Spire Tunbridge Wells Hospital

Quality Report

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

Ratings

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

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

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

Summary of findings

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Tunbridge Wells Hospital is run by Spire Healthcare Limited, which is part of Spire Healthcare PLC. It is a 40 bedded acute hospital situated in the rural area of Kent located within five miles of Royal Tunbridge Wells and on the boundaries of West Sussex. Spire Tunbridge Wells Hospital provides services to predominately insured and self-pay private patients along with patients funded by the NHS under the Standard Acute Contract and a local contract.

The organisation offers a range of services and facilities including two operating theatres, a sterile services department; a dedicated endoscopy suite, and a diagnostic and imaging department with a MRI and CT scanner. There are outpatient and physiotherapy departments. There is a hot lab on site which comes under the umbrella of Spire Alexandra Hospital which is a MHRA & UKAS accredited Pathology laboratory.

We carried out an announced inspection of Spire Tunbridge Wells Hospital between the 26 and 27 July 2016 and an unannounced inspection of the hospital on 08 August 2016.

Spire Tunbridge Wells Hospital provides adult elective surgery, outpatients, diagnostic imaging, and endoscopy. Services to children and young people are provided in outpatients only.

For the purpose of the inspection, young person's services have been included in our findings of the outpatients' core service and the small amount of end of life care has been included in the medicine core service.

The hospital does not provide maternity or termination of pregnancy services.

Overall, we judged the hospital to be good.

Overall summary

Our key findings were as follows:

- The overall leadership was good. The senior management team were visible, had good oversight of governance and continually strove for improvement. They rewarded good performance by the staff and fostered a culture of transparency and openness. This was also reflected in local leadership at departmental level.
- The cleanliness of the hospital was good and this was reflected in their infection control policies, processes and infection rates.
- Staffing levels were well monitored and provided a high standard of care despite challenges in recruitment. Staff turnover was low and was mainly due to staff progressing to more senior roles.
- Mortality rates were low
- The hospital took a lot of care in monitoring nutrition and hydration levels. It was evident that the care taken to ensure that patients who had a diminished appetite, due to being unwell, were provided with alternatives to ensure that nutrition was good to facilitate their recovery.
- Spire Healthcare is finalising with NHS England its approach to report Workforce Equality Standard (WRES) data. The hospital was able to provide local information to demonstrate it reviews the ethnicity of its workforce.

We saw several areas of outstanding practice including:

- The hospital had systems and processes in place that supported staff in providing a good service.
- The catering department met both patients and staff individual requirements, and visited with patients daily.
- The leadership from the senior management team was described as approachable, available and visible.

Summary of findings

- Patients and their families were cared for by kind and compassionate staff who went out of their way to support them.
- Two-hourly patient "quality rounds" on the ward, led by the nurse-in-charge.
- Regular scenario-based training to ensure staff responded appropriately to emergency situations was undertaken.

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

The provider should:

- Ensure that if a patient declines a chaperone this is recorded in the patient's notes for inpatients, in line with hospital policy.
- Consider making the layout of some rooms on the ward more accessible for wheelchair users.
- Consider providing training to ward staff to help them better meet the needs of physically disabled patients.
- Consider using observational hand hygiene audits to monitor hand washing.
- Ensure dedicated hand hygiene sinks in patient bedrooms are included when carrying out refurbishment in accordance with the Department of Health's Health Building Note 00-09.
- The hospital should progress Joint Advisory Group (JAG) accreditation for endoscopy services.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	We rated each of the key questions, Safe, Effective, Caring, Responsive and Well-led as good. Overall, we rated medical care services as good because: • Staff understood and fulfilled their responsibilities to raise concerns and report incidents that were fully investigated. There was evidence of shared learning from incidents to prevent recurrences. • There was sufficient emergency resuscitation equipment available and evidence of assurances that this was safe and fit for purpose. • The hospital planned, implemented and reviewed staffing levels to keep people safe at all times and responded to any staff shortages quickly and effectively. • We saw that patient care was provided in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice. • Staff received meaningful and timely supervision and appraisal. We saw evidence of an appropriate approach for supporting and managing staff when their performance was poor. • The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. These were benchmarked against other independent hospitals and within the Spire Healthcare network. The hospital used this information to improve patient care. • Overall, feedback from people who used the service and those close to them was positive about the way staff treated people. • The service had links with other services to help patients living with cancer and those close to them cope emotionally with their care and treatment. • Waiting times, delays and cancellations were minimal and the service managed these appropriately and kept patients well informed. • The hospital coordinated the care and treatment it provided with other services and other providers, and had made positive improvements to make the service more accessible for patients living with dementia.

Summary of findings

• There were high levels of staff satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture.
• There were robust governance arrangements. Governance and performance management arrangements were proactively reviewed and reflected best practice. The vision and values of the hospital were well embedded amongst staff and leaders drove continuous improvement.
However:
• The service did not always meet the needs of wheelchair users, in terms of ease of access on the ward.
• There were no dedicated hand hygiene sinks in patient bedrooms. This meant staff had to wash their hands in the sinks in patients' en suite bathrooms contrary to the Department of Health's Health Building Note 00-09.
• The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services.

Surgery

Good

- We rated each of the key questions, Safe, Effective, Caring, Responsive and Well-led as good.Overall, we rated surgery as good because:
- Patients were protected from the risk of abuse and avoidable harm. Staff knew how to escalate key risks that could affect patient safety, such as safeguarding from abuse. They took steps to prevent abuse from occurring, responded appropriately to any signs of abuse and worked effectively with others to implement protection plans.
- Levels of staffing including medical, nursing, therapy and support staff were safe and met patients' needs. The hospital was visibly clean and there were appropriate systems in place to prevent and control healthcare associated infections. Medicines were managed safely. Staff completed mandatory training with good compliance rates.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- During the inspection, we observed staff respond compassionately when people needed help and support to meet their basic personal needs.

Summary of findings

People's privacy and confidentiality was respected at all times. Patients' feedback through interviews and comments cards was entirely positive. Patients praised all aspects of the service with comments such as 'level of care has been fantastic', 'friendly', 'and excellent', and 'nothing is too much trouble'.

- The hospital monitored patient outcomes to provide assurance of the effectiveness of the service. Patients were well cared for on the ward and in theatres. Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals. Pain control was well managed. There was evidence of excellent multidisciplinary working and out-of-hours services were provided when needed.
- Complaints about the service were investigated and lessons learnt were shared with staff. There was a clear governance structure in place with committees such as clinical governance, infection control, heads of department and risk management feeding into the medical advisory committee (MAC) and hospital senior management team (SMT).
- There was clear and visible leadership provided by senior management and within the departments. Staff spoke highly of their managers, who told us they were visible and approachable, and told us the senior management team had an 'open door' approach, and visited departments daily. Staff told us they felt 'proud' to work at the hospital, and there was good team spirit and atmosphere, and staff felt a part of a 'big family'.
- However we found:
- There were a lack of dedicated washbasins in patient bedrooms; this is not in accordance with Department of Health's Health Building Note 00-09: infection control in the built environment.

Summary of findings

The hospital was aware of this and we saw the installation of washbasins was included in their proposed programme of works due to start in January 2017.

- There were no observational hand hygiene audits to monitor hand washing.
- All written information, including pre-appointment information, leaflets and signage was in English only. However, Staff had access to a translation service. Information gathered at the referral stage identified patients who would need the assistance of the interpretation service and translators were booked when the appointment was made.

Outpatients and diagnostic imaging

Good

We rated each of the key questions, Safe, Effective, Caring, Responsive and Well-led as good. Overall, we rated outpatients and diagnostic services as good because:

- 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. Staff had appropriate safeguarding awareness and people were protected from abuse.
- Staff followed cleanliness and infection control procedures. Potential infection risks were anticipated and appropriate responses implemented and measured.
- 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.
- People were always made aware of waiting times and meals were offered to those delayed or in clinic over meal times.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- Medicines were stored safely and checks on emergency resuscitation equipment were performed routinely. Incidents and adverse

Summary of findings

events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.

- The leadership, governance and culture within the departments were strong. Staff were supported by their managers and were actively encouraged to contribute to the development of the services.

Summary of findings

Contents

Good

Spire Tunbridge Wells Hospital

Services we looked at
Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Spire Tunbridge Wells Hospital

Spire Tunbridge Wells Hospital is run by Spire Healthcare Limited, which is part of Spire Healthcare PLC. It is a 40 bedded acute hospital situated in the rural area of Kent located within five miles of Royal Tunbridge Wells and on the boundaries of West Sussex. Spire Tunbridge Wells provides hospital services to predominately insured and self-pay private patients along with patients funded by the NHS under the Standard Acute Contract and local contract

Spire Tunbridge Wells Hospital opened in 1991, originally as an independent hospital changing ownership to Goldsborough, then Bupa and then in 2007 a private equity company called Cinven purchased a number of BUPA Hospitals of which Spire Tunbridge Wells Hospital was one and Spire Healthcare was established. Spire Healthcare became a public limited company in 2014.

The organisation offers a range of services and facilities including two operating theatres, a sterile services department, a dedicated endoscopy suite, and a diagnostic and imaging department with a MRI and CT scanner. There are outpatient and physiotherapy departments providing services six days week. There is a hot lab on site which comes under the umbrella of Spire Alexandra Hospital which is a MHRA & UKAS accredited Pathology laboratory.

Main specialties treated are: orthopaedics; general surgery, breast surgery; gynaecology; ENT; ophthalmology; urology; gastroenterology; cosmetic; dental; vascular; general medicine.

Between April 2015 to March 2016, there were 2,881 visits to the operating theatre, with the most commonly performed procedures being: phacoemulsification of lens with implant and shoulder surgery.

Spire Tunbridge Wells Hospital was selected for a comprehensive inspection using our new methodology. We carried out an announced inspection of Spire Tunbridge Wells Hospital between the 26 and 27 July 2016. We also carried out an unannounced inspection of the hospital on 08 August 2016

The inspection team inspected the following core services:

- Surgery
- Outpatients and diagnostic imaging
- Medicine

Adrian Connolly the Hospital Director is the Registered Manager and has been in post for 7 years.

Our inspection team

Our inspection team was led by:

Inspection Lead: Elaine Biddle, Care Quality Commission Inspection manager

The team included 4 CQC inspectors and a variety of specialists including: a theatre nurse specialist a paediatric nurse specialist and a radiographer.

Why we carried out this inspection

Spire Tunbridge Wells Hospital was selected for a comprehensive inspection. The inspection was conducted using our new methodology.

Summary of this inspection

How we carried out this inspection

The inspection team make an evidence based judgment to ascertain if services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led.

Prior to the announced inspection, we reviewed a range of information and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups (CCG), NHS England, Local Area Team (LAT), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges and the local Health watch. We carried out the announced inspection on 26th and 27th July 2016. An unannounced visit was carried out on the 08 August 2016.

We held focus groups with a range of staff including: nurses, doctors, therapists, administrative and clerical staff.

We also spoke with staff and patients individually. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

Information about Spire Tunbridge Wells Hospital

Spire Tunbridge Wells Hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures.
- Surgical procedures.
- Treatment of disease, disorder or injury.
- Family planning.
- Services in slimming clinics.

Referrals are received from self-funding patients, patients with medical insurance, and NHS patients commissioned by the Clinical Commissioning Group (CCG). Spire Tunbridge Wells Hospital provides adult elective surgery, outpatients and diagnostic imaging, and endoscopy. Services to children and young people in outpatients only.

For the purpose of a comprehensive inspection, we undertook an on-site review of surgery, outpatients and medicine. Young person's services have been included in our findings of outpatients and the small volume of end of life care have been included in the medicine core service. The hospital does not provide maternity or termination of pregnancy services. Spire Tunbridge Wells pathology department is accredited by Clinical Pathology Accreditation (CPA). The hospital's sterile services department meets the requirements and is awaiting approval of accreditation by Société Générale de Surveillance (SGS) under ISO 13485. Pathology tests requested that are not processed in house or within Spire Network are processed through a pathology partnership service at a local hospital.

The accountable officer for controlled drugs is Adrian Connolly.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

There were clear procedures in place for safeguarding patients with a safeguarding lead monitoring the safety of patients. Incidents were recorded and monitored and lessons learnt were used to improve services. There was clear evidence of adherence to the duty of candour. There was good management of the number and skills of staff to provide good levels of care including 24 hour residential medical cover .The hospital had good arrangements for communication with consultants and handover from one resident medical officer to another.

Are services effective?

Good

Hospital policies, and care and treatment were in line with guidance from the National Institute for Health and Care Excellence (NICE) and the Department of Health guidelines. Benchmarking of outcomes was carried out locally and nationally within the Spire Health group and the hospital participated in a number of national audits including the national nephrectomy audit and joint registry. There were 24-hour cover arrangements of consultants and theatre staff for any unplanned readmissions or returns to theatre. All the staff had a clear understanding of the Mental Capacity Act and Deprivation of Liberty Standards and these was also part of the consultants' mandatory training under their practising privileges agreement. Consent to treatment was well documented.

Are services caring?

Good

Feedback from people who used the service and those who are close to them was positive about the way staff treated people. Staff treated people with dignity, respect and kindness and patients felt supported and cared for. Patients and their loved ones were encouraged to be partners in their care. The service had links with other services to help patients living with cancer and those close to them to cope emotionally with their care and treatment. In October 2015 – March 2016, the hospital scored 100% in the NHS Friends and Family Test in five out of six months in this period. November 2015 was the only month where the hospital scored less than 100%. The hospital scored 97% in this month. The proportion of patients completing the Friends and Family Test ranged from 33% in March 2016 to 73% in January 2016. Response rates were better than the England average in all except two months during the reporting period.

Summary of this inspection

Are services responsive?

Good

The hospital adhered to the corporate 'Admission and Discharge Policy', which outlined the clinical risk assessment criteria for patients. Most admissions were planned. These were all elective procedures and included private and NHS patients. Staff were proactive in meeting patient needs. There was daily planning by staff to ensure patients were admitted and discharged in a timely manner. Outpatient services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these well and kept patients well informed.

Evening and Saturday outpatient clinics were routinely offered, which afforded additional choice and convenience to patients and particularly those that worked or had childcare commitments during the week.

The hospital coordinated the care and treatment it provided with other services and other providers. Access to care and treatment was monitored and exceeded the national average and patients could book procedures at a time to suit them. NHS patients were consistently admitted within the 18-week referral to treatment target.

There were good procedures in place to deal with out of hour's emergencies or re-admissions.

The hospital made positive improvements to make the service more accessible for patients living with dementia. Staff had a good understanding of the complaints process and followed the policy. Complaints and concerns were discussed at monthly staff meetings. Information about the complaints procedure was available for patients and relatives.

Are services well-led?

Good

There was a clear governance structure in place with committees such as clinical governance, infection control, heads of department and risk management feeding into the medical advisory committee (MAC) and the hospital senior management team (SMT). The medical advisory body (MAC) reviewed outcomes from the Clinical Governance Committee and ratified clinical policies and practising privileges. The hospital reviewed practising privileges of consultants every two years.

The hospital had strong governance arrangements that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored.

The corporate Spire Hospital values were well embedded with staff who could tell us what they were and how they applied to them. There was clear and highly visible leadership provided by senior

Summary of this inspection

management and managers within the departments. The senior management team had an 'open door' approach, and visited departments daily. The hospital had consistently high levels of constructive engagement with staff at all levels. Leaders listened to staff and valued their input. Leaders drove continuous improvement and organisational growth. There were examples of local leadership. These included the introduction of two-hourly quality rounds led by the nurse-in-charge to ensure patients received a high standard of care. There was a strong culture of openness and transparency. A large proportion of the incidents the hospital reported were "near misses". All individual independent hospital with NHS contracts worth £200k or more are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Spire Healthcare is finalising with NHS England its approach to report Workforce Equality Standard (WRES) data. The hospital was able to provide local information to demonstrate it reviews the ethnicity of its workforce.

Detailed findings from this inspection

Mental Health Act responsibilities

All the staff had a clear understanding of the Mental Capacity Act that was included in their mandatory training, and this was also part of the consultants' mandatory training under their practising privileges agreement. Information on the Mental Capacity Act 2005 was displayed in the nurses' office to remind staff of their responsibilities and the correct processes.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital followed their corporate 'Deprivation of Liberty Safeguards Policy' (dated April 2016). Staff demonstrated awareness of situations that may require deprivation of liberty safeguards (DoLS). We were told they would escalate any concerns in this area to the matron, who would apply for a standard authorisation from the local authority. A standard authorisation gave permission for hospital staff to restrict a patient's liberty that lacked mental capacity when this was necessary and proportionate to keep the patient safe from avoidable harm. The clinical nurse manager knew how to access the hospital's policy on DoLS. We also saw information on DoLS displayed in the nurses' office to remind staff of their responsibilities and the correct processes.

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Medical care

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

Information about the service

The hospital had a small inpatient medical care service. This was mainly chemotherapy and day case endoscopy procedures. Endoscopy is a procedure that involves examining the inside of the body using a long, thin, flexible tube attached to a camera.

The hospital occasionally admitted patients needing blood transfusion and administration of intra-venous antibiotics for chest infections. In April 2015 – March 2016, the hospital had 25 medical admissions. The hospital did not provide inpatient medical care services to children under the age of 18.

The hospital provided only one specific type of chemotherapy: intravesical instillation of a pharmacological agent. This technique involves putting liquid drugs directly into the bladder through a catheter to treat bladder cancer. The hospital provided 29 treatments with this technique from April 2015 to March 2016.

The service carried out 641 endoscopies from April 2015 to March 2016. The most common endoscopy procedure being diagnostic oesophago-gastro-duodenoscopy (OGD), which accounted for 243, or 38% of procedures. OGD is an examination of the oesophagus, stomach and duodenum (the first part of the small intestine). The second most common procedure was diagnostic colonoscopy (examination of the large intestine), which accounted for 135, or 21% of, procedures.

Between April 2015 and March 2016, 27% of patients treated at the hospital received NHS funding. The remaining 73% either paid for their own treatment or used medical insurance to fund their care. The hospital did not provide chemotherapy services to any NHS-funded patients during this period.

There were policies and processes for end of life care. However, the hospital rarely provided end of life care, and no patients received end of life care between April 2015 and March 2016.

The hospital has a single ward of 33 bedrooms, where staff cared for both medical patients and patients recovering from surgery. All patient bedrooms had en suite bathroom facilities. Endoscopy patients had their procedure in the endoscopy theatre, before returning to the ward afterwards to recover.

We visited all clinical areas including the ward, the endoscopy theatre and the endoscope cleaning room during our inspection. We also undertook an unannounced visit nine working days after our announced inspection.

During our inspection, we spoke with 25 members of staff including doctors, nurses, administrative staff, catering staff, housekeeping staff and senior managers. We spoke with six patients and two patient relatives. We also reviewed 14 comment cards with feedback from patients. We reviewed six sets of patient records and a variety of hospital data including meeting minutes, policies and performance data.

Good

Medical care

Summary of findings

We rated each of the key questions, Safe, Effective, Caring, Responsive and Well-led as good. Overall, we rated medical care services as good, because:

• Staff understood and fulfilled their responsibilities to raise concerns and report incidents and to ensure that they were fully investigated. There was evidence of shared learning from incidents to prevent recurrences.

• There was sufficient emergency resuscitation equipment available and evidence of assurance that this was safe and fit for purpose.

• The hospital planned, implemented and reviewed staffing levels to keep people safe at all times and responded to any staff shortages quickly and effectively.

• We saw that patient care was provided in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.

• Staff received meaningful and timely supervision and appraisal. We saw evidence of an appropriate approach for supporting and managing staff when their performance was poor.

• The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. These were benchmarked against other independent hospitals and within the Spire Healthcare network. The hospital used this information to improve patient care.

• Overall, feedback from people who used the service and those close to them was positive about the way staff treated people.

• The service had links with other services to help patients living with cancer and those close to them cope emotionally with their care and treatment.

• Waiting times, delays and cancellations were minimal and the service managed these appropriately and kept patients well informed.

• The hospital coordinated the care and treatment it provided with other services and other providers, and had made positive improvements to make the service more accessible for patients living with dementia.

• There were high levels of staff satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture.

• There were robust governance arrangements. Governance and performance management arrangements were proactively reviewed and reflected best practice. The vision and values of the hospital were well embedded amongst staff and leaders drove continuous improvement.

However:

• The service did not always meet the needs of wheelchair users, in terms of ease of access on the ward.

• There were no dedicated hand hygiene sinks in patient bedrooms. This meant staff had to wash their hands in the sinks in patients' en suite bathrooms contrary to the Department of Health's Health Building Note 00-09.

• The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services.

Good

Medical care

Are medical care services safe?

Good

We rated safe as good because:

• Staff understood and fulfilled their responsibilities to report incidents and near misses. The hospital fully investigated incidents and shared learning from them to prevent recurrences.

• The hospital planned implemented and reviewed staffing levels to keep people safe at all times and the hospital responded to any staff shortages quickly and effectively.

• The hospital had effective systems to assess and respond to patient risk.

• There was sufficient emergency resuscitation equipment available and evidence of assurance that this was safe and fit for purpose.

• Staff received up-to-date mandatory training in safety systems including fire training and infection prevention and control to enable them to keep patients safe.

• The hospital stored and checked medicines appropriately in line with legal requirements.

However:

- There were no dedicated hand hygiene sinks in patient bedrooms. This meant staff had to wash their hands in the sinks in patients' en suite bathrooms contrary to the Department of Health's Health Building Note 00-09.

