudsman for NHS patients. For private patients the complaint could then be escalated to stage three, which was an independent investigation by the Independent Sector Complaints Adjudication Service (ISCAS).
- Staff in the outpatient department told us if someone was unhappy with the care or service they had received, they would try to resolve it themselves and inform their manager. Patients were given a copy of the 'Please talk to us' leaflet, which included information about making a complaint. We found the leaflet provided useful information about making a complaint.
- The hospital received 36 complaints from July 2016 to June 2016. None of these complaints related to the OPD. This was supported by the staff we spoke with who told us the OPD had not received any complaints from patients, in the last 24 months.
- The clinical lead told us all learning from complaints was discussed at the senior management team meeting that occurred bi-weekly, also at heads of departments and MAC meetings. Learning from complaints received was then cascaded to individual departments and teams, via team meetings.
- The hospital offered complainants the opportunity to meet and discuss their concerns further in their final response letter.

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good

Outpatients and diagnostic imaging

Leadership / culture of service

- The experienced and longstanding senior outpatients nurse had recently left the hospital, as had the recently appointed outpatients manager. However, the team were receiving leadership support from the clinical lead, who had been appointed in this role a month before the inspection. The senior outpatient nurse, who had left their permanent position, had also recently re-joined the hospital as part of the bank team, and was available as and when required.
- Although the team had been through a local leadership change recently, all staff we spoke with told us they felt supported by the clinical lead and told us the culture and morale of the team was good. Staff told us the clinical lead was approachable, open and supportive.
- Staff in the outpatient department told us there was a good relationship between the medical and nursing staff.
- Staff we asked were familiar with the hospital's senior management team and said they were visible, and regularly visited the departments.
- The hospital had a Spire group-wide whistleblowing policy in place and posters on staff noticeboards which informed staff of the policy. Staff we spoke with told us they would be comfortable speaking up if they had a concern to either their managers or directly to the senior management team.
- Information the hospital gave us showed that between July 2015 and June 2016 in the outpatient department there was no turnover for nurses.

Vision and strategy for this core service

- The hospital displayed its vision, values and mission statement for the staff and public to see. The vision for the hospital was "to be recognised as a world class health care business". The values were; "Caring is our passion, succeeding together, driving excellence, doing the right thing, delivering our promises and keeping it simple."
- Staff spoke passionately about the service they provided and the care they offered to patients but they were unable to articulate what the vision was for the individual departments that we visited.

- The hospital had agreed a three-year business and clinical strategy, which included six areas of focus. This included the need to increase self-paying private patients, to develop off-site diagnostics, and improve patient satisfaction.
- The hospital had a clear vision for the development of the hospital over the next three years, which included expansion of services both on and offsite. This included the need to develop the site, this had been in the planning phase for a number of years, teams were aware of this potential expansion.

Governance, risk management and quality measurement

- There was defined governance and reporting structure in the hospital, which departments fed into. Managers from departments attended the clinical governance committee, heads of department meetings, health and safety committee meetings and the infection prevention and control committee meetings. The outpatient clinical lead attended all these meetings for the OPD and fed back and shared information with the local team.
- There was a daily morning meeting led by the hospital matron that was attended by heads of department. The purpose of this meeting was for departments to update each other about workload and risks. There was also a clinical meeting to identify staffing and any particular clinical needs or risks of patients.
- Departments held their own team meetings, in which information was fed back from the hospital-wide meetings. We were told that the outpatient department held team meetings every month and the diagnostic imaging department held meetings every two or three months. These meetings covered different topics, such as: department news, hospital news, service development and continued professional development. We reviewed minutes of the most recent meetings in each department. All meeting minutes were saved on the internal computer system and staff could access these at all times.
- Risk registers had recently been implemented at the hospital. These were at both hospital and departmental level. However, the OPD did not have a local risk register. The clinical leads for outpatients and diagnostic team told us they raised any risks and concerns with the

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hospital matron during the daily meeting. These risks were then highlighted, by the matron, to senior management team, at the weekly senior management meetings.

- We saw evidence that risk was a standing agenda item at the weekly senior management team meeting and was discussed in detail at least once per month.
- All applications for practising privileges were reviewed every three months by the medical advisory committee (MAC). The specialities were all represented by members of the MAC. There was a system in place to review practising privileges annually and to remove the privileges of consultants who did not meet the required standards or had not used the hospital in the previous 12 months.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test (FFT).

- The hospitals FFT scores were above the England average for NHS patients across the period January 2016 to June 2016.
- There was a staff newsletter produced by the hospital. This gave information about upcoming education sessions which staff could attend for learning. The newsletter also reported on charity events and fund raising that hospital staff had been involved in. Staff awards were also reported.
- The hospital ran staff forums and had a committee for staff to engage with management.

Innovation, improvement and sustainability

- The service was implementing the NHS Accessible Information Standard.
- The diagnostic imaging department offered digital mammography, which is offered at few independent hospitals. This is a mammography technique, where X-ray protections are taken from a range of different angles and reconstructed to produce a 3D image of the breast.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital SHOULD take to improve

- The provider should review its own internal review document regarding the endoscope decontamination room and the actions identified.
- The provider should ensure that the handwashing sink located in the endoscope decontamination room is accessible at all times to enable staff to wash their hands.
- The provider should ensure theatre deep-clean requirements are robust and that checks are put in place after a deep-clean has taken place.
- The provider should ensure that the theatre environment is reviewed and that it conforms to infection prevention standards.