Incidents

- The hospital reported no patient deaths related to medicine in April 2015 – March 2016.
- The hospital reported no never events related to medicine in April 2015 – March 2016. Never events are serious, wholly preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.
- In April 2015 – March 2016, the hospital reported 277 clinical incidents. Of these, seven incidents (2.5%) related to medicine. We identified no common themes from these incidents. The hospital categorised four of the seven incidents as no harm. In three out of the seven incidents, the patient sustained minor harm, for example needing basic first aid treatment.
- The hospital used an online software system for reporting incidents. Staff could describe the process for reporting incidents, and gave examples of times they had done this. All staff we spoke to had confidence in the incident reporting process.
- The hospital had robust systems to ensure staff learned from incidents to improve patient safety. The hospital's governance lead investigated incidents with oversight from the matron for incidents involving medical patients. We saw from meeting minutes that a detailed review of incidents was a standard agenda item on the clinical governance committee minutes. Staff told us the clinical nurse manager or nurse-in-charge fed back to them any learning from incidents at ward meetings. We saw evidence from ward meeting minutes that the team discussed feedback from the clinical governance committee and received a copy of the clinical governance committee minutes. Ward staff and the clinical nurse manager told us that staff also received an email if any immediate action was necessary following an incident.
- Staff we spoke with were aware of the Duty of Candour (DoC) under the Health and Social Care Act (Regulated Activities Regulations) 2014. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of "certain notifiable safety incidents" and provide them with reasonable support. Staff knew what DoC meant and could describe their responsibilities relating to it. We also saw openness and honesty in a complaint response in-line with DoC
- A doctor told us the hospital discussed mortality and morbidity at clinical governance committee meetings. We also saw evidence of this in the clinical governance committee minutes.

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

- The safety thermometer was a national tool used for measuring, monitoring and analysing common causes

of harm to hospital inpatients. These included falls, new pressure ulcers, catheter-associated urinary tract infections (UTIs) and venous thromboembolism (VTE) (blood clots in veins).

- The hospital reported no falls, new pressure ulcers, catheter-associated UTIs or VTEs related to medical inpatients in April 2015 – March 2016. This meant the hospital had a 100% harm-free care rate for medical inpatients.

Cleanliness, infection control and hygiene

- The hospital reported no infections of methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile or methicillin-sensitive Staphylococcus aureus (MSSA) in April 2015 – March 2016. The hospital also reported no cases of Escherichia coli in the same period.
- All clinical areas were visibly clean and tidy. The hospital scored 100% in the patient-led assessment of the care environment (PLACE) audit 2016. This was better than the England average of 98% for the same period.
- We saw "bare below the elbows" posters displayed throughout the hospital. These served to remind clinical staff of the importance of not wearing any clothing or jewellery below the elbows to reduce the risk of infection to patients. We saw that all staff adhered to this policy.
- In the endoscopy unit, we saw personal protective equipment (PPE), including disposable aprons, gloves, theatre hats and masks, available to staff decontaminating endoscopes. We saw a member of staff using PPE during endoscope cleaning to protect them from infection. We also saw the staff member wash their hands appropriately after endoscope cleaning to reduce the risk of contamination to staff and patients.
- Alcohol hand sanitiser was available throughout clinical areas and in patient bedrooms to enable staff and visitors to decontaminate their hands. We saw hand sanitiser being used appropriately between patients during a ward round.
- The hospital audited staff compliance with hand hygiene sanitiser as part of its infection prevention and control (IPC) programme. The hospital overall achieved an average hand hygiene score of 20 in 2015. This was better than the Spire Healthcare target of 18.
- Recent hand hygiene results for the ward showed that between January and March 2016, hand hygiene compliance was 15.7. This was worse than the Spire Healthcare target of 18. However, the most recent results available at the time of our inspection showed that the ward scored 21 between April and June 2016. This was better than the target of 18.
- On the ward, we saw there were no dedicated hand hygiene sinks in patient bedrooms. This meant staff had to wash their hands in the sinks in patients' en suite bathrooms. This is contrary to the Department of Health's Health Building Note 00-09, which states, "healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes". However, we saw that the hospital planned to install clinical wash hand basins in patients' bedrooms as part of their programme of refurbishment works due to start in January 2017.

Environment and equipment

- We checked 26 items of medical equipment in the equipment store cupboard on the ward. This included three intravenous pumps. All electrical items we checked had evidence of portable appliance (PAT) testing. This provided the hospital with assurances around the electrical safety of these items. We saw maintenance stickers providing assurances that an external company had regularly checked and maintained medical devices. We saw that all disposable items such as oxygen masks were in-date. We also saw that all reusable items had "I am clean" stickers. This showed the staff had cleaned these items ready for the next patient.
- We checked the crash trolley on the ward. The defibrillator and the portable suction unit both had evidence of PAT testing and regular maintenance checks to provide assurances around the safe function of these emergency items. We saw that staff checked all equipment daily to ensure that it was safe to use in an emergency.

- We checked nine items of equipment in the endoscopy theatre. Again, we saw evidence of PAT testing and regular maintenance checks for all items.
- We checked 14 items of medical equipment in room 24 on the ward, including a hoist. We saw evidence of PAT testing, cleaning and maintenance checks for all except one item of equipment. This was a bladder volume calculator, which was on-loan from a third party provider. We did not see evidence of PAT testing for this item, which meant the hospital might not have had assurance of its electrical safety.
- We asked a nurse and a member of the housekeeping team to describe the processes for the disposal of cytotoxic waste (equipment and bodily fluids that have been in contact with chemotherapy drugs). Both could describe the process, and explained that nurses disposed of cytotoxic waste in purple-lidded bins labelled as cytotoxic. Correct segregation and labelling of waste was vital to prevent potential harm to staff and external contractors who handled waste. We saw that this was in-line with the Spire Tunbridge Wells Hospital's policy for intravesical chemotherapy. The housekeeper also told us staff double-bagged all linen that may have been in contact with cytotoxic drugs to protect staff from inadvertent exposure.
- We observed the process of endoscope decontamination. We saw staff put used endoscopes into a tray in theatres after wiping them with a "pre-clean" detergent, and then placed the tray inside a sealed red plastic bag. This was important to retain moisture and prevent endoscopes drying out before decontamination, which could make soil more difficult to remove. This was in-line with guidance from the Department of Health's "Choice Framework for local Policy and Procedures 01-06 – Decontamination of Flexible Endoscopes: Operational Management". The red colour of the bag showed the endoscope had been used and needed cleaning. The endoscopy unit used green bags to cover clean endoscopes to differentiate between the clean and dirty.
- We saw staff used an enzyme-based cleaning agent, which could remove blood, protein, mucous, vomit and faecal matter. We saw a water fill-level line clearly marked on the sink. This was important to ensure staff used the correct ratio of detergent to water to allow effective cleaning of endoscopes. We saw staff filled the sink to the marked level and followed the cleaning protocol displayed on the wall next to the sink. Staff used single-use disposable brushes for endoscope cleaning to prevent the spread of infections.
- The endoscopy decontamination room did not have a second sink for rinsing of endoscopes following manual cleaning. This was contrary to guidance from the Department of Health's "Choice Framework for local Policy and Procedures 01-06 – Decontamination of Flexible Endoscopes: Operational Management". The guidance stated, "The second sink is filled with cold water and the washed endoscope is immersed before each lumen is syringed through to remove the detergent."
- Following manual cleaning of endoscopes, the hospital used an endoscope washer-disinfector for decontamination. We saw that the machine printed a receipt providing assurance it had performed complete decontamination after every cycle. Staff told us the printout alerted them if the machine had not worked correctly. This allowed staff to resolve any faults and re-process the endoscopes to ensure complete decontamination.
- The endoscope washer-disinfector had a barcode tracking system. This enabled the hospital to track the decontamination of endoscopes used by individual patients for quality control.
- The hospital sent water samples from the endoscope washer-disinfector unit for weekly microbial testing. We saw the results of weekly microbial testing for the eight-week period before our visit. This provided assurances that the machine was free from contamination. We asked a member of staff what action they would take if water testing showed evidence of bacterial growth. The staff member told us there was a clear escalation policy, and showed us how to access this at the front of the water-sampling folder.
- We saw an emergency chemical spill kit in the endoscopy theatre. This was clearly signposted and contained sand to mop up any spillage of endoscope cleaning chemicals. Staff knew how to access the spill kit. The kit also contained PPE, including a full-face mask to protect staff from inhaling any toxic chemicals.
- Ward corridors had carpets, which may be difficult to clean in the event of a spillage. Department of Health's

Health Building Note (HBN) 00-09: infection control in the built environment states "Spillage can occur in all clinical areas, corridors and entrances" and "in areas of frequent spillage or heavy traffic, they can quickly become unsightly". However, we saw carpets were visibly clean and free from stains. We also saw regular deep cleans of carpets had taken place.

Medicines

- We checked controlled drugs (CD) records on the ward. Controlled drugs were medicines liable for misuse that required special management. We saw evidence of daily CD checks, documentation of administration, and receipt of CDs including batch numbers, expiry dates and serial numbers. We saw two people signed for all CDs in line with national standards for medicines management.
- The CD cupboard was locked, and only authorised staff could access CDs. We saw denaturing kits were available, and staff used these to inactivate any unused stocks of CDs greater than 10ml so that they could dispose of them safely.
- We saw locked "pods" available to hold patients' own drugs securely while they were on the ward.
- The pharmacy technician completed daily temperature checks of the drug fridges and ambient temperatures on the ward. We reviewed temperature monitoring records for April and May 2016. We saw that staff had fully completed the records, with no omissions. All temperatures were inside the safe range.
- The pharmacy team could describe what action they would take if a fridge temperature were outside the safe range. This ensured the hospital stored refrigerated drugs, as well as drugs designed to be stored at room temperature, within the correct temperature ranges to maintain their function and safety. Pharmacy staff demonstrated awareness of the policy explaining this process, and knew how to access it. The policy included reporting any anomalies as a clinical incident.
- We reviewed five patients' prescription charts on the ward. We saw that staff had fully completed all charts, including the patients' allergy statuses, the frequency and dosage of medicines. We saw that staff had signed to confirm they administered all medications.
- We reviewed four endoscopy patient records on the ward. We saw that two of these records had evidence of an antibiotic review. This was appropriate for the type of procedure these two patients received.
- The hospital pharmacy was open Monday – Friday between 8.30am – 4pm. The pharmacist dispensed medication during these hours. The pharmacist visited the ward each morning and reviewed all prescriptions for clinical appropriateness and adequate pain management.
- The pharmacy team saw most patients with to take-out (TTO) drugs at discharge. This enabled the pharmacist to counsel the patient on the dosage and possible side effects of the medicine before discharge.

Records

- We reviewed the records for one chemotherapy patient and four endoscopy patients on the ward. Staff stored notes securely in the nurses' office, which had a locked door to prevent unauthorised access to confidential patient data. We saw evidence of clear documentation, and staff had signed and dated all entries. This was in-line with guidance from the General Medical Council. All five patients had care plans that identified all their care needs. We saw staff had fully completed all five care plans.
- Staff told us the hospital kept patient records on-site. This allowed hospital staff to access patient records to assist with clinical decision-making and keep up-to-date documentation. We saw the hospital's patient records policy. The policy was up-to-date and referred to national standards and statutory obligations such as The Data Protection Act 1998. The policy stated that consultants and doctors with practicing privileges must "ensure that a copy of the operation notes and relevant medical records are accessible within the hospital".

Safeguarding

- All staff we spoke to knew how to escalate any safeguarding concerns. All staff could correctly identify the hospital's safeguarding lead.
- The head of clinical services was the safeguarding lead for the hospital. She had level three safeguarding training. This was appropriate for the medicine core service where the hospital only treated adults aged 18 and over.

Good

Medical care

- The hospital reported one safeguarding concern in April 2015 – March 2016. However, this did not relate to medical care.
- We saw a copy of Spire Healthcare's safeguarding vulnerable adults policy. The policy was in-date and referred to relevant professional guidance and legislation.
- The hospital told us all staff received level two safeguarding training. This was an appropriate level of training for staff providing medical care because the hospital did not accept medical admissions for children. Hospital records at the time of our inspection showed a 97% compliance rate in safeguarding vulnerable adults training for staff that treated medical patients. This was better than the Spire Healthcare target of 95%. It meant the hospital had assurance staff had up-to-date training to enable them to identify safeguarding concerns.
- Records showed 100% of staff treating medical patients completed safeguarding children training in January 2015 - December 2015. This was better than the Spire Healthcare target of 95%.

Mandatory training

- The overall mandatory training rate for staff that cared for medical patients was 97% between May 2015 and May 2016. This was better than the Spire Healthcare target of 95% and demonstrated that staff kept their skills up-to-date to keep patients safe.
- Mandatory training included the following areas: fire safety; health and safety; infection control; safeguarding children levels one and two; safeguarding adults levels one and two; manual handling; compassion in practice; and equality and diversity and information governance.

Assessing and responding to patient risk

- Chemotherapy and endoscopy patients received treatment as day-cases. This meant they went home on the same day as their treatment.
- For patients who needed to stay overnight, we saw the hospital's admissions policy. There were four levels of risk assessment, and clear criteria as to which level of assessment a patient would require based on the treatment they were having, any pre-existing conditions and their individual needs. The lowest-risk patients had a level one assessment, which involved a healthcare professional's review of the patient's completed pre-assessment medical questionnaire. Level four was the highest level of risk assessment. This involved referral to an anaesthetist.
- The hospital reported 15 unplanned medical admissions in April 2015 – March 2016. Unplanned medical admissions involved patients already under the care of a consultant with practicing privileges who became unwell and required an overnight stay in hospital. The reasons for these admissions were mostly respiratory-related, such as chest infections that needed antibiotic treatment. Other reasons included cellulitis, blood transfusion and drainage of seroma (a pocket of clear fluid that can sometimes develop as a complication of surgery). The hospital had a clear policy for these types of admission, and only accepted patients when an appropriate consultant was able to attend the hospital to assess the patient upon arrival.
- The hospital used the National Early Warning System (NEWS) track and trigger flow charts. NEWS was a simple scoring system of physiological measurements (for example blood pressure and pulse) for patient monitoring. This enabled staff to identify deteriorating patients and provide them with additional support. We reviewed NEWS charts for five medical patients. Staff had completed all five charts accurately and fully. We saw that staff had followed the associated guidance regarding escalation.
- The hospital did not have any level two or three critical care beds. This was appropriate for the type of medical care the hospital provided, as the hospital did not deal with any complex acute medicine.

  In the event that a patient's condition deteriorated, the hospital had a service-level agreement with a local NHS hospital. This enabled them to transfer any patients who needed critical care support.
- The hospital had a transfer policy, and a doctor was able to describe details of this, such as blood potassium levels that might trigger escalation. Staff knew how to access the policy, and told us there were printed copies of the policy throughout the hospital, including the nurses' station on the ward. Staff could also access the policy electronically and knew how to do this.

Nursing staffing

- The hospital used a 1:5 nurse: patient ratio for day shifts and a 1:7 ratio for nights. The hospital told us they previously tried a national staffing tool, but found this too complex for their needs. The hospital told us a supernumerary nurse-in-charge was on duty on most day shifts. The clinical nurse manager confirmed that the nurse-in-charge occasionally needed to cover an unfilled clinical shift, but that this did not happen often. The service adjusted the ratio to 1:1 or 1:2 nurses: patients for patients who needed a higher level of care according to their individual needs.
- The clinical nurse manager told us the nurse-in-charge used a forward planner to assess the number of patients planned for the following week to ensure the ward filled all shifts. The hospital had a daily bed meeting every morning, which the nurse-in-charge attended. This allowed the ward to make any staffing adjustments on a daily basis depending on the number and acuity of patients.
- At the time of our inspection, the ward had 21 nurses. Some staff worked part-time, and there were 15.1 whole-time equivalent (WTE) nurses and 1.4 whole-time equivalent (WTE) healthcare assistants (HCAs). The ward had three whole-time equivalent (WTE) nurse vacancies and two WTE healthcare assistant (HCA) vacancies. However, the hospital had recruited new staff to fill the vacancies. The clinical nurse manager told us four new nurses recently accepted positions at the hospital, and all would start working on the ward by September 2016.
- Bank and agency staff often worked on the ward to make up the shortfall in staff numbers. The use of bank and agency nurses in April 2015 – March 2016 varied. The lowest rates were 7% in April 2015 and December 2015, and the highest rate was 22% in September 2015. Bank and agency rates were about the same as the average for other independent hospitals we hold data from during this period, with the exception of one month. In September 2015, rate of bank and agency nurse use (22%) was worse than the average independent hospital rate of 16% in the same month.
- The ward did not use any bank or agency HCAs in April 2015 – March 2016, apart from in two months during this period. The ward used 7% bank and agency HCAs in June 2015 and 28% agency HCAs in February 2016. The percentage of bank and agency HCAs on the ward in February 2016 was worse than the average rate of 11% for other independent hospitals we hold data for in the same month. However, HCA bank and agency use was better than the average rate for other independent hospitals in 11 out of 12 months during the reporting period.
- The bank to agency staff ratio on the ward was one to 0.26. This meant that most of the non-permanent staff on the ward were bank staff rather than agency. Staff who worked via the hospital's own bank of staff were more likely to be familiar with the hospital's policies, environment and ways of working than agency staff who might not have worked at the hospital before.
- We observed a nurse handover, which was very effective in terms of communication and information sharing. We saw handover forms the nurses used. There was space to document information such as infections. This facilitated clear communication of important clinical information to colleagues at the start of their shift.

Medical staffing

- The hospital used an agency to provide 24-hour, seven days a week resident medical officer (RMO) cover on a rotational basis. This ensured a doctor was on-site at all times of the day and night should an emergency arise. The RMO on duty showed us evidence of in-date advanced life-support training. The RMOs worked one week on followed by one week off.
- The RMO conducted regular ward rounds to ensure patients were safe. The RMO visited the ward every two hours between 8am and 11pm. The hospital had a clear policy describing situations in which staff should contact the RMO during the night, for example, if a patient's condition deteriorated and their NEWS score triggered escalation. The RMO told us all staff followed this policy, which allowed the RMO to get adequate rest during the night by only disturbing them when clinically necessary.
- An RMO told us consultants were easy to contact and responsive in the case of a medical emergency. The RMO gave us an example of a consultant who arrived at the hospital within 20 minutes after the RMO alerted them of a patient with suspected sepsis. This was in-line with the terms of Spire Healthcare's practicing privileges, which required consultants to be able to attend within 45 minutes whenever they had a patient in the hospital.

Good

Medical care

- The hospital also had a nominated on-call consultant every day. The RMO could contact the on-call consultant in an emergency if the patient's consultant was not available. The RMO knew how to access the on-call consultant and the hospital kept a folder in reception with contact details for the on-call consultant each day.
- The RMOs had a formal handover when they changed shifts. We spoke to the RMO on duty, who showed us a handover form the RMOs completed to ensure thorough communication around patients with specific needs, such as those on antibiotics. However, we were unable to observe a handover as there was no change over during our visit

Major incident awareness and training

- Staff told us about regular scenario-based training exercises for major incidents they undertook. This included a cardiac arrest scenario involving a pulmonary embolism in July 2016. We saw an evidence folder in the nurses' office on the ward with details of exercises staff completed. Staff told us they found the exercises useful, and felt participation helped them keep their skills up-to-date.
- We saw the hospital's business continuity policy. The policy was in-date set out clear roles and responsibilities to ensure service continuity in the event of a business continuity incident. It contained a set of action cards so staff knew what to do in scenarios such as adverse weather. It also contained a list of useful contact numbers, including the hospital's electricity and water suppliers, to enable appropriate staff to work to restore activity as quickly as possible.
- The hospital had an emergency power supply via a back-up generator. The head of estates told us this responded within 20 seconds of a mains outage. The hospital tested the generator monthly and performed maintenance checks twice a year in-line with its corporate contract. Generator testing records provided the hospital with assurance that the generator would provide back-up power and enable services to continue in the event of a power failure.

Are medical care services effective?

Good

We rated effective as good. This was because:

- Staff planned and delivered patient care in line with current evidence-based guidance, standards, best practice and legislation. The hospital monitored this to ensure consistency of practice.
- The hospital routinely collected and monitored information about people's care and treatment, and their outcomes. The hospital benchmarked their findings against other providers and used this information to improve care.
- Staff received meaningful and timely supervision and appraisal. We saw evidence of an appropriate approach for supporting and managing staff when their performance was poor.
- Staff obtained and recorded consent in line with relevant guidance and legislation.
- Staff could access the information they needed to assess, plan and deliver care to people in a timely way.

However:

The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services.

Evidence-based care and treatment

- We saw the hospital's policy for intravesical chemotherapy. This procedure involved putting liquid drugs directly into the bladder through a catheter to treat bladder cancer. The policy was in-date and incorporated evidence-based guidance from National Institute for Clinical Excellence (NICE) quality standard QS106 for bladder cancer. This included administration of a chemotherapy drug into the bladder at the same time as transurethral resection of bladder tumour (surgery to remove cancerous tumours from the bladder lining). Research showed that a single dose of intravesical chemotherapy given at the same time as surgery reduced the chance of cancer returning after treatment. Staff could describe the policy and knew how to access it.

- We saw that two patients having gastroscopy had an antibiotic review as part of their pre-assessment. This was appropriate for these patients in-line with the British Society of Gastroenterology's (BSG) guidelines for antibiotic prophylaxis in gastrointestinal endoscopy. The hospital's endoscopy standard operating procedure also made reference the BSG guidelines, and stated that endoscopy staff must adhere to the guidelines. Staff could access the guidelines electronically.
- The Spire Healthcare head office produced a monthly bulletin highlighting new NICE guidelines, National Patient Safety Agency (NPSA) alerts, and updates on regulation and internal policies. The senior management team told us they shared this information with all staff and provided assurance of action taken to the Spire Healthcare head office. We saw evidence of discussion of updated NICE guidelines and NPSA alerts in senior management team and clinical governance committee minutes. We also saw from the ward minutes that the clinical governance lead disseminated clinical governance committee feedback and meeting minutes to staff on the ward.

Pain relief

- Patients had their pain assessed regularly. The nurse-in-charge carried out quality rounds to assess patients every two hours. We observed a quality round, and saw that the nurse asked patients to rate their pain between zero and four, zero meaning no pain and four being extreme pain. The nurse arranged additional pain relief for patients who required it. We saw that each patient had a quality round form, which documented their pain score and any action staff took to help patients manage their pain.
- We reviewed five sets of patient notes and saw that staff recorded pain scores as part of patient observations. The hospital's clinical scorecard for January – December 2015 showed that, on average, staff recorded pain scores with 99% of observations. This was better than the Spire Healthcare target of 95% and showed that staff regularly assessed patients' pain.
- In the patient satisfaction survey (March 2016), 94% of patients felt that staff did everything they could to control their pain. This was better than the Spire Healthcare average of 91%.

Nutrition and hydration

- The hospital offered day case medical patients a light meal. The catering team prepared meals fresh on-site. We reviewed patient menus and saw a balanced variety of choices. This included options for vegetarians and patients with special dietary needs such as gluten intolerance.
- The catering team accommodated specific requests for food that was not on the menu. A chef gave us an example of how the team looked ahead at patient lists and ensured they prepared a jacket potato for a patient who always requested one when they attended for chemotherapy.
- The nurse-in-charge assessed nutrition and hydration as part of two-hourly quality rounds. Patients told us nurses routinely offered them drinks as part of these rounds, and we saw water available at patients' bedsides. Quality rounds also included an assessment for patients who were fasting to ensure they were comfortable, such as those preparing for endoscopy under general anaesthetic.
- Staff told us, and we saw for ourselves, that the head chef visited patients on the ward to discuss their dietary needs and preferences. The catering team used this information to ensure patients had adequate nutrition. The consultant representative for medicine on the hospital's medical advisory committee told us they felt the chef helped contribute to the recovery of patients by taking these measures to ensure patients were well nourished.
- The hospital did not have a dietician on site, but had access to an external dietician when required.

Patient outcomes

- The hospital measured its performance in a number of areas relevant to medical care. These included blood transfusions and unplanned transfers to hospitals with critical care facilities. Spire Healthcare compared results from all hospitals across the group. This allowed the hospital to benchmark its performance against other hospitals.
- The hospital audited compliance against its blood transfusion threshold. The hospital measured the percentage of transfusions where the patient's pre-transfusion haemoglobin (the pigment contained inside red blood cells) fell below the threshold of 80 grams per litre. In January – December 2015, the hospital reported that 100% of transfusions occurred at

or above the threshold. This was better than the Spire Healthcare target of 85% and better than the average score of 89% for all hospitals across the Spire Healthcare Network.

- The hospital told us they were in the process of registering for the 2016 national comparative blood transfusion audit. This was a national audit into the safe and appropriate use of blood. The hospital did not register for the 2015 audit due to a very low number of blood transfusions performed that year. Only one patient met the inclusion criteria in 2015. This meant the hospital did not have enough data to submit.
- Consultants monitored outcomes following intravesical chemotherapy for patients under their care. Consultants performed routine flexible cystoscopy (looking inside the bladder using a flexible tube)during follow-up appointments after treatment. The frequency of surveillance depended on the likelihood of cancer returning. For example, patients at low risk had a flexible cystoscopy three months after chemotherapy finished and then every year. The Hospital could request outcome data from individual consultants.
- The hospital contributed data to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) when this was applicable. However, the hospital reported only one patient death between April 2015 – March 2016 and this was not related to medical care services.
- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS.
- The hospital did not have Joint Advisory Group (JAG) accreditation for endoscopy services at the time of our visit. JAG accreditation by the Royal College of Physicians was formal recognition that an endoscopy service was competent to deliver against defined measures in a global rating scale for endoscopy standards.
- The theatre manager and the Matron told us the hospital had significant work to do in order to qualify for JAG accreditation. This included improvements to the ventilation system. Due to the extent of the work required, the director of clinical services felt that a strategy of working towards JAG accreditation in 2017 was a realistic target.
- However, the hospital had already planned some improvements to endoscopy services that would help the service move towards JAG accreditation. A member of the endoscopy team told us the hospital planned to buy an endoscope drying cabinet and an electronic reporting system. We saw a purchase order for installation of an electronic reporting system and three days of training to teach staff how to use it. The theatre manager told us the endoscopy service was reconfiguring a storeroom to make space for the reporting system. Once the service had completed the reconfiguration works later in 2016, the hospital would arrange delivery of the electronic reporting system.

Competent staff

- Hospital data showed 100% of staff received a performance appraisal between April 2015 - March 2016. Staff told us they received at least two appraisals each year. This demonstrated that the service regularly reviewed staff performance and held assurance around staff competencies.
- A manager described the process for a member of staff who was being performance-managed. The staff member received weekly peer support to address performance issues. The manager reviewed the performance plan with the staff member every two months until they were satisfied the issues were resolved. This demonstrated the service took action to address any staff competency issues.
- We reviewed the continuing professional development (CPD) folders for six members of nursing staff. We saw that all certificates were up-to-date, for example, immediate life support and blood transfusion updates. In one folder, we saw a member of staff had undergone a competency assessment to mentor new members of staff. We saw that a senior member of the nursing team had signed the staff member off as competent. This process provided assurances that mentors were competent to supervise newer staff.
- All six folders we reviewed included competency records for intravesical chemotherapy. The competency assessment tested staff ability in several areas, including the ability to reconstitute and administer chemotherapeutic agents safely, and the safe disposal of cytotoxic waste. We saw that an external assessor had signed all staff off as competent to provide intravesical chemotherapy. We also saw an up-to-date staff list showing that all staff administering intravesical chemotherapy were competent to do so.

- Staff CPD records also contained evidence staff had attended syringe driver training and attained competency in this area. A syringe driver is a small, battery-powered pump that delivers continuous medication into a syringe, then into the body through a needle placed just under the skin. Medical care services can use syringe drivers to provide continuous pain relief, often for patients at the end of their lives. We saw that the ward had syringe drivers available for this purpose.
- The hospital had a named nurse lead for end of life care. All staff we spoke with knew who the lead nurse was for end of life, and when they would ask them for help and advice.
- The hospital had a robust system for granting and reviewing practicing privileges in-line with the Spire Healthcare practicing privileges policy. Consultants completed an extensive application form and provided evidence of adequate insurance or indemnity cover, immunisation status and an enhanced disclosure check. The hospital director and director of clinical services interviewed all new applicants. Consultants applying for practicing privileges also had to provide a reference from their responsible officer at their normal place of work. The hospital only granted practising privileges for procedures or techniques that were part of the consultant's normal NHS practice. The hospital would only consider making an exception to this rule if a consultant provided evidence of adequate training and competency.
- Only six consultants, or 5% of all consultants with practicing privileges, treated no patients at the hospital in April 2015 – March 2016. We saw from the medical advisory committee minutes that the hospital wrote to consultants with no activity over a 12-month period with an invitation to discuss their practice. The hospital removed the practicing privileges of any consultants who did not respond within two months of the invitation. This helped ensure that only consultants who had up-to-date skills and competencies worked at the hospital.

Multidisciplinary working (in relation to this core service)

- We observed effective multi-disciplinary working between staff providing medical care services. For example, we saw a member of the endoscopy team call the nurse-in-charge on the ward to inform them that a patient was ready to return to the ward. The nurse explained that the nurse-in-charge on each shift held a telephone specifically to receive calls from theatres. This enabled the nurse-in-charge to ask the patient's named nurse to collect the patient, or to go them self if the named nurse was busy. On that occasion, the member of the endoscopy team offered to escort the patient back to the ward to help their colleagues as the ward had been busy.
- We also saw effective multi-disciplinary working between nurses and catering, housekeeping and pharmacy staff.
- Ward staff met monthly, and we saw minutes from the last two ward meetings. The clinical nurse manager told us half of the ward staff met on one day and the other half on another. The groupings then changed at the next meeting to ensure that all staff regularly attended the same meetings as each other. This system ensured there were enough staff available to care for patients while meetings took place.
- The hospital audited multi-disciplinary input for oncology (cancer) patients and compared their results to other hospitals in the Spire Healthcare network. The hospital's 2015 clinical scorecard showed 71% of cancer patients had evidence of multi-disciplinary team discussion. This was better than the Spire Healthcare target of 65% and the same as the Spire Healthcare average for the same period. The most recent data from 2016 showed 91% of oncology patients had evidence of multi-disciplinary team discussion in January – March 2016. One-hundred per cent of oncology patients had evidence of multi-disciplinary team discussion in April – June 2016. Both of these results were better than the Spire Healthcare 2016 target of 80%.
- We reviewed five sets of notes for patients receiving medical care services. In all five, we saw evidence of multi-disciplinary input.
- Nurses providing chemotherapy had external links with a specialist oncology nurse at a local NHS trust. The team also had links with other external specialist oncology nurses. The hospital had a service level agreement with a urology nurse specialist who supported the consultant urologists. This nurse was linked to a cancer network. Cancer networks worked in local areas with clinicians, patients and managers to deliver the national cancer strategy, to improve performance of cancer services and to facilitate communication and engagement around cancer issues.

- The hospital had a pathway to refer all patients diagnosed with cancer to the multi-disciplinary oncology team at a local NHS trust. There were also pathways for urology consultants at other hospitals to refer patients for intravesical chemotherapy at Spire Tunbridge Wells. For patients who received a cancer diagnosis at a different hospital, the service requested evidence of multidisciplinary discussion and planned treatment from the referring consultant.
- The service had links with a local hospice for patients receiving end of life care.

Seven-day services

- Elective endoscopy services ran five days a week, Monday to Friday. The hospital also provided intravesical chemotherapy services five days a week.
- However, the hospital was open seven days a week and could provide inpatient care for any unplanned medical admissions that needed to stay in over a weekend. Patients who received medical care services on a day case basis could also contact nurses on the ward with any urgent concerns 24 hours a day, seven days a week.
- The diagnostic imaging department provided a 24-hour a day, seven day a week service for urgent examination request, via an on call system. This allowed staff to access diagnostic services in a timely way to support clinical decision-making.
- The hospital pharmacy team provided cover Monday to Friday 8.30am to 4pm.Outside of these hours, the RMO could dispense medicines from the hospital pharmacy. The RMO told us they always dispensed medicines with a registered nurse to provide a second check. We saw that this practice was in-line with the corporate "Management of Medicines in Spire Healthcare" (April 2016) policy.

Access to information

- Staff could access local policies and procedures electronically, and all staff we spoke to knew how to do this. Staff could access national guidance via the internet, and we saw computers available in staff areas to enable them to do this.
- The hospital held patient notes on-site. As well as keeping confidential patient data safe, this ensured timely access to information needed for patient care. We reviewed five sets of notes for patients receiving medical care services. All five contained sufficient information to enable staff to provide appropriate patient care. This included diagnostic test results, management plans and care plans.
- The endoscopy team put a copy of the patient's endoscopy report in the patient notes. The notes went back to the ward with the patient after their procedure. The consultant's secretary subsequently sent a letter along with a copy of the report to the patients GP once the patient left the hospital. We saw that this was in-line with the hospital's endoscopy standard operating procedure. This process allowed the patient's care to continue in their community or with other services where appropriate.
- We saw the ward had an end of life resource box, this included information and resources to support staff caring for patients at the end of their lives.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We reviewed consent forms for two endoscopy patients. We saw that patients and staff had fully completed, signed and dated the consents to ensure they were valid. We saw that the patients had signed their consent forms before the day of their procedure. This was important to ensure patients had sufficient time to consider the procedure and make an informed decision.
- The patient's consultant obtained consent for medical procedures. We spoke to the RMO, who told us the hospital had never asked them to take consent from a patient because they did not perform planned procedures and could therefore not fully advise the patients of all the benefits and risks.
- Staff gave an information leaflet to each patient prescribed intravesical chemotherapy. This was important to ensure the patient felt informed about their treatment and the potential side effects. This was in-line with the hospital's policy for intravesical chemotherapy.
- We spoke to the clinical nurse manager, who demonstrated awareness of situations that may require deprivation of liberty safeguards (DoLS). The clinical nurse manager told us they would escalate any concerns in this area to the matron, who would apply for a standard authorisation from the local authority. A standard authorisation gave permission for hospital staff to restrict a patient's liberty that lacked mental capacity when this was necessary and proportionate to

keep the patient safe from avoidable harm. The clinical nurse manager knew how to access the hospital's policy on DoLS. We also saw information on the Mental Capacity Act 2005 and DoLS displayed in the nurses' office to remind staff of their responsibilities and the correct processes in these areas.

- We spoke to two other members of staff, who demonstrated some uncertainties around which patients would need a standard authorisation. However, both told us they would escalate any patients who might need DoLS to the clinical nurse manager or matron, and both knew how to access the relevant policy.
- Staff were aware of do not attempt cardiopulmonary resuscitation (DNACPR) orders and knew that patients may apply different ceilings of care to these. At the time of our inspection, there were no patients with a DNA CPR order in place. Very few patients used DNACPR orders due to the nature of the medical care services provided. For example, the largest group of patients receiving medical care services were patients undergoing elective endoscopy.
- Spire Tunbridge Wells followed a corporate resuscitation policy (dated March 2016). We saw that the policy clearly identified the process for decisions relating to DNACPR orders. The hospital used a unified DNACPR form. The form took into account the person's capacity to make decisions. Staff told us they checked patients' resuscitation statuses and documented this both before and during their admission.

Are medical care services caring?

Good

We rated caring as good. This was because:

- Overall, feedback from people who used the service and those who are close to them was positive about the way staff treated people.
- Staff treated people with dignity, respect and kindness. Patients felt supported and cared for by staff.
- Staff encouraged patients and their loved ones to be partners in their care.
- Staff respected people's privacy and confidentiality at all times.
- The service had links with other services to help patients living with cancer and those close to them cope emotionally with their care and treatment.

Compassionate care

- The hospital carried out monthly patient satisfaction surveys. The most recent available results from March 2016 showed that 100% of patients were satisfied with the care and attention they received from nurses at the hospital. This was better than the Spire Healthcare average of 98% for the same month.
- In October 2015 – March 2016, the hospital scored 100% in the NHS friends and family test in five out of six months in this period. November 2015 was the only month where the hospital scored less than 100%. The hospital scored 97% in this month. This meant nearly all the hospital's patients who responded to the survey said they would recommend the hospital to their family and friends.
- The friends and family survey response rate varied throughout the above reporting period. The proportion of patients completing the friends and family test ranged from 33% in March 2016 to 73% in January 2016. However, response rates were better than the England average in all except two months during the reporting period. This meant the hospital obtained the views of a meaningful number of its patients.
- We observed caring interactions between the nurse-in-charge and patients during a quality round. The nurse checked patients were comfortable and asked how they were feeling. We saw that the nurse responded promptly and compassionately to patients who were experiencing any discomfort, for example, a patient who felt nauseous.
- We received many patient comment cards telling us about their experiences of care. The responses were overwhelmingly positive. Comments included, "The level of care has been fantastic, friendly and thorough"; "all team members were really lovely, informative and helpful", and "very efficient, friendly staff".
- We saw that staff always respected patients' privacy and dignity. For example, we saw that staff always knocked on patients' bedroom doors to check the patient was happy for them to come in before they entered. In the hospital's March 2016 patient satisfaction survey, 99% of

patients felt staff gave them enough privacy when discussing their condition or treatment. This was better than the Spire Healthcare average of 97% for the same month.

- We saw posters on the ward informing patients of their right to request a chaperone for any consultation, examination or treatment. Staff told us they offered patients a chaperone before any intimate examination or procedure. This was in-line with the Spire Healthcare chaperones guidelines policy. However, we also saw the policy stated, "A record must be made where the patient declines a chaperone regardless of reason." Staff told us they did not routinely document in the medical notes if a patient declined a chaperone. This meant there was no formal record staff had followed the policy and offered the patient a chaperone.
- The hospital rarely nursed end of life care patients on the ward. The hospital last admitted a patient for end of life care over a year before our visit. However, the ward manager outlined the care they gave to a patient who had chosen to die on the ward. The ward staff supported the patient and relatives jointly, and the patient died in their place of choosing in a dignified way.

Understanding and involvement of patients and those close to them

- We spoke with two endoscopy patients. Both said communication from their consultant and the nursing team was good. Both felt their consultant fully explained their treatment and included them in decisions made about their care. Both patients were aware of the next steps after their procedure and felt fully informed. We also spoke to a chemotherapy patient, who told us their consultant gave them thorough written and verbal information about the potential side effects of their proposed treatment. This demonstrated that patients were involved as partners in their care.
- In the hospital's March 2016 patient satisfaction survey, 91% of all patients said they were involved as much as they wanted to be in decisions about their care. This was the same as the Spire Healthcare average for the same month.
- During a quality round, we saw that a patient's partner wanted to be involved in discussions about their care and the nurse included them. We also spoke to a chemotherapy patient, who told us their consultant involved their partner in their care at every consultation.
- Patients had a named nurse to care for them on the ward during their treatment. For endoscopy patients, the patient's named nurse collected them from the endoscopy theatre and escorted them back to their room on the ward. This allowed continuity of care for patients and enabled them to receive care from a familiar member of staff immediately after their procedure to help them feel more comfortable.

Emotional support

- We spoke to a patient who had chemotherapy at the hospital. They were very positive about the emotional support they received from staff. The patient gave us an example of a time they were away on holiday and needed emergency admission to another hospital.The patient telephoned Spire Tunbridge Wells Hospital's nursing team, who spent 30 minutes talking to the patient and providing reassurance.
- In the hospital's March 2016 patient satisfaction survey, 90% of patients said they were able to find a member of staff to talk to about any worries or fears. This was better than the Spire Healthcare average of 88% for the same month.
- The ward had open visiting, and we saw a notice on the ward stating that friends and relatives could visit anytime between 9am and 10pm each day. This meant that any unplanned medical admissions could receive emotional support from those close to them during their hospital stay. Patients attending for medical day case procedures could also bring a relative or friend to support them if they wanted to.
- The service had links with specialist McMillan nurses to provide additional support for patients living with cancer. The hospital also had a breast link nurse who supported patients who received a breast cancer diagnosis.
- Nurses told us that if a patient were going to receive bad news from a consultant, then they would always make sure that there was a nurse present as well to provide additional support. The ward manager also said nurses planned to attend additional training in breaking bad news.
- Staff told us that there were no existing relationships with religious or other support organisations. However, we saw a list of contact details that staff could use for different religions in the local area.

Good

Medical care

Are medical care services responsive?

Good

We rated responsive as good. This was because:

- Services generally ran on time. Waiting times, delays and cancellations were minimal and the service managed these appropriately and kept patients well informed.
- The hospital coordinated the care and treatment it provided with other services and other providers.
- The hospital made positive improvements to make the service more accessible for patients living with dementia.

However:

- The service did not always meet the needs of wheelchair users in terms of ease of access on the ward.

Service planning and delivery to meet the needs of local people

- The hospital provided a small number of medical care services. These mainly consisted of an elective endoscopy service and intravesical chemotherapy to treat bladder cancer. However, the hospital was within five miles of a large NHS trust. Therefore, patients with more complex medical care needs had access to additional services in their local area.
- The executive team had regular meetings with local NHS care commissioning groups (CCGs). This enabled the service to regularly review their provision to NHS patients against the needs of the local population.
- The hospital director also met quarterly with the medical director of the local NHS trust. This allowed the service to maintain links with local NHS services that referred patients to the hospital.
- We observed a multi-disciplinary bed meeting. These meetings took place every morning and enabled the service to plan for the next two days. This ensured that the service could accommodate patients and avoid delays waiting for a room. For example, we saw that the following day would be busy, with 26 patients coming onto the ward. We saw that the nurse-in-charge allocated patient rooms according to the time of patient arrival. This meant that one patient might occupy a particular room in the morning and another patient in the afternoon. The nurse-in-charge informed the housekeeping team so that they could carry out an additional clean of these rooms partway through the day. This would ensure that the team had prepared patient rooms ready for the next patient to avoid any unnecessary delays.
- The theatre manager reviewed endoscopy lists in advance. This ensured there was sufficient time to arrange all necessary staff and equipment. Due to the elective nature of the endoscopy service, planning was relatively straightforward because the workload was predictable.
- We saw that staff worked together to help each other during a busy day, for example, with the transfer of endoscopy patients from theatres back to the ward. Staff told us their manager supported them by covering their breaks on busy days. Staff also told us that they sometimes took shorter breaks on busy days. This helped ensure that patients received the same level of care, regardless of how busy it was.

Access and flow

- Referral to treatment waiting times (RTTs) for non-admitted, NHS-funded patients having treatment at the hospital showed that the hospital treated between 97% - 100% of patients within 18 weeks of referral in April 2015 – March 2016. This was better than the target of 95%. Patients who received endoscopy services fitted into this category because nearly all had treatment on a day case basis.
- The hospital did not monitor RTT waiting times for cancer patients. This was because the hospital did not treat any NHS patients with a cancer diagnosis.
- Patients attending for day case medical care services reported to the main reception on arrival at the hospital. Staff from the ward then escorted patients to their room to prepare for their treatment. Patients having intravesical chemotherapy either received treatment in their room or in theatres if they received chemotherapy at the same time as surgery. The patient's named nurse escorted endoscopy patients to theatres for their procedure and back to the ward again afterwards.
- We saw that services generally ran on time. In response to patient feedback, the hospital improved communication with patients around any delays. Reception staff told us they informed patients on arrival

if there were any delays. They also said they aimed to go over and speak to any patient sat waiting for more than 10 minutes to keep them informed of any delays and check their wellbeing.

- We saw that the nurse-in-charge on the ward carried a telephone that linked directly to the endoscopy team in theatres. This enabled the endoscopy team to keep ward staff informed of any delays. We saw from the quality round forms that the nurse-in-charge communicated any delays with endoscopy lists to patients as part of their two-hourly quality rounds.
- Endoscopy lists ran five days a week, Monday to Friday. On some days, the lists started at 8.30am and finished at 6pm to help minimise time away from work for patients who worked during the week.
- A chemotherapy patient gave us an example of a time they needed urgent treatment for a blocked catheter. The patient told us they telephoned the ward at 1am, and staff invited them to come in straight away. The patient said their consultant and the nursing team were ready and waiting for them when they arrived at the hospital. The consultant promptly treated the patient and resolved the issue.
- The hospital's admissions policy described clear procedures for emergency admissions, conversions from day case to inpatient stay, and readmissions. The hospital did not accept any emergency admissions until an appropriate consultant discussed the case directly with the patient's GP to assess suitability for acceptance and confirmed availability to assess the patient upon arrival at the hospital.
- For patients receiving end of life care, the hospital did not have a mortuary facility on site. In these circumstances, staff told us they would contact the chosen funeral parlour, who would collect the deceased patient directly.

Meeting people's individual needs

- The service had access to a telephone interpreting service for patients who needed an interpreter. Staff could describe how to access this. We saw a poster with details of this service displayed in the nurses' office on the ward. We saw that staff could access interpreters in 52 different languages. However, staff told us they rarely needed to use this service. A nurse said she had never needed to use an interpreter in the two years she had worked at the hospital. This was because very few people living in the local area spoke English as a second language.
- The hospital scored 84% satisfaction for patients living with dementia in the national patient-led assessments of the care environment (PLACE) audit2016.This was better than the England average score of 75% for the same period. It was also a significant improvement on the hospital's 2015 score of 61%. This improvement reflected the hospital's appointment of a dementia champion and subsequent changes to better meet the needs of patients living with dementia.
- We met the hospital's dementia champion. The dementia champion took on this role in March 2016. She described positive changes the service had made to accommodate dementia patients. These included providing dementia training to all hospital staff. At the time of our visit, the dementia champion had provided training updates to approximately 60% of hospital staff, including the team on the ward. She had also provided dementia information folders to every hospital department to help educate staff in this area. We saw one of these folders available to staff in the nurses office on the ward.
- In addition to face to face training, all staff completed dementia awareness training as part of a "compassion in practice module" within their mandatory training programme. At the time of our inspection, 96% of all staff across the hospital had completed this training. This was better than the 95% Spire Healthcare target.
- The hospital used dementia passports. Patients living with dementia and their carers completed the passports before their treatment, detailing person-centred information about the patient. This enabled staff to recognise and respond to the patient's individual needs. However, we did not see any completed passports as there were no patients living with dementia receiving treatment at the time of our visit. The dementia champion told us the hospital only treated very small numbers of patients living with dementia- approximately one patient every two to three months.
- The dementia champion also showed us activity boxes available to patients living with dementia. We saw that these contained appropriate materials to help occupy patients living with dementia while they were in hospital

and lessen any anxieties. The boxes included adult-appropriate colouring books and pencils, stress balls, flashcards to aid communication and 1950s memorabilia.

- We observed a bed meeting on the ward and saw that staff allocated a wheelchair user a larger room with easier access. Staff told us they routinely did this to help accommodate wheelchair users. However, we spoke to a patient who used a wheelchair and their partner. Both felt that the larger rooms and en suite bathrooms were still difficult to access. They told us that on some occasions, these rooms contained two beds. This restricted space for the patient to move around in their room, and staff were unable to move the second bed out of the room. Both also felt that nursing staff on the ward were unfamiliar with caring for wheelchair users. This led to the patient's partner having to assist the patient with basic needs, such as transfer from bed to chair or to the toilet. They also told us the grab rails in the bathrooms were too low for patients to be able to pull themselves up from the toilet without assistance.

However, the hospital told us staff were familiar with caring for wheelchair users due to the high number of orthopaedic patients cared for at the hospital. This meant that the use of wheelchairs, and assistance required as a result, was a daily occurrence on the ward

Learning from complaints and concerns

- The hospital received 35 complaints between April 2015 and March 2016. Of these, only one complaint related to medical care services. This suggested that most patients were satisfied with the care they received, or that the service effectively resolved concerns informally.
- We saw a patient complaint regarding medical care services and the hospital's response. We saw that the hospital formally acknowledged the complaint the same day. This was in-line with the Spire Healthcare complaints policy. The policy required the hospital to acknowledge all written complaints within two days of receipt.
- We saw that the hospital investigated the complaint within three days of receipt. This prompt investigation was in-line with the Spire Healthcare complaints policy, which required the hospital to respond within 20 days. Within the complaint response, we saw that the hospital apologised for the issues the patient experienced. We saw openness and honesty in the response. The hospital also invited the complainant to discuss their concerns further over the telephone, and to receive the investigation results. We saw that the hospital had fed back to staff to enable learning from the complaint and to help improve the service
- The service was responsive to patient feedback. We saw a "you said, we did" board displayed on the ward. This showed ways in which the service had responded to patient feedback. For example, a patient said, "a handheld mirror is needed". The hospital responded by providing these for patients to use. A patient told us, and senior managers confirmed that their feedback led to the hospital installing automated entry doors at the main entrance to facilitate access for wheelchair users.

Are medical care services well-led?

Good

We rated well led as good. This was because:

- There were high levels of satisfaction across all staff groups. Staff were proud of the organisation as a place to work and spoke highly of the culture.
- The hospital had consistently high levels of constructive engagement with staff at all levels. Leaders listened to staff and valued their input.
- The hospital had robust governance arrangements. Governance and performance management arrangements were proactively reviewed and reflected best practice.
- Leaders drove continuous improvement and organisational growth.
- We saw strong collaboration and support across all staff groups and a common focus on improving the quality of care.
- The vision and values were well embedded amongst staff.
- Leaders actively encouraged staff to raise concerns. There was a culture of openness, and all staff we spoke to could describe their responsibilities relating to Duty of Candour.

Vision and strategy for this this core service

- The hospital had a clear three-point vision. The first point was to be the leading elective healthcare provider

in West Kent, highly rated by patients, consultants and GPs. The second was to deliver the highest standards of care in an excellent environment. The final point was to be a great place to work.

- All staff we spoke to could describe the hospital's vision without quoting it verbatim. Staff descriptions included, "To be the best healthcare provider in this area" and "To improve services to consultants and patients". This showed the hospital's vision was fully embedded amongst staff.
- We saw evidence of performance appraisals linked to Spire Healthcare's corporate values in staff development folders. These were, "Caring is our passion"; "Succeeding together"; "Driving excellence"; "Doing the right thing"; "Delivering on our promises", and "Keeping it simple". Staff demonstrated how they had performed in relation to these areas. This ensured that staff worked to improve their performance in-line with the corporate values.
- The Matron told us the hospital planned to incorporate working towards Joint Advisory Group (JAG) accreditation for endoscopy into its 2017 strategy. The theatre manager and the director of clinical services described improvements the service would need to make to achieve JAG accreditation. We saw evidence of progress towards these improvements, such as a purchase order for an electronic reporting system.

Governance, risk management and quality measurement for this core service

- We saw a diagram of the hospital's governance structure. Nursing staff who cared for medical patients on the ward reported to the clinical nurse manager. Endoscopy staff reported to the theatre manager. Managers met with other heads of departments monthly and reported to the senior management team. The hospital's clinical governance and medical advisory committees (MAC) also provided quality and safety assurances to the senior management team. A member of the nursing team on the ward was the clinical governance lead. We saw from meeting minutes that the clinical nurse manager also represented medical care services at clinical governance committee meetings. We met the consultant who represented medicine on the MAC.
- The hospital told us, and we saw evidence from meeting minutes, that the MAC and clinical governance committees met every three months. We saw from meeting minutes that the Hospital Director and the Matron/Head of Clinical Services attended both MAC and clinical governance committee meetings. This showed that the senior management team had a thorough understanding of governance issues within the hospital.
- The hospital reviewed consultants' practicing privileges every two years. We saw evidence from MAC minutes that the committee reviewed consultants' practicing privileges in-line with this policy. The hospital removed the practicing privileges for 12 consultants in April 2015 – March 2016. The hospital suspended the practicing privileges for 25 other consultants in the same period. The hospital told us, and we saw evidence from MAC minutes, that this was because these consultants failed to supply documentation the hospital needed in order to renew their practicing privileges. This included evidence of annual appraisal at their usual place of work and evidence of indemnity insurance. These actions demonstrated the hospital had robust procedures to ensure all consultants were competent and fit to care for patients.
- The Spire Healthcare head office produced a monthly network governance bulletin highlighting new NICE guidelines, National Patient Safety Agency (NPSA) alerts, and updates on regulation and internal policies. We saw evidence of discussion around updates in the clinical governance committee minutes, and evidence the service shared learning with relevant staff.
- The hospital had a robust clinical audit system, and maintained a clinical scorecard with audit results. These allowed the hospital to benchmark their performance against other hospitals in the Spire Healthcare Network and identify areas for improvement. For example, we saw that the hospital had changed its discharge practices and a member of the pharmacy team, rather than a nurse, provided patients with instructions and advice on take-out (TTO) medicines and counselled them on any potential side effects. The hospital introduced this change after benchmarking results showed that patients at the hospital previously felt less informed around TTO medicines than patients at other Spire Healthcare hospitals.
- We saw that clinical effectiveness was a standard agenda item at clinical governance committee

meetings. We saw that the committee reviewed clinical audit and clinical scorecard performance every quarter. Areas audited included infection prevention and control, record keeping and controlled drugs.

- We saw the hospital's risk register. This was comprehensive, and covered all areas of the hospital. The hospital used a risk matrix to assess the likelihood and severity of possible risks to the service. We saw that the hospital had no high-risk items on the register. We saw that areas of risk we identified, such as use of agency staff due to recruitment difficulties, were on the register. This aligned with areas the senior management team told us they were working to improve. This showed the senior management team understood the areas of risk relating to medicine.

Leadership and culture of service

- Every member of staff we met spoke positively about their relationships with both their line manager and the senior management team. Staff told us managers were approachable and dealt with any issues they raised in a timely fashion. Staff told us the senior management team were highly visible. A member of the endoscopy team told us the director of clinical services visited the team every morning to see if there were any issues for the day ahead. Staff on the ward also said they saw the director of clinical services on a daily basis.
- The senior management team told us they had an "open door" policy for staff. We spoke to a member of staff, who told us they had made use of this policy to discuss concerns they had relating to sick leave. They told us the Matron was very helpful and supportive towards them. All staff we spoke to felt the senior management team were very approachable. Another member of staff told us they "felt appreciated" by the senior management team and said senior managers "always listened to suggestions".
- We also saw positive examples of local leadership from the clinical nurse manager on the ward. She told us about positive changes she had made since joining the hospital two years ago. These included the introduction of two-hourly quality rounds led by the nurse-in-charge to ensure patients were comfortable, had everything they needed, and had the opportunity to ask questions about their care. She had also introduced staff who did not have a login to the hospital's email system. This helped improve staff communication. Another nurse we interviewed felt these changes were highly positive.
- All staff we spoke with told us one of the best things about working at the hospital was the team. We saw positive working relationships between staff. Due to the small size of the service, everyone knew each other's names and we observed friendly interactions between staff from all departments in the hospital. Some staff described the strong team ethic we observed as a "family".
- All staff we spoke to were proud to work at the hospital. We met several members of staff who had worked at the hospital for many years. All told us the hospital had accommodated their needs during this time by reducing or increasing their hours at their request, for example, to fit in with the needs of their families. Another member of staff gave an example of the hospital accommodating their prayer times according to the needs of their faith.
- There was a strong culture of openness and transparency. For example, we saw that a large proportion of the incidents the hospital reported were "near misses". All staff we spoke to knew what Duty of Candour meant and described their responsibilities relating to it.

Public and staff engagement

- The hospital was proud of its high level of staff engagement. The hospital reported 91% staff engagement in the 2015 staff engagement survey. This was better than the Spire Healthcare average of 88% for the same year.
- The hospital was also proud of its positive relationships with consultants. In the Spire Healthcare consultant survey 2015, 85% of consultants who worked at the hospital rated it as "excellent" or "very good". This was better than the Spire Healthcare average of 79% for the same period, and better than the hospital's 2014 score of 79%.
- The hospital actively engaged to seek the views of patients and their relatives. They did this through their monthly patient satisfaction surveys. The hospital benchmarked its results against other hospitals in the Spire Healthcare network to identify areas for improvement. The service also made improvements based on patient feedback, and we saw evidence of this displayed on the "you said, we did" board in the ward corridor. The hospital also obtained patient feedback

through the NHS friends and family test. Engagement in this area was better than the England average for NHS patients treated in the independent sector in four out of six months between October 2015 and March 2016.
- The hospital also ran patient focus groups. The senior management team told us they had limited patient engagement in this area, and they were trying to make focus groups more patient-friendly to improve this.
- The hospital had recently commenced staff forums, where staff from all departments could attend to discuss any issues or concerns and share ideas and learning. We saw in the June 2016 newsletter, the hospital risk register was discussed.

Innovation, improvement and sustainability

- The Spire Healthcare network's internal clinical benchmarking system ensured the hospital regularly reviewed its clinical performance and benchmarked this against other hospitals. This helped the service work towards continuous improvement.
- We saw that the hospital valued and recognised employees with long service. We met a member of staff who had worked at the hospital for 21 years. They wore a long-service badge recognising this achievement. They told us they attended a corporate day out with other staff from across the Spire Healthcare network who had also served for 21 years. The staff member told us this was an enjoyable day and it made them feel valued.
- The hospital had an "Inspiring People" programme, which encouraged staff to identify innovative ideas to improve services for patients and their colleagues. The best ideas received regular awards. The hospital also used this scheme to recognise staff who went "above and beyond" for a patient, visitor or colleague. Exceptional ideas or performance were nominated for the provider's national annual awards ceremony
- We saw from meeting minutes that the hospital used the Spire Healthcare "refer a friend" initiative. The initiative rewarded employees who referred a friend who successfully applied for a position at the hospital. The hospital hoped this initiative would help fill vacancies for registered nurses. The senior management team told us they had an active recruitment drive, and the hospital had increased the number of contracted clinical posts from 59 to 71 in 2015.
- The hospital's leadership strategy included succession planning for the future to nurture existing talent within the workforce. There was a variety of leadership training opportunities, including residential management development programmes, for new and existing managers
- The senior management team told us that the hospital's activity volume had increased by 11% in 2016. This was better than its target growth of 5%.

Good

Surgery

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

Information about the service

Surgery services at Spire Tunbridge Wells covers a wide range of specialities, including hip and knee arthroplasty, vascular, upper gastrointestinal and colorectal, gynaecological and breast surgery. The hospital treats adults aged 18 and over and does not currently provide surgical services for children.

Between April 2015 to March 2016, there were 2,881 visits to the operating theatre. The most common during the reporting period was phacoemulsification of lens with implant, used to treat cataracts. Phacoemulsification of lens with implant accounted for 267 of the procedures. Shoulder surgery, was the second most common surgical procedure and accounted for 144 procedures. Between April 2015 and March 2016, approximately 27% of patients were NHS funded, and the remaining 73% were privately insured and self-paying. Fifty-one percent of patients required an overnight stay, of those overnight stays 25% NHS funded and 26% were other funded.

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

The ward has 22 inpatient beds and ten day-case beds. All patient bedrooms have facilities. The hospital was open seven days a week to care for patients after surgery that needed to stay in hospital overnight and the weekend.

During the inspection, we visited all clinical areas including theatres, the ward areas and the pre assessment clinic. We also undertook an unannounced visit within ten working days of our announced inspection.

We spoke with six patients and 20 members of staff including, nurses, physiotherapists, health care assistants, consultants, administrators and managers. As part of our inspection, we looked at hospital policies and procedures, staff training records and audits. We looked at ten sets of patient's notes, seven prescription charts and the environment and equipment staff used. We also received thirteen comment cards with feedback from patients who had surgery at the hospital.

Good

Surgery

Summary of findings

We rated each of the key questions, Safe, Effective, Caring and Responsive and the Well-led domain to be good. Overall, we rated surgery as good because:

- Patients were protected from the risk of abuse and avoidable harm. Staff knew how to escalate key risks that could affect patient safety, such as safeguarding from abuse. They took steps to prevent abuse from occurring, respond appropriately to any signs of abuse and worked effectively with others to implement protection plans.
- Levels of staffing including medical, nursing, therapy and support staff were safe and met patients' needs. The hospital was visibly clean and there were appropriate systems in place to prevent and control healthcare associated infections. Medicines were managed safely. Staff completed mandatory training with good compliance rates.
- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- During the inspection, we observed staff respond compassionately when people needed help and support to meet their basic personal needs as and when required. People's privacy and confidentiality was respected at all times. Patients' feedback through interviews and comments cards was entirely positive. Patients praised all aspects of the service with comments such as 'level of care has been fantastic', 'friendly', 'and excellent', and 'nothing is too much trouble'.
- The hospital monitored patient outcomes to provide assurance of the effectiveness of the service. Patients were well cared for on the ward and in theatres. Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges. The rate of unplanned readmissions and unplanned patient transfers to other hospitals was within expected levels when compared to national averages and other independent hospitals. Pain control was well managed. There was evidence of excellent multidisciplinary working and out-of-hours services were provided when needed.
- Complaints about the service were investigated and lessons learnt were shared with staff. There was a clear governance structure in place with committees such as clinical governance, infection control, heads of department and risk management feeding into the medical advisory committee (MAC) and hospital senior management team (SMT).
- There was clear and visible leadership provided by senior management and within the departments. Staff spoke highly of their managers, who told us they were visible and approachable, and told us the senior management team had an 'open door' approach, and visited departments daily. Staff told us they felt 'proud' to work at the hospital, and there was good team spirit and atmosphere, and staff felt a part of a 'big family'.
- All written information, including pre-appointment information, leaflets and signage was in English only. However, Staff had access to a translation services. Information gathered at the referral stage identified patients who would need the assistance of the interpretation service and translators were booked when the appointment was made. The hospital also had a contract with a translation service who translated written information on request with a two hour turnaround when needed.

However we found:

- There were a lack of dedicated hand washbasins in patient bedrooms; this is not in accordance with Department of Health's Health Building Note 00-09: infection control in the built environment. The hospital was aware of this and we saw the installation of hand washbasins was included in their programme of works due to start in January 2017.
- All written information, including pre-appointment information, leaflets and signage was in English only. However, Staff had access to a translation service.

Good

Surgery

Information gathered at the referral stage identified patients who would need the assistance of the interpretation service and translators were booked when the appointment was made.
- There were no observational hand hygiene audits to monitor hand washing.

Are surgery services safe?

Good

We rated safe as good because:

- There were effective systems in place to report incidents. Incidents were monitored and reviewed and staff gave examples of learning from incidents. Staff understood the principles of Duty of Candour regulations, were confident in applying the practical elements of the legislation
- Staff were aware how to report incidents, safeguarding issues. There were safe arrangements for managing medicines and for responding to suspected or actual incidents of abuse. Staff were up to date with their mandatory training. Records were stored safely, up to date, legible, and were available for staff. Emergency equipment was in place.
- Levels of nursing and surgical staffing were adequate throughout the department. Staff followed hospital infection prevention and control practices and these were regularly monitored, to reduce the risk of spread of infections.
- The patient environment throughout the surgical service was clean and fit for purpose, including three theatres, two of which, had laminar flow ventilation. Appropriate equipment was available and most were suitably maintained.

However:

- There were a lack of dedicated hand washbasins in patient bedrooms; this is not in accordance with Department of Health's Health Building Note 00-09: infection control in the built environment. The hospital was aware of this and we saw the installation of hand washbasins was included in their programme of works due to start in January 2017.
- There were no observational hand hygiene audits to monitor hand washing.

Incidents

- The hospital followed their corporate 'Adverse Event / Near Miss Reporting Policy' (dated August 2015).
- All staff we spoke with had a good understanding of the reporting system and could access it. All incidents, accident and near misses were reported using either the

paper based system (which would then be uploaded to the electronic system), or directly onto the electronic system. Staff gave us examples of the type of incidents they reported. For example the misspelling of a patients name or when a patient's case number was not correct on patient labels. We saw staff recorded the incident number in the patient's notes.

- The hospital had reported one 'never event' in 2015, which had related to an issue in a wrong site block in theatre, prior to a procedure. 'Never events' are serious, largely preventable patient safety incidents, which should not occur if the available preventable measures have been implemented by healthcare providers. The event had been investigated thoroughly and appropriate actions taken to prevent any reoccurrence. We saw 'stop before you block' posters on display, and staff we spoke with were aware of the incident, and the actions taken.
- Incidents were reviewed and investigated by an appropriate manager (depending on where the incident took place) to look for improvements to the service. They were also investigated through a process of root cause analysis (RCA), with outcomes and lessons learned shared with staff. We saw three root cause analysis reports which had been completed, with recommendations and action plans, which confirmed the process. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron.
- The hospital reported no serious injuries between April 2015 and March 2016.
- The hospital reported one case of unexpected death between April 2015 and March 2016. The hospital notified the Care Quality Commission (CQC) of this case. The death had been thoroughly investigated and the hospital had responded appropriately.
- Data we received from the hospital showed between April 2015 and March 2016 there had been 277 clinical incidents reported across the hospital and 197 (71%) occurred within surgery or inpatients. For example, a patient with a latex allergy had not been identified pre admission. The theatre was alerted on the patient's admission and they made sure the correct precautions were in place, to ensure safe surgery for the patient.
- The governance lead for the hospital told us they had provided additional training for completing incident forms in May 2016. Forty-two members of staff attended from all wards and departments. The governance lead told us, they have now seen an improvement in the completing of forms.
- Staff told us they either received feedback directly if they were involved in an incident or during monthly team meetings where incidents and complaints would be discussed. We saw evidence of this in the team meeting minutes we looked at.
- Staff told us that they all received a monthly governance newsletter, which updated them about events and incidents at the hospital.
- Theatre staff had a daily morning brief, which ensured all staff had up to date information about risks, concerns and incidents.
- All incidents and adverse events were discussed at the quarterly Medical Advisory Committee (MAC) and Clinical Governance Committee (CGC) and the monthly Senior Management Team (SMT) Meeting. Minutes of the MAC, CGC and SMT meetings confirmed this.
- The hospital did not carry out specific mortality and morbidity review (M&MR) meetings, due to the low number of patients treated and the resulting low numbers of patients who would fall into this category. The Chair of the MAC told us, any reviews needed would be discussed at the consultants NHS trust M&MR meetings. Any deaths, unplanned returns to theatre and key performance indicators (KPIs) were reviewed at the monthly clinical effectiveness meetings.
- Staff described the basis and process of duty of candour, Regulation 20 of the Health and Social Care Act 2008, which relates to openness and transparency. It 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. Patients and their families were told when they were affected by an event where something unexpected or unintended had happened. We saw five examples where the hospital had complied with the duty of candour response process..

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

- The hospital used the Safety Thermometer, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. These included falls, new pressure ulcers, catheters and urinary tract infections (UTI's) and venous

thromboembolisms (VTE) which are blood clots in veins. However, the results of the safety thermometer were not on display, so patients and staff can see their areas performance.

- Between April 2015 and March 2016, safety thermometer data showed no urinary tract infection.
- The hospital reported six cases of hospital acquired venous thromboembolism (VTE) between April 2015 and March 2016, and a screening rate of 98% at the end of 2015. The number of acquired VTE was higher than expected despite following national guidelines and the hospital was continuing to monitor this and this was recorded on their risk register. We looked at ten sets of patients notes, which showed all patients had been risk assessed for VTE. We saw three root cause analysis reports that had been completed, with recommendations and action plans. Action plans were monitored and had been completed within required timescales.

Cleanliness, infection control and hygiene

- The hospital followed their corporate 'Prevent and Control of Infection' policy (dated November 2015), which included hand hygiene, use of personal protective equipment such as gloves and aprons, and spillage of body fluids.
- All areas of the hospital we visited appeared visibly clean. Some areas of the ward (corridors) had carpet, which could not be as easily cleaned as the laminated flooring when spills occurred. Department of Health's Health Building Note (HBN) 00-09: infection control in the built environment states 'Spillage can occur in all clinical areas, corridors and entrances' and 'in areas of frequent spillage or heavy traffic, they can quickly become unsightly'. However, we saw carpets were visibly clean and free from stains, we also saw regular deep cleans of carpets had taken place.
- The hospital had two operating theatres which had laminar flow theatre ventilation, which was best practice for ventilation within operating theatres, particularly important for joint surgery to reduce the risk of infection. We saw evidence the theatre filtration systems had three and six monthly and annual checks to ensure compliance.
- We observed staff following the local policy and procedure when scrubbing, gowning and gloving prior to surgical interventions. When a procedure had commenced, movement in and out of theatres was restricted. This minimised the infection risk.
- The 'Infection Prevention and Control Annual Plan' (dated 2016) detailed the activities to ensure the hospital met the requirements of the Department of Health, Code of Practice on the prevention and control of infections and related guidance. This programme of work was mapped to the compliance criteria within the Code of Practice and included systems to manage and monitor the prevention and control of infection, maintain a clean and appropriate environment and ensure all staff are fully involved in the process of preventing and controlling infection.
- We saw that waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the HTM 07-01, control of substance hazardous to health (COSHH) and health and safety at work regulations.
- All waste was kept in appropriate bins that were locked and secure on the hospital premises until collected.
- We found equipment was visibly clean throughout the department, and staff had a good understanding of responsibilities in relation to cleaning and infection prevention and control. All equipment we saw had 'I am clean' stickers on them, which indicated the date the equipment had been cleaned.
- We saw personal protective equipment, and hand-sanitising gel was available in all patient bedrooms. Posters were displayed which explained the '5 moments for hand hygiene' in line with World Health Organisation guidance.
- Hand hygiene compliance was monitored by measuring the usage of hand sanitising agents every quarter. The lead infection control nurse told us hand sanitising usage audit in March 2016, was 15.7, which was below the corporate target of 18. As a result, a hand hygiene product company had been invited to the hospital to provide hand hygiene teaching sessions, and raise awareness about cleaning hands. Following the teaching sessions, the usage of hand sanitising agents was re audited in June 2016, which was 21, which was better than the corporate target of 18.
- There were no observational hand hygiene audits to monitor hand washing.

- There were no dedicated hand washbasins in patient bedrooms, staff and visitors used the basin in the bedroom's bathroom or the washing facilities in the sluice. This is not in accordance with Department of Health's Health Building Note 00-09: infection control in the built environment, which states 'healthcare providers should have policies in place ensuring that clinical wash-hand basins are not used for other purposes'. The corporate Prevention and Control of Infection (November 2015) states 'In each single-bed room, a minimum of one clinical HWB should be available. En suite single-bed rooms should have a separate general hand-wash basin for patients' facility.'
- However, the hospital told us they were aware the lack of dedicated HWB inpatient bed rooms, and we saw the installation of HWB was included in their programme of works due to start in January 2017.
- At the pre-operative assessment stage, staff screened high-risk patients for methicillin-resistant Staphylococcus aureus (MRSA) and Methicillin-Sensitive Staphylococcus Aureus (MSSA), such as orthopaedic surgery, and those who had been in hospital previously and patients who had previously tested positive for the bacteria. This is in line with Department of Health: Implementation of modified admission MRSA Screening guidance for the NHS (2014). MRSA and MSSA are infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection and is resistant to many antibiotics. MSSA is a type of bacteria in the same family as MRSA but is more easily treated.
- If a patient was identified with carrying MRSA or MSSA, they received treatment in the 5 days leading up to the surgery. The scheduling of theatre lists allowed for patients who had infections to be last on the theatre list. Patients identified with MRSA could be isolated in their rooms to prevent cross infection risks.
- Hospital data showed that between April 2015 and March 2016 there had been a total of 14 surgical site infection (SSI) following surgery at the hospital, for primary hip arthroplasty, other orthopaedic and trauma, gynaecological, upper gastrointestinal, colorectal, and urological surgery. The lead nurse for infection control told us, they investigate all SSI that occur. We saw investigations for ten SSI, actions plans were monitored and staff implemented elements of action plans where appropriate. For example, following an investigation led to a change in the use of surgical skin preparation solution.
- There were no reported SSI for primary knee arthroplasty, spinal, breast, and vascular surgery between April 2015 and March 2016.
- All SSI were discussed at the quarterly clinical governance committee and infection prevention and control meetings, we saw evidence of this in the minutes.
- The hospitals Patient Led Assessment of the Care Environment (PLACE) audit for 2016 showed the hospital scored 100% for cleanliness, which was better than the England national average.
- The infection control meeting met quarterly and discussed incidents, water safety, decontamination and feedback from audits or reports. We saw the minutes of the Infection Control meetings held in December 2015 and March 2016.
- We looked at ward areas, patient rooms and facilities, corridors and waiting areas. We found that all the areas we looked at were visibly clean. We spoke with support services staff that were all able to describe their roles, and understood methods for cleaning areas, which ensured that they were not cross contaminating areas during this process.
- Cleaning staff used single use mop heads and cloths to avoid cross contamination. We observed staff using and disposing of equipment correctly.

Environment and equipment

- The ward and theatre areas were visibly clean, well maintained and free from clutter.
- Water supplies were maintained at safe temperatures and there was regular testing and operation of systems to minimise the risk of Legionella bacteria colonisation. During our inspection, we saw the minutes of infection prevention and control meetings held in December 2015 and March 2016, and saw water safety and legionella testing were discussed. This is in line with the requirements of Health and Safety Executive (HSE) L8; and Health Technical Memorandum HTM 04-01 A and B guidance on the control of legionella.
- None of the staff we spoke with had concerns about equipment availability and if anything required repair, they reported that it was fixed quickly. Staff were aware of the process for reporting faulty equipment.
- Storage facilities within the hospital for supplies and equipment were well organised and tidy.

- Equipment safety checks were undertaken daily in theatres by the operating department practitioners (ODP's). This included checks of oxygen cylinders. The anaesthetic machines had a secondary check from the anaesthetist prior to use.
- We saw two resuscitation trolleys in the theatre and the ward. Both trolleys were locked. Records showed the trolleys were checked daily. All drawers had correct consumables and medicines in accordance with the checklist. We saw consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order.
- During our inspection, we checked 26 items of medical devices in the equipment store cupboard on the ward. This included three intravenous pumps. All medical devices we saw had up to date portable appliance testing (PAT). This is a process by which electrical appliances are routinely checked for safety once a year. This meant the hospital could give assurance that medical devices were safe to use. We also saw maintenance stickers providing assurances that medical devices had been checked regularly and maintained by an external company.
- We checked 14 items of medical equipment in room 24 on the ward, including a hoist. We saw evidence of PAT testing, cleaning and maintenance checks for all except one item of equipment. This was a bladder volume calculator, which was on-loan from a third party provider. We did not see evidence of PAT testing for this item, which meant the hospital may not have had assurance of its electrical safety.
- All disposable items we saw were in date, such as syringes and wound dressings.
- There was a system in place to ensure safety alerts relating to patient safety, medicines and medical devices were cascaded to staff across the surgical services and responded to in a timely manner. Staff showed us the alert folder on the ward with, patient safety alerts; we saw the action points arising were completed within required timescales.
- The hospital had its own sterile services department (SSD). Staff in SSD performed sterilisations and other actions on medical devices, equipment and surgical instruments for use by healthcare professionals working in the operating department. A member of the SSD attended the daily morning brief, to ensure surgical instruments were available, and to inform staff of any potential problems. For example, we were told when one of the sterilising machines, was waiting repair the theatre list was altered so the SSD could make sure the correct surgical instruments were available. This meant patient's surgery would not be cancelled.
- The Patient Led Assessments of the Care Environment (PLACE) for April 2016 showed the hospital scored 99% for the condition, appearance and maintenance, which was better than the England average of 93%.
- Equipment and space in theatres was appropriate and there was a portable ventilator if a patient required transferring to an intensive care unit in another hospital.

Medicines

- There were good measures for the supply of non-stock medicines out of hours. Alternatively, the resident medical officers RMO had access to the pharmacy out of hours via an access code, staff told us the RMO contacted the on-call pharmacist prior to entering the pharmacy department and a member of nursing staff would accompany the RMO. The RMO made a record of medication removed from the pharmacy, which was countersigned by nursing staff. If controlled drugs were required from the pharmacy, the on-call pharmacist would attend to make the supply.
- The pre assessment questionnaire included asking patients about regular medicines, including any herbal and homeopathic medicines, purchased from the pharmacy. As well as, allergy status, recent treatment with steroids and anticoagulants and a consent form containing a record of medicines brought in from home, including a consent form related to use of patients own medicines during stay.
- We reviewed seven prescription charts that they were appropriately completed. Patient details, allergy status and weights were clearly documented. Prescriptions were completed with evidence of pharmacy endorsements.
- The pharmacy technician completed a stock top-up on the ward and in theatres.
- We observed appropriate storage and record keeping of controlled drugs consistent with the Misuse of Drugs Regulations, 2001.
- There was a clear process for the wards and theatres to order controlled drugs (CDs). The pharmacy team

maintained a list of signatures of staff authorised to order CDs. Overall medicines optimisation met the needs of the service and was well developed to support patients throughout their inpatient journey.

- The pharmacist visited the ward daily to facilitate patient discharge to meet the hospital 11am discharge time, complete clinical review of the inpatient prescriptions, check patient's own medication to determine suitability of use and support the multidisciplinary team with clinical decisions regarding patient's medication. We saw evidence of pharmacy endorsements on inpatient medication record cards, documentation verifying the suitability of a patient's pre-filled compliance aid and pharmacist input into prescription of adequate pain relief. Pharmacy staff gave us examples of good multidisciplinary working with other staff groups. Examples included the pre-assessment nurse contacting pharmacy to discuss patients with complex medication histories and a physiotherapist discussing difficulty mobilising patients post joint operations and pharmacy working with consultants to optimise pain management protocols in this group to aid mobility. Both ward nursing staff and the RMO described a good working relationship with pharmacy staff.
- We saw up-to-date copies of the British National Formulary across all departments. Copies of the Antibiotic Prescribing Guidelines July 2015 V2 were available on the ward and in theatres, which signposted to the local NHS trust antibiotic formulary.
- The hospital had a self-administration of medicines policy and a patient information sheet and consent forms were available on the ward for staff to give to appropriate patients. There were no patients on the ward self-administering medication at the time of inspection.
- Hospital audits against the corporate policy Safe Management of Controlled Drugs showed a reduction in compliance against standards of the policy related to record keeping in recovery, endoscopy and theatres accompanied by an action plan. Pharmacy staff told us that training had been completed with relevant staff groups.
- Entries for the administration of controlled drugs on the ward had a secondary signatory as per the Nursing and Midwifery Council (NMC) Standards for Medicines Management.
- There was evidence of daily controlled drugs stock checks in the ward controlled drug register.
- Ward staff were familiar with policies regarding the destruction of controlled drugs.
- The pharmacy technician completed daily temperature checks in the pharmacy and various areas of this hospital including the intravenous drug store, ward and drug fridges. Other areas such as theatres, radiology and outpatients completed their own daily temperature checks using a standardised form.
- The pharmacy team and engineering and estates manager were able to describe the process of dealing with out of range temperatures and told us that staff had access to a policy explaining the process, which included reporting it as an incident on the electronic reporting system.
- The hospital used the corporate policy Management of Medicines in Spire Healthcare, April 2016 and a number of local and organisation wide audits were completed to assess compliance with the policy. Examples of audits completed included temperature monitoring audits, audit of monthly fridge freezer cleaning, date opened filled in for all liquid medicines and locked drug cupboards.
- We also saw evidence of audits against NICE Medicines Optimisation Guidelines, March 2015 such as medicines reconciliation within 24 hours and audits to assess compliance against National Patient Safety Alerts such as missed doses. We reviewed inpatient medication charts and noted overall compliance with prescribing standards monitored by the hospital including documentation of allergy status.
- There was a good mechanism of feedback related to audit results and incidents at the hospital. We saw evidence of minutes of the medicines management meetings, where these were discussed and cascaded to staff via the heads of departments. The minutes included learning from local incidents and serious incidents at other Spire hospitals.
- Pharmacy staff described a robust process of receiving Medicines and Healthcare Regulatory Agency (MHRA) and NHS Patient Safety Alerts and these were actioned and cascaded appropriately, there was evidence of these being discussed at the medicines management meetings.

Records

- The hospital followed their corporate 'information Lifecycle Management and patient Records' policy (dated August 2013), which included confidentiality of patient records, documentation by clinicians, length of time records were to be kept and patient records on discharge or transfer.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely, in line with the Data Protection Act. When not in use on the ward, patient notes were kept in a locked office. Access to them was via swipe card system, this provided assurance that records were kept safely and securely.
- We saw the medical records of ten patients. All medical records were tidy with no loose filing, legible, dated and signed, which was in accordance with the hospitals documentation policy.
- All records were complete and up to date. Each patient had the appropriate care pathway in place dependent upon the procedure they had. Evidence was available to show discharge was planned.
- Records showed where staff had completed patient risk assessments. These included risk assessments for falls, malnutrition and pressure ulcers. All risk assessments completed followed national guidance. For example, all patients were risk assessed on admission for their risk of VTE, and this was in line with the National Institute for Health and Care Excellence (NICE) QS3 – statement 1.
- Medical records for Spire Healthcare patients were held securely on site in the medical records porta cabin. There was an archive facility for patient notes, which would be stored on site for three months, and then transferred off site to a secure location. There was a tracker system in place, which we saw, this meant staff knew where notes where at all times.
- Medical records for NHS patients would be transferred from the local NHS hospital. The hospital held the NHS medical records on site while the patient was under the care of Spire Tunbridge Wells. After discharge, the NHS medical records would be transferred back to the local NHS hospital, with a copy of all documentation from the patient's admission. This allowed staff access to all relevant medical information and helped with continuity of care. The original documents would be retained by the hospital and transferred of site.
- Staff told us that they had no difficulty in retrieving medical records in time for patient's admission.

Safeguarding

- Staff received mandatory training in the safeguarding of adults and children, as part of their induction followed by safeguarding refresher training yearly.
- Safeguarding vulnerable adults training was undertaken every year for levels one and two. Data indicated, 96% of required staff had completed safeguarding vulnerable adults training, this was better than the Spire Healthcare target of 95%.
- There was a corporate 'Procedure for the Care of Children and Young People in Spire Healthcare' (dated March 2016), and 'safeguarding vulnerable adults' (dated January 2016) policies with defined responsibilities at national, regional and hospital level. The hospital had an up to date local 'management and safeguarding of vulnerable persons' policy reflecting the corporate policy for local responsibilities.
- The hospital had a senior named nurse lead for safeguarding for both adults and children. All staff we spoke with knew who the lead nurse was for safeguarding, and when they would ask them for help and advice.
- There has been one safeguarding concern reported within the last twelve months, October 2015. We saw the correct steps had been taken to deal with the concern, and evidence of shared learning.
- All safeguarding issues, including changes to policy were discussed at the quarterly MAC, CGC and the monthly SMT meeting. We saw the minutes of these meetings confirmed this.

Mandatory training

- Mandatory training for all staff groups was comprehensive with many modules accessed through an on line learning system. Mandatory training modules included equality and diversity, manual handling, infection control and information governance. Other training was role specific, for example medical gas training, food safety and blood transfusion.
- We saw records which showed 96% of staff working within surgical services had completed their mandatory training, which was better than the target of 95%.
- The resident medical officers (RMO) were required to undertake their mandatory and statutory training with the agency that supplied them as part of their contract, and showed us evidence of in-date advanced life support training.

- Consultants had to complete mandatory training with the trust they worked for as part of their appraisal process.

Assessing and responding to patient risk

- Pre assessment of patients was in accordance with British Association of Day-care Surgery (BADS).
- As part of the preoperative assessment process, patients completed a comprehensive Pre-Admission Medical Questionnaire (PAMQ). These were reviewed at pre-assessment appointments to assess the suitability of patients for surgery and to carry out health assessments such as an electrocardiogram (ECG), and discussions about the procedure. Depending on the information provided in the PAMQ, the pre assessment nurse either carried out a short telephone pre assessment for lower-risk surgery, or invited the patient in for a face-to-face pre assessment. The pre assessment nurses confirmed that if discussions at either a telephone or face-to-face pre assessment highlighted a potential safety concern, the escalated the issue to the surgeon or anaesthetist.
- As part of the PAMQ, all female patients of child-bearingage were asked the date of their last menstrual period (LMP), to check their pregnancy status. On admission to the ward, female patients had an additional pregnancy test performed. This was in line with the National Patient Safety Agency 2010 Rapid Response Report, which highlights the 'unreliability of LMP as a sole indicator of potential pregnancy'. Risks to patients were assessed and monitored at pre assessment, and then checked again prior to treatment. These included risks relating to mobility, medical history, pressure ulcer risk and VTE. Rates for screening VTE were at 98% at the end of 2015, which was above the target of 95%. During our inspection, we looked at ten sets of notes, which showed risk assessments had been completed correctly.
- The hospital used the National Early Warning Score (NEWS), and escalation flow charts. NEWS is a simple scoring system for physiological measurements, such as blood pressure and pulse, for patient monitoring. If a patient's score increased, staff were alerted to the fact and a response was prompted. The response varied from increasing the frequency of the patient observations, to urgent review by the consultant. Observation of the ten records showed these were complete.
- The hospital used a 'quality round form', to ensure their patients were safe and comfortable. The quality round form included pain control, nutrition, falls risk and NEWS score. Quality rounds were undertaken every two hours for all inpatients and day patients, this meant staff could anticipate any potential complications before they happened.
- The theatre team used the 'five steps to safer surgery' World Health Organisation (WHO) checklist to minimise errors in surgery, by carrying out a number of safety checks before, during and after surgery. The use and completion of the WHO surgical checklist was regularly audited by staff. We saw the observational audit of the checklist gained 95% and the documentation audit scored 98%. During our inspection, we observed two theatre teams undertake the WHO checklist correctly, and saw ten sets of notes, which showed the WHO had been completed fully.
- All patients saw their named consultant at each stage of their journey. The hospital had a transfer agreement in place so patients could be transferred to a local NHS trust if needed. If a patient's health deteriorated, staff were supported with medical input to stabilise a patient prior to transfer. The RMO gave us an example of a consultant who arrived at the hospital within 20 minutes after the RMO had alerted them to a patient with suspected sepsis. This was in line with Spire Healthcare practising privileges, which requires consultants to attend within 45 minutes, whenever they have a patient in the hospital. We saw in theatres emergency transfer equipment was available, such as a portable ventilator.

Nursing staffing

- The hospital told us they had previously tried a national staffing tool to decide the number of nurses required on shift, but found this too complicated for their needs. The hospital used a one nurse to five patient ratios for day shifts and a one nurse to seven patient's ratio for nights. The hospital told us the nurse in charge was supernumerary to the numbers and was on duty on most day shifts. We spoke with the ward manager who confirmed this, but told us that the nurse in charge had to occasionally cover any clinical shifts that had not been filled, but this did not happen very often. The service adjusted the ratio to one nurse to one patient or one nurse to two patients ratio for patients who needed a higher level of care based on their individualised needs.

- At the time of our inspection, the ward had 21 nurses. Some staff worked part-time, and there were 15.1 whole-time equivalent (WTE) nurses and 1.4 WTE healthcare assistants (HCA). The ward had three WTE nurse vacancies, and two WTE HCA vacancies. However, the ward manager told us four new nurses had recently been appointed posts at the hospital and would commence employment in September 2016.
- Bank and agency staff often worked on the ward to make up the shortfall in staff numbers. The use of bank and agency nurses between April 2015 – March 2016 varied. The lowest rates were 7% in April 2015 and December 2015, and the highest rate was 22% in September 2015. Bank and agency rates were about the same as the average for other independent hospitals we hold data from during this period, with the exception of one month. In September 2015, the rate of bank and agency nurse use (22%) was worse than the average independent hospital rate of 16% in the same month.
- The ward did not use any bank or agency HCAs between April 2015 – March 2016, apart from in two months during this period. The ward used 7% bank and agency HCAs in June 2015 and 28% agency HCAs in February 2016. The percentage of bank and agency HCAs on the ward in February 2016 was worse than the average rate of 11% for other independent hospitals we hold data for in the same month. However, HCA bank and agency use was better than the average rate for other independent hospitals in 11 out of 12 months during the reporting period.
- The hospital told us they held daily forward planning meetings. The ward manager confirmed the nurse in charge would go the a daily bed meeting every morning, this allowed them to assess the number of patients planned for the following week to ensure the ward filled all the shifts, and escalate and shortfalls in staffing.

Surgical staffing

- There were 128 consultants who had been granted practising privileges at the hospital, of which 47 were surgeons. Out of the 47 surgeons, 11 were no longer actively working at the hospital. Practising privileges is a term used when doctors have been granted the right to practise in an independent hospital. The majority of these also worked at other NHS trusts in the area. They included consultants with specialities such as urology and orthopaedics.
- There was a corporate 'Consultants Handbook' (dated June 2014), which included granting and maintain practising privileges, and defined responsibilities at national, regional and hospital level. The hospital had an up to date 'Maintenance of Practicing Privileges' policy reflecting the corporate policy for local responsibility.
- Operating theatres were generally in use between 8.30am and 7pm, Monday to Friday and 8am to 5pm on Saturday. If a patient was required to return to theatre out of hours due to complications, there was a comprehensive on call system in place to notify staff. The RMO and staff knew how to access the on call consultant or anaesthetist and told us the hospital kept a folder in reception with contact details of the on call consultant or anaesthetist each day.
- The hospital works within recommendations of the Association for Perioperative Practice (AfPP) for the numbers of staff on duty during a standard operating list. This consisted of two nurses, an operating department practitioner, a healthcare assistant, a consultant and an anaesthetist. We saw staffing rotas to confirm this.
- The hospital used an agency that provided a resident medical officer (RMO) onsite 24 hours a day, seven days a week, on a rotational basis. This meant a doctor was on-site at all times of the day and night in the event of an emergency. The RMOs worked one week on, followed by one week off.
- The RMO undertook regular wards round to make sure patients were safe. The RMO visited the ward every two hours between 8am and 11pm. If the RMO was called out during a significant part of the night. The RMO told us there were contingency plans in place to obtain cover.
- All staff and the RMO told us there were no concerns about the support they received from consultants and their availability.
- The RMO had a formal handover when they changed shifts. We spoke to the RMO on duty, which showed us a handover form that was completed by the RMOs to make sure there was good communication around the patients with specific needs; however, we were unable to observe a handover as there was no change over during our visit.

Major incident awareness and training

Good

Surgery

- The hospital has a business continuity plan (dated November 2015) in place in the event of potential emergencies. The plan covered major incidents such as how to respond in the event of loss of power, loss of staffing, adverse weather or flood. Staff were aware of the plans in place.
- Scenario based training were held regularly to make sure staff responded appropriately to emergency situations. Staff told us the most recent scenario involved a patient who was difficult to intubate (the placement of a plastic tube into the windpipe to maintain an open airway).

Are surgery services effective?

Good

We rated the services good for effective because:

- The hospital monitored patient outcomes to provide assurance of the effectiveness of the service. Patients were well cared for on the ward and in theatres. Patients received care and treatment in line with national guidelines such as National Institute for Health and Clinical Excellence (NICE) and the Royal Colleges, such as Royal College of Anaesthetics. Staff were competent to deliver good quality care.
- There was a good multidisciplinary team approach to care and treatment. Staff had the right qualifications, skills and knowledge to do their job. Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards legislation.
- The department undertook a variety of local based audits. Outcomes of surgical procedures were monitored and national benchmarking showed good results. Patients had comprehensive assessments of their needs, which included consideration of clinical needs, physical health and wellbeing, and nutrition and hydration needs. Pain relief was discussed with patients and administered when required.
- Patients received a choice of meals and drinks and the chef catered for patient's individual needs including those that required special diets. The hospital had access to a dietitian and other specialist services.

Evidence-based care and treatment

- Care and treatment was delivered to patients in line with the National Institute for Health and Care Excellence (NICE) and Royal College's guidelines, for instance the Royal College of Anaesthetics. For example, the national early warning system (NEWS) was used to assess and respond to any change in a patients' condition. This was in-line with NICE guidance CG50.
- 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 guidelines CG92.
- NICE guidance CG65 for hypothermia: prevention and management in adults having surgery was followed, the patient's temperature was monitored before anaesthetic and then every ten minutes.
- The hospital followed NICE guidance for preventing and treating surgical site infections (SSI) NICE guidelines CG74. Following discharge, the hospital had implemented follow up call for all hip and knee patients as part of the 30-day SSI audit.
- We saw NICE guidelines NCG45 for pre operatives tests were being adhered to, by the pre assessment nurses.
- Consultants confirmed that Spire surgical procedures were in-line with best practice and were always followed. We saw evidence of this in the quarterly clinical governance committee, which highlighted latest NICE guidance.
- Comprehensive care pathways were in place for patients undergoing local and general anaesthesia. This included quality indicators of anaesthesia, management of pain and recommendations for the management post discharge complications. This meant there was a standard system in place for each patient.

Pain relief

- There was a pain assessment scale within the National Early Warning Score (NEWS) chart used within the hospital. We reviewed ten sets of notes, which showed these had been completed correctly.
- Pain score and assessment prompts were included in the 'quality round form' used by staff, to ensure their patients were safe and comfortable. Quality rounds are undertaken every two hours for all inpatients and day patients. Patients told us nurses routinely asked them about pain as part of these rounds.
- In the patient satisfaction survey (March 2016), 94% of patients felt that staff did everything they could to control their pain.

- We spoke with six patients who told us their pain management needs were met. One patient told us their 'pain was managed well'. Another patient told us the staff were 'very good', and had explained about pain management in a supportive way.
- Patients were given information leaflets to take home which provided information on how to manage pain following discharge from hospital.

Nutrition and hydration

- All patients were screened for malnutrition and the risk of malnutrition on admission, using the Malnutrition Universal Screening Tool (MUST). MUST was documented within the integrated care pathway records. We reviewed ten sets of notes, which showed these had been completed correctly.
- The hospital took part in the Patient Led Assessment of the Care Environment audit (PLACE) audit 2016, which showed the hospital scored 99% for organisational food, which was better than the England national average of 87%. However, the hospital score for ward food were lower than the England average.
- We spoke with six patients who all spoke very positively about the quality of the food offered; they told us they were offered a choice of food and drink. One patient told us the 'choice of meal is great', another patient told us the 'food was good'. The chefs were adaptable and accommodating, happy to prepare any specific foods patients wanted, even at short notice. They were aware of side effects from surgery and treatments and recognised the importance for patients to eat something they chose and to their liking. Staff also told us the catering department also ensured their individual dietary requirements, were catered for. We saw the catering department had a list of staff with special dietary requirements.
- Pre-assessment 'dietary requirement' questionnaires were sent, which asked patients if they had special dietary requirements or allergies, which meant individual patient needs were met.
- The hospital provided three meals a day for inpatients. Choices could be seen on the menus. A member of catering staff spoke with patients daily to discuss any individual needs.
- Day patients were routinely offered a choice of sandwiches, but would be given an alternative, such as soup or salad if the patient requested, or provide specific requests for food that was not on the menu.
- Nutrition and hydration prompts were included in the 'quality round form' used by staff, to ensure their patients were safe and comfortable. Quality rounds are undertaken every two hours for all inpatients and day patients. Patients told us nurses routinely offered them drinks as part of these rounds.
- The hospital did not have a dietician on site, but we were told there was a service level agreement there to access an external dietician when required.
- Nausea and vomiting was assessed using a scoring system and recorded. We reviewed ten sets of notes, which showed these had been completed correctly.
- Staff told us if patients were unable to feed themselves they would assist them.
- Staff followed guidance on fasting prior to surgery, which was based on the recommendations of the Royal College of Anaesthetists, (RCA) which states that food can be eaten up to six hours and clear fluids can be consumed up to two hours before surgery. Information regarding fasting was provided to patients in their preadmission pack stating that they needed to fast for 6 hours prior to surgery.
- All patients were given these standard instructions and therefore patients could be admitted early, but not attend theatre until later in the morning. However, daily briefing meetings were held in theatre, where patients were discussed, including intake of fluids prior to theatre, this information would be passed to the ward staff. This meant the RCA guidelines were complied with where possible. As part of the 'quality round', there was an extra prompt that fasting of patients was to be assessed and addressed if applicable.
- The hospital had a five star rating in the local authority 'Food Hygiene Certification Scheme'. This gave assurance that all best practice in food hygiene standards were adhered to.

Patient outcomes

- Under a service level agreement with the local NHS trust, seven patients had been transferred out to an NHS hospital in the year April 2015 to March 2016 because of post-operative complications. However, the proportion of unplanned transfers was found to be 'not high' when compared to other independent acute hospitals we hold this data for.
- There were eight cases of unplanned readmission within 29 days of discharge in the reporting period of April 2015

to March 2016. The Care Quality Commission (CQC) had assessed the proportion of unplanned readmissions to be 'not high' compared to other independent acute hospitals we hold this data for.

- The hospital provided data to the national Patient Reportable Outcome Measures (PROMS). All NHS patients having hip or knee replacements,varicose vein surgery or groin hernia surgery are being invited to fill in Patient Reported Outcome Measures (PROMs) questionnaires. The PROMs questionnaires ask patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards.
- The hospital provided PROMS data for hip replacements (Oxford hip score) and knee replacements (Oxford knee score), along with groin hernia surgery (EQ-5D and EQ VAS indexes).
- For the 13 NHS funded patients treated for groin hernia between April 2015 and March 2016, 76.9% of patients reported their health had improved following surgery, 15.4% felt their health had worsened under the criteria EQ-5D. Under EQ VAS for twelve of the 13 patients during the same reporting period, 25% were reported as improved and 25% as worsened. The EQ-5 profile asked patients to report on their health based on self-assessed levels of problems ('no', 'some', 'extreme'). The EQ-VAS questionnaire asked patients to describe their overall health on a scale that ranged from 'worst possible' to 'best possible' health. However, the hospital did not have enough data available to calculate average health adjusted scores for PROMS in any of the three areas for the period between April 2015 and March 2016.
- Due to the small numbers of patients involved, these findings cannot be compared to national data. PROMS programme required at least 30 patients in each category to calculate the average health adjusted scores and compare these outcomes to other hospitals. In addition, due to the low numbers involved, the data for hip and knee replacements has been suppressed to protect patient confidentiality.
- The hospital took part in the Patient Led Assessment of the Care Environment audit (PLACE) audit 2016, which showed the hospital score to be higher than the England average for all measures including cleanliness, organisational food, dementia, ward food, condition, appearance and maintenance, privacy, dignity and wellbeing.

Competent staff

- Hospital records showed that 100% of staff had received a performance appraisal between April 2015 and March 2016. Appraisals were linked to the hospital and corporate vision and values. Staff told us they received at least two appraisals each year, their objectives were set at appraisal and learning needs and further training was discussed and planned.
- Staff were encouraged to undertake continuous professional development (CPD) and were given opportunities to develop their clinical skills and knowledge through training relevant to their role. We saw six CDP folders for nursing staff and two for theatre staff. All certificates were up to date, for example life support and pain management, and competency assessments were completed. In three of the folders we also saw six compliment letters, emails and feedback forms from patients relating to the member of staff. We were told at a focus group that some staff that had joined the hospital without any qualifications but had been encouraged to gain a variety of qualifications.
- 100%of nurses who worked within the surgical services for six months or more had recorded validation of professional registration. This meant the hospital conducted annual checks to make sure all the nurses are registered with the Nursing and Midwifery Council (NMC) and is considered good practice.
- Applications for practising privileges from consultants were reviewed and where practising privileges were granted or declined by the Hospital Director these were endorsed by the Medical Advisory Committee (MAC). This involved checking their suitability to work at the hospital, checks on their qualifications, references, immunisations and indemnity insurance. The hospital only granted practising privileges for procedures or techniques that were part of the consultant's normal NHS practice. The hospital would only consider making an exception to this rule if a consultant provided evidence of adequate training and competency.
- Practising privileges were reviewed every two years by the MAC. This included a review of patient outcomes, incidents and complaints as well as annual appraisals, General Medical Council (GMC) registrations and medical indemnity insurance. We saw the last four minutes of the MAC, which showed the committee reviewed consultants practising privileges in line with policy. The hospital told us six consultants had had their

practising privileges removed between April 2015 and March 2016, and 24 other consultants had had their suspended. We saw from the MAC minutes this was because these consultants had failed to supply documentation the hospital needed to renew their practising privileges. This included evidence of annual appraisal, or evidence of indemnity insurance. This showed the hospital had a strong procedure in place to make sure all consultants were experienced and fit to care for patients.

- Consultant revalidation was part of the requirement for maintaining their practising privileges. If a consultant wanted to carry out a new procedure, this had to be agreed as part of their practising privileges.
- Six consultants, or 5% of all consultants with practicing privileges, had not treated patients at the hospital from April 2015 – March 2016. We saw from the MAC minutes that the hospital wrote to consultants with no activity over a 12-month period with an invitation to discuss their practice. The hospital removed the practicing privileges of any consultants who did not respond within two months of the invitation. This helped ensure that only consultants who had up-to-date skills and competencies worked at the hospital.
- Surgeons only performed operations they were used to performing at the acute NHS trusts where they were employed. This ensured they were competent and confident in undertaking the procedures.

Multidisciplinary working (in relation to this core service only)

- Throughout our inspection, we saw evidence of good multidisciplinary working in all areas. We observed positive interaction and respectful communication between professionals. We saw effective arrangements were in place for collaborative working between consultants, nursing and operating department practitioners. The waiting areas were comfortable and uncrowded. Our review of ten patient records, talking with 20 members of staff and six patients confirmed there was effective multidisciplinary working practices, which involved nurses, doctors, pharmacists and physiotherapists. Staff described the multidisciplinary team as being supportive of each other. Staff told us they felt supported, and that their contribution to overall patient care was valued. Staff told us they worked hard as a team to ensure patient care was safe and effective.
- Clinicians reported effective working relationships within the hospital, in a wide range of contexts. This included the management team, the 'excellent' nurses on night duty and the availability of equipment.
- The preoperative assessment nurses liaised with anaesthetists and surgeons to coordinate preoperative investigations; including confirming what assessments were needed and following up the communication once results were obtained.
- We observed one nurse handover during our announced visit. The handover was structured and provided consistent information, and included details of patients' need, the operation they had or when they had this operation, pain scores and starve times. This meant that that nurses had sufficient information and patients would receive the care they needed.
- Discharge letters were sent to the patient's GP on the day of discharge, with details of the treatment provided, follow up arrangements and medicines provided.
- Theatre staff had a daily morning brief, which ensured all staff had up to date information about issues with scheduling or cancellations, risks, concerns and incidents.
- The nurse in charge on the ward would attend the a daily bed meeting every morning, this allowed them to assess the number of patients planned for the following week to ensure the ward filled all the shifts, and escalate and shortfalls in staffing.
- The multidisciplinary theatre team met monthly, and we saw minutes from the last two meetings.
- We saw physios on the ward going to see patients and effective communication between physios and nurses. We also spoke with a patient, who told us about specific exercises a physio had given them to help with their recovery post-surgery.

Seven-day services

- Theatre lists in theatres one and two ran Monday to Friday from 8.30am to 7pm, and Saturday from 8am to 5pm. The theatre schedule was managed by the theatre manager. There was an on-call theatre rota in place for staff to attend quickly if a theatre was needed on a Sunday or out-of-hours.
- We saw rotas were in place for key hospital staff, consultants and anaesthetist, to ensure patients had speedy access to services. However, staff told us they rarely needed to come into work while on call, as very few patients needed to return to theatre. The hospital

had four unplanned returns to theatre between April 2015 and March 2016. We were told there was a service level agreement for Intensivist (a doctor who provides specialist support to critically ill patients) support, from the local NHS trust.

- Endoscopy lists in theatre three ran from Monday 8.30 to 6pm, Wednesday 8.15am to 5pm, Friday 8.30 am to 4pm and Tuesday and Thursday 2pm to 6pm. The endoscopy schedule was managed by the theatre manager. The on call theatre team would attend on a weekend or out-of-hours.
- We saw the Spire Consultants Handbook (dated June 2014), which included practicing privileges for consultants. The handbook required the consultants to be available by telephone, and in person if required, 24 hours a day, whenever they had a patient in the hospital. This ensured inpatient recovering from surgery over the weekend had 24-hour access to consultant input if needed. If a consultant was not available, the handbook required them to arrange for another consultant to provide cover.
- The diagnostic imaging department provided a 24-hour a day, seven day a seek service for urgent examination request, via an on call system. This allowed staff to access diagnostic services in a timely way to support clinical decision making.
- The hospital pharmacy team provided cover Monday to Friday 8.30am to 4pm. The pharmacy was staffed by a pharmacist and a pharmacy technician. A pharmacist was available on-call outside of these hours. Bank staff supported annual leave, sickness and the part of the on-call rota.
- Outside of these hours, there was a procedure for the resident medical officers (RMO) and senior registered nurse on duty to obtain access to medicines. We saw a copy of the corporate 'Management of Medicines in Spire Healthcare' (dated April 2016), which the hospital followed, which reflected this.
- The hospital was open seven days a week to care for patients after surgery that needed to stay in hospital overnight and at the weekend.
- The physiotherapy department provided in patient services Monday to Friday 8am to 8 pm. Saturday and Sunday 8am to 5pm.
- Pre-assessment clinics ran Monday to Friday starting at 7.30am, with variable finish times between 3pm to 7pm. The hospital told us they occasionally ran Saturday clinics when needed.

Access to information

- There were comprehensive pathway records available to staff that contained all of the information staff needed to deliver effective care and treatment. These included risk assessments for venous thromboembolism (VTE), falls and nutrition, and medical notes. We reviewed ten sets of notes, which showed these had been completed correctly.
- Patients were required to complete a comprehensive pre-admission medical questionnaire prior to surgery, which included their past medical history and their current medications. Dependent upon a patient's history, patients may receive either a Nurse-led telephone clinical assessment, be invited to undertake a face to face meeting with a pre assessment staff where a number of investigations could take place, or be referred for an Anaesthetic review. This would provide healthcare professionals information of the patient's current health status.
- Staff told us they had access to policies and procedures and felt they were kept informed by the management team. Staff told us that they all received a monthly governance newsletter, which updated them about events and incidents at the hospital.
- Surgical staff had access to results of diagnostic imaging procedures and reports 24-hour a day, seven day a week. This allowed staff to access diagnostic services in a timely way to support clinical decision-making.
- The Patient Satisfaction Survey (March 2016), found 97% of patients were satisfied with the way they were prepared for discharge. Eighty-five percent of all inpatients responded 'very' to 'how organised was the discharge process', with the remaining 15% responding 'fairly'.
- For NHS patients, the patients NHS notes would be transferred from the local NHS hospital. The hospital held the NHS notes on site while the patient was under the care of The Spire Tunbridge Wells. After discharge, the NHS notes would be transferred back to the local NHS hospital, with a copy of all documentation from the patient's admission to the hospital. This allowed staff access to all relevant medical information and assisted in continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguard

Good

Surgery

- The hospital followed their corporate 'Deprivation of Liberty Safeguards Policy' (dated April 2016), and corporate 'Consent to Investigation of Treatment' Policy (dated January 2016). Staff had knowledge of these policies and how to use them.
- Patient Led Assessments of the Care Environment (PLACE) for April 2016 showed the hospital scored 84% for dementia, which was higher than the England average of 75%. The dementia lead told us they are looking at ways of discreetly identifying patients with dementia. For example, different coloured wristbands. As part of the ward redecoration they will look at ensuring contrasting colours in patients bedrooms were 'dementia friendly' Contrasting colours on the walls and floors can give the person with dementia a sense of depth and perspective in a room. Having furniture in contrasting colours can make it easier for them to find and use.
- The PLACE assessment for Dementia was included for the first time in 2015, and focused on key issues such as, flooring, decoration (for example contrasting colours on walls), and signage, along with seating and availability of handrails, which can prove helpful to people living with dementia.
- We saw ten sets of notes during our inspection. We saw evidence of staff following the consent policy and seeking written consent from patients prior to procedure, and on the day of procedure. This meant staff were working in line with the General Medical Council guidance for consent and the hospital policy which meant patients are involved and understand the reason for the procedure.
- Staff told us if there were concerns over a patient's capacity to consent, they would seek further advice and assistance. For example, ward nurses told us of a patient whose relative was living with dementia, the patient was anxious about their relative being left at home. The hospitals admitted both the patient and relative to a double side room for the duration of the patient stay.
- Spire Tunbridge Wells followed their corporate 'Resuscitation' (dated March 2016) policy, which clearly identified the process for decisions relating to 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) orders. A Unified DNACPR form was used at Spire Tunbridge Wells. The form took into account the person's capacity to make decisions.
- At the time of our inspection, there were no patients with a DNA CPR order in place. Patients' resuscitation status was assessed and documented both pre and during their admission.

Are surgery services caring?

Good

We rated caring as good because:

- Patients and relatives feedback was constantly very positive about the care provided from all of the staff at the hospital. Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care or treatment.
- Patients felt supported and said staff cared about them, and that 'nothing was too much trouble'.
- Staff responded compassionately when patients needed help and supported them to meet their basic personal needs as and when required. Staff were highly motivated to offer care that promotes people's privacy and confidentiality was respected at all times.
- Interactions between staff and patients were welcoming, caring and supportive.

However:

- There was a lack of documentation if a patient declined a chaperone; this was not in line with the corporate policy.

Compassionate care

- Staff treated patients with kindness, dignity and respect. Staff interacted with patients in a positive, professional and informative manner. This was in line with National Institute for Health and Care Excellence (NICE), QS 15.
- We spoke with six surgical patients on the ward. All patients we spoke with said the care they received was of a very good standard. One patient told us 'faultless team from start to finish'. 'The ladies I have met here have all been attentive, patient and caring'. Another patient said 'level of care has been fantastic'.
- We observed many positive interactions between staff and patients during out inspection. We witnessed staff approach people rather than waiting for requests for assistance. Staff introduced themselves with 'my name is'. A patient told us, 'All staff treated me with the

greatest respect and dignity'. Patients we spoke with were very positive about the way staff treated them. Patients told us staff were 'excellent', 'friendly', 'fantastic' and 'nothing was too much trouble'.

- We observed nurse handovers which maintained patient confidentiality.
- We saw patients being treated as individuals and staff spoke with patients in a kind and sensitive manner.
- We saw that chaperones were available. The hospital followed with corporate 'Chaperones Guidelines' (dated February 2013), which outlined the roles and responsibilities for chaperoning, including training, and documentation.
- We saw posters informing patients that chaperones were available on display in the main corridor of the ward. Patients were given the opportunity to accept or decline a chaperone during their stay. The chaperoning policy states 'A record must be made where the patient declines a chaperone regardless of reason.' We spoke with staff who told us they did not record in the medical notes if a patient declined a chaperone.
- The NHS Friends and Family Test is a satisfaction survey that measures patients' satisfaction they have received. The test data for all patients between October 2015 and March 2016 showed the hospital had consistently high scores (greater than 97%) and the response rates varied between 33% and 73%. The response rates for this period were the same as, or better than the average England response rates for NHS patients. This showed that most patients were positive about recommending the hospital to their friends and family.
- In the hospital patient satisfaction survey (March 2016), 100% of patients were extremely likely or likely to recommend the hospital to family and friends. Eighty-seven percent of all in patients responded 'excellent' to care and attention provided by nursing, with the remaining 13% responding 'very good', and 69% rated 'excellent' to patient experience.
- We received thirteen comment cards from patients who have recently had surgery at the hospital. All were very positive about the care and treatment they received. Comments included 'very efficient friendly staff. Excellent experience', 'my experience here was great, the staff were very helpful and caring' and 'excellent overall'.

Understanding and involvement of patients and those close to them

- We saw ten patient records and saw they included pre admission and pre-operative assessments that took into account individual patients preferences.
- We saw staff introduced themselves to patients, explained their role and the examination that was about to be performed.
- Discharge planning was discussed pre operatively to ensure appropriate post-operative caring arrangements were in place. We saw examples of written information that was given to patients to take home.
- Staff sent detailed information about the surgery patients were booked in for with the admission letter, which included admission date and time, and length of stay. We saw examples of this information and it was in clear, simple language.
- All patients we spoke with told us that their care was discussed in detail with them. Patients told us they were given time and were able to ask questions, and felt included in the decisions that were made about their care. One patient told us, 'I felt like I could ask any questions and that they actually cared and listened to me'. In the patient satisfaction survey (March 2016), 91% of all patients said they were involved as much as they wanted to be in the decisions about their care.
- Clear and concise information was provided to patients prior to their admission. They told us the reception staff treated them with kindness.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required. We spoke with six patients who told us, nursing staff answered the call bells promptly.

Emotional support

- Patients told us they felt able to approach staff if they felt they needed any aspect of support.
- All patient bedrooms were private and could be used to deliver any bad news which may adversely affect a patient's future. Nurses told us that if a patient was going to receive 'bad' news from a consultant, then they would always make sure that there was a nurse present as well to provide additional support. The ward manager also said they were arranging additional training, for breaking bad news.
- Staff told us that there were no existing relationships with religious or other support organisations although we were provided a list of contact details, which staff could use for different religions in the local area.

Good

Surgery

- There was a new breast care link nurse for the ward who was working on organising a support group for patients following breast surgery.

Are surgery services responsive?

Good

We have rated responsive as good because:

- Access to care and treatment was monitored and exceeded the national average.
- Complaints were handled in line with policy. Staff had a good understanding of the complaints process, and complaints were discussed at monthly staff meetings. Information about the complaints procedure was available for patients and relatives.
- Patients were assessed prior to undergoing surgery and staff were proactive in meeting patient needs. There was daily planning by staff to ensure patients were admitted and discharged in a timely manner.
- Vulnerable adults, such as patients living with learning disabilities and with dementia were identified at the referral stage and appropriate steps were taken to ensure they were appropriately cared for.
- Access to surgical services was timely and patients could book procedures at a time to suit them. NHS patients were consistently admitted within the 18-week referral to treatment target.
- Staff had access to translation services.
- All written information, including pre-appointment information, leaflets and signage was in English only. However, Staff had access to a translation services.
- Information gathered at the referral stage identified patients who would need the assistance of the interpretation service and translators were booked when the appointment was made.The hospital also had a contract with a translation service who translated written information on request with a two hour turnaround when needed.

Service planning and delivery to meet the needs of local people

- The hospital followed their corporate 'Admission and Discharge Policy' (dated June 2014) which outlined the clinical risk assessment criteria for patients. As part of the preoperative assessment process, patients with certain medical conditions would be identified via the Pre-Admission Medical Questionnaire (PAMQ), which would help identify certain patients who may need further assessment. For example, patients with a history of a heart attack and had a pacemaker, would be assessed by an anaesthetist, prior to planned surgery, and a decision was made whether they could be operated on at the hospital.
- All admissions for surgery planned in advance were elective procedures and included private and NHS patients. Due to the surgery being elective at the hospital, service planning was straightforward as the workload was mostly predictable.
- Most of the patient bedrooms on the ward were single rooms, so patient privacy could be maintained.
- Signage around the hospital was clear. We saw staff stopping to ask patients and visitors if they required assistance or direction, if they saw them appearing to be lost.

Access and flow

- There were 3906 overnight and day-case patients admitted to the hospital between April 2015 and March 2016.
- Between April 2015 and March 2016, approximately 27% of all patients were NHS funded, and with the remaining 73% were private insured and self-paying patients.
- The NHS patients were either referred to the hospital via their general practitioners (GP), via the 'chose and book' system, or were referred directly to the hospital from the local NHS trust.
- During our inspection, the theatre lists ran on time. The inspection did not highlight any concerns relating to the admission, transfer or discharge of patients from the ward or theatres. The patients we spoke with did not have any concerns in relation to their admission, waiting times or discharge arrangements.
- Theatre staff, consultants and anaesthetists had an on call rota arrangement to manage any unexpected returns to theatre including weekends and overnight. This meant staff were available to ensure patients had speedy access to services.
- There were 2,881 visits to the operating theatre between April 2015 and March 2016. Hospital data showed there had been 18 operations cancelled on the day of surgery, for a non-clinical reason between April 2015 and March 2016, which demonstrated that a relatively small proportion of operations were cancelled at the hospital.

- Theatre staff told us patients identified as high risk, such as diabetic patients, were usually scheduled for surgery at the beginning of the theatre lists in case they developed complications during their procedure.
- Referral to treatment waiting times (RTT) for NHS-funded patients having inpatient surgery at the hospital, on average, was 97% of patient received treatment within 18 weeks of referral. This was better than the national target of 90%.
- Theatre staff had a daily morning brief, which ensured all staff had up to date information about issues with scheduling or cancellations.
- A pre assessment phone call or meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage.
- We reviewed discharge arrangements as saw these were started as soon as possible. We saw four discharge letters which included admission details, clinical assessment and medication on discharge, all four were fully completed. One copy would be given to the patient, another sent to the patient's general practitioner, and the third copy retained in the notes. This ensured continuity of care for the patient once discharged.
- At discharge, nurses gave patients a direct telephone number to the ward in their discharge pack. Patients could call this number and speak to a nurse, if they had any concerns, and the service was available 24 hours per day, seven days a week.

Meeting people's individual needs

- All admissions were pre-planned so staff could assess patients' needs prior to treatment. This enabled staff to plan patient's care to meet their specific requirements, including those relating to any cultural, linguistic, mental or physical needs.
- Relatives were able to stay overnight if this was required, a collapsible bed was provided for them.
- Patients had access to a variety of information leaflets in the hospital. Leaflets were in English, however the hospital has a contract with a translation service who translated written information on request with a two hour turnaround when needed.
- Staff told us they had access to a translation service. Information gathered at the referral stage identified patients who would need the assistance of the interpretation service and translators were booked when the appointment was made. Staff told us they would not use family members to translate for consent which was in line with best practice guidance.
- Patient Led Assessments of the Care Environment (PLACE) for April 2016 showed the hospital scored 84% for dementia, which was better than the England average of 75%.
- The hospital had a named nurse lead for dementia. All staff we spoke with knew who the lead nurse was for dementia care, and when they would ask them for help and advice. We saw both theatres and the ward had a dementia resource folder on the ward, this included information and resources to support staff care for patients living with dementia.
- Vulnerable adults, such as patients living with learning disabilities and dementia were identified at the referral stage and appropriate steps were taken to ensure they were appropriately cared for. Steps included ensuring they were accompanied by a relative or carer for their admission, and would be placed into a larger double room. Staff told us it was rare for such patients to be treated at the hospital.
- Staff had received training in consent, the Mental Capacity Act and DoLs. We spoke with the lead nurse for dementia who told us they had undertaken face to face training with 60% of hospital staff so far which enabled staff to become a 'dementia friend'. We saw two members of staff wearing a 'dementia friend' badge. The dementia lead nurse told us, if at pre assessment a patient living with dementia, they would be given a 'this is me' care passport to complete with support from their family and carers. 'This is me'is a simple and practical tool that people with dementia can use to tell staff about their needs, preferences, likes, dislikes and interests An alert form would be sent to the ward and theatre and the ward prior to admission.
- In addition to the face to face training, dementia training forms part of all staff's mandatory training programme, via Spires online learning system. At the time of inspection 96% of all staff across the hospital had completed this training, which was better than the target of 95%.
- There were leaflets available that explained the payment options, and procedure and gave advice of who to contact if there were any queries. Staff told us they would provide quotes and costs, and ensure that

patients understood what the costs involved. Patients were also given a contact number on discharge. The hospital website also clearly described the different payment options available.
- We were told there was a service level agreement for specialist nurses for specific patient groups were available, for example urology and breast care.
- Pharmacy staff showed us examples of a leaflet adapted for impaired vision about medicines post cataract surgery, they also told us they were able to print medicine labels with bigger writing and gave some patients with a medication record sheet on discharge explaining when to take each medicine and what it is for if they felt this was needed.
- Hoists were available on the ward for patients who required assistance to transfer. Bariatric care was provided and specialist equipment, such as hoists and commodes were available. The matron also told us they took into consideration, bariatric patients when they renewed the reception area, ensuring there were larger chairs and sofas available for all patients, so as not to single out bariatric patients. This meant patient's dignity was maintained.

Learning from complaints and concerns

- The hospital received 35 complaints between April 2015 and March 2016. No complaints had been referred to the Independent Sector Complaints Adjudication Service (ISACS). The Care Quality Commission (CQC) had assessed the level of complaints to be similar to other independent hospitals.
- The hospital had clear processes in place for dealing with complaints, including, an up to date 'Complaints Policy' (dated January 2014). Staff we spoke to were aware of the complaints procedure. We saw complaints 'Please talk to us' leaflets were available for patients to use when required. It explained the three-stage process used for complaints handling. The provider's website had a section detailing how to make a complaint. The patient leaflets advised patients the process of taking their complaint to an independent adjudication service in the event of an unsatisfactory response from the hospital.
- Complaints were discussed with all members of staff with any learning points identified. We saw complaints were a standing action point in the minutes of the monthly theatre team meetings.
- A senior manager had overall responsibility for responding to all written complaints. The hospital acknowledged complaints within 48 hours of receiving the complaint with an aim to have the complaint reviewed and completed within 20 days. There was an expectation that complaints would be resolved within 20 days. If they could not, a letter was sent to the complainant explaining why.
- We saw the minutes for the quarterly clinical governance committee meetings and medical advisory committee and saw that complaints and actions were a regular agenda item. We also saw complaints were discussed at the monthly senior management team meeting. This meant that the hospital learned from complaints and improved services where appropriate.

Are surgery services well-led?

Good

We rated the service good for well-led because:

- There was a clear governance structure in place with committees such as clinical governance, infection control, heads of department and risk management feeding into the medical advisory committee (MAC) and hospital senior management team (SMT).
- The hospital had strong governance arrangements that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored.
- The corporate Spire hospital values were well embedded with staff who could tell us what they were and how they applied to them.
- There was clear and highly visible leadership provided by senior management and within the departments. Staff spoke positively of their managers, who told us they were visible and approachable, and told us the senior management team had an 'open door' approach, and visited departments daily.
- There were high levels of staff satisfaction across all staff groups. Staff told us they felt "proud" to work at the hospital, and there was good team spirit and atmosphere, and staff felt a part of a big family.

Vision and strategy for this this core service

- Staff told us they provided best quality care, by making sure they listened to patients, staying up to date with current practice, and ensured they learned from feedback.
- The Spire values were well embedded with staff, which were able to explain the hospitals and corporate values and objectives across the surgical area and wards. We saw the vision displayed on notice boards. Appraisals were linked to the hospital and corporate 'values' included 'caring is our passion', 'doing the right thing' and 'driving excellence'.

Governance, risk management and quality measurement for this core service

- The hospital had clear governance in place. The hospital held meetings through which governance issues were addressed. The meetings included Medical Advisory Committee (MAC), Senior Management Team (SMT) meeting, Infection Control and Medicines Advisory Committee.
- The hospital followed their corporate Clinical Governance and Quality Assurance Policy (dated October 2014).
- The Clinical Governance Committee met quarterly and discussed incidents, complaints, patient safety issues (such as, infection control, safeguarding and falls) and risk register review. There was also a standing agenda item to review NICE guidance, to ensure the hospital implemented and maintained best practice, that ensured any issues affecting safety and quality of patient care were known, disseminated, managed and monitored. During our inspection, we saw the minutes of Clinical Governance Committee meetings held in September and November 2015 and March and May 2016.
- The MAC met quarterly and the minutes of the last four meetings were reviewed. The minutes showed the key governance areas such as complaints, incidents and outcomes, health and safety and feedback from the clinical governance committee were discussed.
- The SMT met monthly and the minutes of the last four meetings were seen. The minutes showed items discussed included, complaints and incidents, patient feedback and key departmental feedback.
- Agendas and minutes showed audits and learning from complaints, learning from risk management, infection control issues, good practice, and clinical audits were discussed and action taken where required.
- We saw actions plans were monitored and staff implemented elements of action plans where appropriate. For example, the action plan from a sharps audit, in May 2016, showed the action points arising were completed within the required timescales.
- Staff told us that they all received a monthly governance newsletter, which updated them about events and incidents at the hospital.

Leadership / culture of service related to this core service

- The overall lead for the surgical service was the matron, who was also the head of clinical services. The surgical inpatient ward was led by clinical nurse manager and they theatre team was led by the theatre manager. Both reported to the matron.
- All staff we spoke with were positive about their relationships with their immediate managers. Staff felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to.
- Staff said all senior managers were available, highly visible within the division and approachable. Leadership of the service was extremely good; there was excellent staff morale and all staff felt supported at ward level. All staff told us they felt encouraged to be engaged in the provision of services and this increased their individual and team motivation. Staff told us the senior management team had an 'open door' approach, and visited departments twice daily to ensure everything was going well and to help with any potential problems
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships. One consultant told us they had chosen to work at the hospital due to the staff and senior management team,
- At ward and theatre levels we saw staff worked very well together and there was respect between specialities and across disciplines. We saw examples of strong collaborative team working on the wards between staff of different disciplines and grades.
- Staff told us they felt "lucky" and "proud" to work for this hospital. There is good team spirit and atmosphere, and staff felt part of a "big family". Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority and

responsibility of all staff. Staff felt their needs were catered for on an individual basis. For example, a member of staff had their religious needs respected by accommodating their individual prayer times.

Public and staff engagement

- Patients were actively encouraged to provide feedback about their experience with a patient satisfaction questionnaire and for NHS patients, the Friends and Family Test.
- In the patient satisfaction survey (March 2016), 100% of patients were extremely likely or likely to recommend the hospital to family and friends. Eighty-seven percent of all in patients responded 'excellent' to care and attention provided by nursing, with the remaining 13% responding 'very good', and 69% rated 'excellent' to patient experience.
- The hospital also acted on and made improvements from patient feedback. We saw a "you said", "we did" board in the corridor of the ward, displaying some of the improvements they had made
- In the Spire Healthcare consultant survey 2015, 85% of consultants who worked at the hospital rated it as 'excellent' or 'very good'. This was better than the Spire Healthcare average of 79% for the same period. All nursing staff we spoke with were aware of this result, and told us of the "brilliant" working relationships they had with the consultants.
- During our inspection, we saw six compliment letters, emails and feedback forms to the staff from patients, expressing their gratitude for the "wonderful" care and treatment they received during their visit to the department.
- The hospital had recently commenced staff forums, where staff from all departments could attend to discuss any issues or concerns and share ideas and learning. We saw in the June 2016 newsletter, the hospital risk register was discussed.

Innovation, improvement and sustainability

- Staff were actively encouraged to develop new and innovative ideas through the hospitals "Inspiring People" programme to improve the services provided where awards were given for the best ideas. For example, the catering manager told us they had recently introduced fruit smoothies for patients who are on a pureed diet. This had proved very successful and now all patients are offered the choice of a smoothie. The scheme was also used to recognise staff who have gone 'above and beyond' for a patient, visitor or colleague. Exceptional ideas or performance were nominated for the providers national annual awards ceremony
- Staff told us about the development of new post-operative patient information leaflets. This gave patients information on wound management and pain relief. The information leaflets are given to patients during pre-assessment and on discharge. This had meant there has been a decrease in post-operative calls from patients following discharge.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

Outpatient facilities comprised ten general consulting rooms, a plaster room, an ophthalmic and audiology room and three treatment rooms. All rooms were located on the ground floor of the hospital and were wheelchair-accessible. The department operated six days a week, including evening sessions.

One of the consulting rooms operated as a 'one stop breast clinic', which enabled breast assessment, investigation and feedback in one appointment.

The imaging department included 'wide bore' magnetic resonance imaging (MRI) and 'open' computerised tomography (CT) scanning, digital infrared breast scanning, ultrasound scan facilities, fluoroscopy room, interventional radiology as well as mobile x-ray facilities. The MRI was capable of working in 'silent mode' for head scans.

The MRI operated seven days a week and all other imaging services were open five days a week, with radiographers also providing on-call after-hours imaging for inpatients.

During the inspection, we observed a range of services. We also reviewed documentary information supplied prior to our visit and provided on request during the inspection and took into account feedback from discussion and written communications from stakeholders. During our visit, we made observations of activity levels, staff interaction with patients, and checked the environment and equipment used by patients. We spoke to a range of staff in a focus group discussion as well as 17 during the visit itself. This included consultants, radiographers, nurses, healthcare assistants and administration staff. We spoke with patients and relatives and reviewed eight cards collected from CQC comment boxes placed in the department during our stay.

In addition to our main inspection, we undertook an unannounced visit on the 8th August 2016, in which we checked equipment and staffing levels, observed interactions between patients and staff, and reviewed care and treatment.

There were 31,553 first and follow-up outpatients appointments booked at the hospital between April 2015 – March 2016, of which 16% were NHS funded and 84% were either self-paid or funded by medical insurance. Orthopaedics, general surgery, ENT and urology were among the most attended clinics accounting for 44% of all outpatients appointments seen at the hospital.

The paediatric register in outpatients showed the department saw 686 children in April 2015 - March 2016.

Good

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated outpatients and diagnostic services at Spire Tunbridge Wells Hospital as good because:

- 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. Staff had appropriate safeguarding awareness and people were protected from abuse.
- Staff followed cleanliness and infection control procedures. Potential infection risks were anticipated and appropriate responses implemented and measured.
- 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.
- People were always made aware of waiting times and meals were offered to those delayed or in clinic over meal times.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.
- Medicines were stored safely and checks on emergency resuscitation equipment were performed routinely. Incidents and adverse events were reported and investigated through robust quality and clinical governance systems. Lessons arising from these events were learned and improvements had been made when needed.
- The leadership, governance and culture within the departments were strong. Managers supported staff and actively encouraged them to contribute to the development of the services.

Are outpatients and diagnostic imaging services safe?

Good

We rated the safety of outpatient and diagnostic imaging services as good. This was because:

- People were protected from avoidable harm. There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.
- These were reliable, minimised the potential for error, and reflected national and professional guidance or legislation. They were also appropriate for the care setting, understood by all staff, implemented consistently and were reviewed regularly and improved when needed.
- Openness and transparency about safety was encouraged. Staff understood their responsibilities and were supported to report concerns, incidents and near misses.
- Opportunities to learn from incidents locally and corporately were identified, cascaded and acted upon.
- There were sufficient staff with appropriate skills working in an appropriate environment to ensure people were safely cared for.

Incidents

- The hospital used a computer software system for reporting incidents. In April 2015 – March 2016, the hospital reported 277 clinical incidents. Of these, five incidents (1.8%) related to children. In all five cases, there was no harm caused to the child. We did not identify any common themes from the incidents, and all involved different clinical specialities.
- Seventy clinical and forty-five non-clinical incidents occurred within Outpatient and Diagnostic Imaging services in the same period. The rate of clinical incidents per 100 attendances was similar to other independent hospitals, but the non-clinical incident rate was higher. The OPD manager attributed this to better reporting and the success of the "no blame" culture supported by the hospital governance committee. Staff were also confident in using the software. There were no trends or patterns apparent.

Good

Outpatients and diagnostic imaging

- Outpatients and diagnostics services reported no serious incidents or never events. Never events are serious, wholly preventable patient safety incidents that should not occur if healthcare providers implemented existing national guidance or safety recommendations. Providers are obliged to report never events for any patient receiving NHS-funded care. The occurrence of never events can highlight potential weaknesses in how an organisation manages fundamental safety processes.
- There were no incidents reported to the Care Quality Commission concerning the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). We saw MRI patients given a safety questionnaire and verbal checks made (six point check protocol) prior to their scans, which helped to assure that potential risks were identified and excluded. Staff gave examples of safe practice, such as an incident when a patient was unable to recollect full details of their medical history. After checking with the radiologist on duty, the patient consented to a preliminary CT scan, which revealed the presence of a cerebral aneurysm clip. This is a life-saving metal device that could have been adversely affected by the strong magnetic field generated during the MRI scan.
- Staff could describe how learning from incidents took place at local, regional and national (corporate) level. Governance meeting minutes and team meeting records we saw confirmed there was dissemination of learning.
- Duty of Candour (DoC) is a statutory requirement under the Health and Social Care Act (Regulated Activities Regulations) 2014 for healthcare providers to disclose safety incidents that result in moderate or severe harm or death to patients or any other relevant person. Staff knew about of the Duty of Candour legislation and we saw records on a corporate training website that indicated DoC was included in mandatory training for all staff.

Cleanliness, infection control and hygiene

- Overall, both departments complied with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015). For example, no cases of MRSA, Methicillin Susceptible Staphylococcus aureus (MSSA), Clostridium difficile (C. diff) or Escherichia coli (E. coli) were reported in the last year. These rates are all below the England average for other hospitals.
- All areas we visited were tidy, clean and uncluttered. This included higher-level dust traps such as door surrounds, window frames and curtain rails. Our findings were consistent with the Patient Led Assessment of the Care Environment (PLACE) audit for 2016, which showed the hospital scored 100% for cleanliness. This was better than other hospital in the group (98.95%) and the national average of 98%.
- Clinical areas did not have fitted carpets. Flooring was seamless, smooth, slip-resistant and provided with an easy clean finish. This complied with Health Building Note 00-09: Infection control in the built environment (Department of Health, March 2013).
- We saw disposable curtains fitted in consultation and treatment or imaging areas. Each had a label showing the date changed, which were within the last four weeks. According to HBN 00-09, using disposable curtains that are routinely changed helps to reduce bacterial cross contamination.
- Reusable items and portable equipment displayed 'I am clean' stickers. This showed that staff had cleaned these items ready for the next patient. The outpatients department extended the use of these stickers to disposable items such as examination couch covers. We were told this was a deliberate policy to provide extra assurance to their patients.
- On our initial visit, we saw that X-ray room one contained a number of equipment storage cases as well as a mobile X-ray machine. This was rectified before we returned on our unannounced inspection.
- We saw a selection of cannulae (small tubes used to deliver medication used in imaging) stored on wall hooks in the X-ray room. These had been sorted into sizes and the hooks had torn some of the packaging. Manufacturer guidelines stipulate that sterile items in damaged wrappers must be rejected. After speaking with the manager, the damaged items were removed from stock.
- We also learned that a newer x-ray unit had been obtained from another Spire hospital and the room was due for renovation. We saw recently approved technical drawings of the works and were told commencement was due shortly. The proposed works included new storage systems for all consumables and cannulae.
- Staff participated in infection control training as part of their annual mandatory training program. We saw infection control posters displayed in the department

that reminded clinical staff of the importance of not wearing any clothing or jewellery below the elbows to reduce the risk of infection to patients. We noted that all medical and other staff adhered to this policy.

- We saw staff using personal protective equipment such as gloves and disposable aprons in all areas visited. All sizes of gloves were readily available in wall-mounted dispensers.
- Hand sanitiser was available in each room and all waiting areas and we saw staff using the product. Hand hygiene compliance was monitored by measuring the consumption of sanitiser every month. The infection control nurse told us hand-sanitising usage in March was 15.7, which was below the corporate target of 18. As a hand-hygiene product company had been invited to the hospital to provide in-service training and raise awareness, the usage of hand sanitising agents was re-audited in June 2016, which was 21 and better than the corporate target of 18.
- Hand washbasins were installed in all clinical areas. These were medium or large integral back-outlet basins with mixer taps and no plugs. This complied with the Health Building Notes (00-10 (2013): Part C – Sanitary assemblies).
- An infection control link nurse was nominated for each area and their activities coordinated through an infection control sub-committee of the Medical Advisory Committee (MAC). We saw examples of completed infection control audits. These audits help managers and staff to assess the effectiveness of their infection control measures and to pinpoint any areas that might require improvement.
- Waste in clinic rooms was separated and staff used different coloured bins used to identify categories of waste. This allowed the hospital to safely handle biological or hazardous waste safely and was in accordance with HTM 07-01, Control of Substance Hazardous to Health (COSHH) and Health and Safety at Work Regulations.
- We reviewed the department's toy cleaning checklist for the two months before our inspection. We saw that staff had cleaned toys at least weekly in accordance with the toy cleaning policy, which stated the service should clean toys "weekly or after each session". We also saw an 'I am clean' sticker on a box of toys inside consulting room eight. This showed staff had cleaned the toys ready for the next patient.

Environment and equipment

- The outpatient environments we observed supported the safe delivery of diagnosis, treatment and care. For example, consultation rooms were well lit, air-conditioned and equipped with appropriate levels of sterile consumables held in covered trolleys and storage racks.
- The waiting area for children was shared with adults. There was a limited selection of toys and a clear chaperone policy. There were no specifically designed paediatric consulting rooms.
- All rooms had call buzzers fitted so emergency assistance could be summoned. We observed an instance of the alarm being triggered during our inspection and noted the rapid response of staff involved.
- There was access to emergency equipment including oxygen and resuscitation items for adults and children. We saw evidence that staff had inspected and checked this equipment weekly.
- We saw, and staff told us, that the outpatient department did not have baby scales for weighing babies and young toddlers who were unable to stand up. Staff asked the parent to stand on adult scales with their child, before staff weighed the parent alone to calculate their child's weight. This practice has the potential to cause inaccuracies in calculating the weight of babies. We raised this issue with the senior management team, who told us they would look into purchasing a set of appropriate scales for weighing babies. When we returned on our unannounced visit, we saw a newly purchased set of baby scales in the outpatients department. The OPD manager told us the service was waiting for an external company to calibrate the scales before staff started using them.
- Patient examination couches, furniture and equipment were labelled with asset numbers and service or calibration dates. This helped to provided assurance that items were managed and maintained in accordance with manufacturer recommendations.
- We saw sharps bins available in treatment areas and correctly used in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. The bins were secure containers, clearly marked and placed close to work areas where medical sharps were used. The bin labels included clear instructions for staff on safe disposal.

- The Medicines and Healthcare Products Regulatory Agency's Managing Medical Devices (April 2015) states that healthcare organisations should risk assess to ensure that the safety checks carried out on portable electrical equipment are appropriate and reasonably practical. These include pre-use testing of new devices in addition to subsequent maintenance tests. We checked between three and six devices in each of the 14 rooms we visited. Electrical devices were labelled with the dates of the most recent portable appliance safety testing, which provided a visual check that they had been examined to ensure they were safe to use.
- Labels were missing from two wall mounted x-ray viewers and a slit lamp, but we were shown records in the equipment file that provided evidence of recent engineering inspections.
- The departmental health and safety file was reviewed and contained copies of relevant and in-date risk assessments. Each document had signed staff lists attached, which indicated that staff were routinely reading the latest updates. The file also contained staff "hand monitoring" forms designed to help managers detect any staff developing skin reactions to latex gloves or cleaning agents. The file and records were clearly presented and complete.
- In the imaging suite, we saw a number of installed features designed to prevent or minimise accidental exposure to ionising radiation or magnetic fields. Doors were fitted with electronic interlocks that functioned to prevent access when the equipment was operating; emergency stop buttons clearly positioned within the rooms and illuminated warning sign signs fitted to doorways linked to the interlock. Key control systems fitted to the imaging devices helped to prevent uncontrolled or unauthorised use. We saw records that confirmed these protective measures and facilities were registered with the health and safety executive (HSE) and audited annually by an HSE approved radiation protection adviser (RPA).
- There was prominent signage outside the MRI suite that warned patients with pacemakers or other surgical devices not to enter due to the powerful magnetic field generated.
- A computerised system supported the management of equipment maintenance hospital wide. This meant that outpatients and imaging staff had access to equipment records such as asset numbers and details about the service contracts including dates of servicing. The estates manager described a robust timetable of maintaining various systems and equipment internally in additional to biannual or annual maintenance by external companies. We saw examples of equipment files and computer records containing these details.
- Single use items of sterile equipment were readily available and stored appropriately in all areas checked. All items we saw were in date, such as syringes and wound dressings. Correct storage and stock rotation ensured the sterility of items was maintained and risks of cross contamination reduced. We saw these items being used once and disposed afterwards.
- Instruments used for patient treatment that required decontamination and sterilisation were processed through the on-site sterile supplies department.

Medicines

- Both outpatients and imaging had safe systems for ordering, storage and the administration of medicines and contrast mediums, in compliance with the hospital policy 'Management of Medicines in Spire Healthcare' (April 2016).
- We saw medicines in both outpatients and imaging stored in locked cupboards. Registered health professionals held the keys. This was in line with standards for good medicines management and prevented unauthorised access to medicines. Pharmacy staff described a robust process of receiving Medicines and Healthcare Regulatory Agency (MHRA) and NHS Patient Safety Alerts and these were actioned and cascaded appropriately, there was evidence of these being discussed at the medicines management meetings.
- In outpatients, medicines were removed from the locked cupboards at the start of clinic and placed in unlocked clinic rooms with doctors in attendance. During clinic, medicines were the responsibility of the consultant in the clinic.
- Staff explained that the pharmacy arranged for the disposal of any date-expired medicines or unused contrast medium as per the hospital policy.
- In outpatients, each consulting room contained a copy of the British National Formulary (BNF) Issue 71, which was the latest edition in print. The BNF is updated in book form twice a year and details all medicines that are generally prescribed in the UK, with information about indications and dosages, contraindications, cautions

and side effects. It is considered an essential resource for safe prescribing and the availability of the latest copy indicted that an appropriate level of support was provided to the consultant in clinic.

- Consultants hand-wrote prescriptions on private prescription (SPF100) forms. Each prescription had a serial number on it. A registered nurse gave a pad to each doctor at the start of clinic who kept the pad with them. The pads were then checked and stored in a locked room at the end of clinic. This reduced the chance of prescription forms being lost or stolen.
- The hospital used an electronic system for requesting x-ray, MRI or other diagnostic tests. We saw that the system provided for authorisation and audit. This meant that imaging requests made by GP's or other practitioners was only made by approved persons in accordance with IR(ME)R.
- We saw that medicines requiring storage in a temperature-controlled environment were held in designated drug fridges. These could be locked and incorporated digital thermometers with an easily readable display that allowed performance to be monitored. Staff undertook fridge temperature checks daily and recorded on a standardised form. Staff could describe the process of dealing with out of range temperatures and showed us the policy explaining the process, which included reporting it as an incident on the electronic reporting system
- We noted an incident report from the week prior to our visit, when a health care assistant realised that emergency drugs stored on a resuscitation trolley were at risk of heat damage during a spell of very hot weather. Demonstrating commendable initiative, the assistant moved the trolley into an air-conditioned room and immediately informed the nurse in charge. The hospital resuscitation team and key staff were then all informed of the trolley location, temporary signs employed and the incident logged on the hospital's risk reporting system. These actions helped to ensure the drugs retained their clinical effectiveness and prevented unnecessary financial loss to the hospital.
- The hospital followed a corporate policy designed to detect and prevent contrast-induced nephropathy (CIN), which is kidney injury in susceptible individuals caused by the use of contrast media in imaging. We saw staff taking blood samples from patients that enabled the doctors to check for CIN. This follows the Royal College of Radiologists Standards for Intravascular contrast agent administration.

Records

- The hospital supplied information that showed one percent of patients were seen in outpatients without all relevant medical records being available. This is lower than other hospitals we hold data for. Staff confirmed these figures when we spoke to them.
- Staff told us the hospital kept patient outpatient records on-site and specially designed self-inking 'patient history & continuation sheets' were available in all rooms we visited. This meant that the original notes were kept in the hospital held medical record. This also enabled clinicians to retain a copy of the medical notes should these be required to be put in notes held elsewhere. This allowed hospital staff to access patient records to assist with clinical decision-making and keep up-to-date documentation. Completion of accurate and contemporaneous medical records formed part of the practicing privileges agreement for all consultants, who also were also registered data controllers with the Information Commissioning Office (ICO) as part of this agreement.
- We saw the hospital's paediatric risk management OPD register. This contained a log of all children who attended outpatients, including their reason for attendance, evidence of verbal consent for procedures such as blood taking, and who accompanied them. We saw that the register was legible, fully completed and up to date. We saw that staff held the register securely in a locked cupboard to maintain confidentiality in line with the Data Protection Act 1998.

Safeguarding

- The hospital had 32 staff involved in treating children. At the time of our visit, we saw records that showed 14 of these had completed safeguarding children level three training. This included nine members of staff from outpatients and diagnostics. A further seven members of staff had started, but not completed, safeguarding level three training. All other staff involved in treated children had enrolled on the course, but had not yet started. This showed the hospital was working towards all staff involved in treating children having safeguarding level three training in line with national guidance from

the intercollegiate document "Safeguarding Children and Young People: Role and Competencies for Health Care Staff" (March 2014). We saw the hospital's updated paediatric policy introduced in July 2016. The policy was easily accessible in the outpatients' paediatric folder, and stated, "Spire has made available a level three online safeguarding training module. The requirement is for this to be repeated every three years".

- The outpatients' paediatric folder included evidence of risk assessment for children who needed minor interventional procedures, such as blood taking. The registered children's nurse, who had level three safeguarding training, performed all risk assessments for children who needed to have a procedure performed by a member of staff trained to safeguarding level two. A nurse told us the department delayed procedures if the registered children's nurse was not available to perform a risk assessment. However, now that more OPD staff had level three training, risk assessment was often not necessary, as there was usually a member of staff with level three training available to perform the procedure. We saw from the paediatric register that the registered children's nurse was available for all children's outpatient procedures in January – June 2016.
- We saw a paediatric policy for chaperones used for older children or adolescents who attended appointments without a parent or guardian. Staff knew how to access this and circumstances in which they may need to use it. However, a nurse told us most children attended with their parents. We saw that the paediatric register documented next to every child seen in outpatients whether they attended with a parent or guardian. In all the records we examined, we saw that a parent or guardian had accompanied their child.
- Staff we spoke with demonstrated a good awareness of what to do if they had safeguarding concerns and could identify the hospital's safeguarding lead. The safeguarding lead told us about the recent safeguarding referral at the hospital. A physiotherapist (level 2 trained) raised a concern with the safeguarding lead. The incident was referred to the local safeguarding team who increased the support available to the patient including additional multidisciplinary involvement in her care. The patient's operation was cancelled because hospital staff were concerned the patient would not have a safe discharge destination following surgery, it was later conducted at another organisation. Following this referral, members of the patient's family contacted the hospital, to thank them for the way they had handled the situation.
- Minutes of the clinical governance meetings showed safeguarding was discussed as a standing item on the agenda.

Mandatory training

- All staff completed mandatory training using online learning and face-to-face training. This included modules in Duty of Candour and the Mental Capacity Act 2005. Compliance rates were monitored and staff advised to attend refresher training when necessary.
- We were shown data that indicated OPD and imaging achieved 97% compliance. This was better than the Spire Healthcare target of 95%.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if requested.

Assessing and responding to patient risk

- Immediate or emergency assistance could be summoned by the use of the hospital "crash call" or resuscitation team. Medical assistance was provided by the resident medical officer (RMO) and the patient's consultant.
- There were clear and known protocols in place for the transfer of patients to the local NHS accident and emergency facility by ambulance.
- The paediatric risk register contained information about every child that was seen. It was documented whether they attended with a parent or guardian and whether the paediatric nurse was available.
- We saw good practice for reducing exposure to radiation in the diagnostic imaging department. For example, local rules were available in every area we visited and signed by all members of staff, which indicated they had read the rules. We also noted imaging protocols and policies stored in folders in each room and that staff demonstrated a clear understanding of these protocols.
- We observed good radiation compliance during our visit. The department displayed clear warning notices, doors were shut during examination and warning lights were illuminated. We saw radiographers referring to the Ionising Radiation (Medical Exposure) Regulations 2000

Good

Outpatients and diagnostic imaging

(IRMER) for patient's examinations. A radiation protection supervisor was on site for each diagnostic test and a radiation protection adviser was contactable if required, which complied with IRMER.

- The Radiation Protection Advisor performed an annual quality assurance check on equipment in the diagnostic imaging department. Departmental staff also carried out regular checks. This helped to assure the hospital that equipment was working correctly and these mandatory checks were in line with Ionising Regulations 1999 and the IRMER 2000. We saw records of these checks during our visit.
- Lead aprons limit exposure to radiation to keep patients safe. We saw lead aprons available in all imaging areas of the department.
- Signs advising women who may be pregnant to inform staff were clearly displayed in the x-ray area, in line with best practice. Pregnancy tests were completed to confirm status for relevant procedures. This helped the hospital prevent potentially harmful exposure to radiation to unborn babies.

Nursing staffing

- Nursing cover was calculated dependent on the number of clinics running and the numbers of patients attending clinic as well as other factors such as procedure support and chaperoning.
- Registered nurses and health care assistants (HCA) staffed the outpatient clinics. We learned that that either overtime was paid or a bank nurse called in when required. No agency staff were used in the department. We saw sufficient staff present during our inspection.
- Staff turnover within the department was low with only one member of nursing staff leaving in the last year. There was no turnover in the HCA staff group which meant the team were stable and experienced. The sister in charge stated that the nursing figure was due to positive factors such as promotion and we saw that sickness rates for all staff were below the average when compared to other independent hospitals.
- The hospital reported they had no unfilled shifts during the last three months. This meant the service had sufficient nursing staff on all shifts to provide appropriate care and support.

Medical staffing

- RMOs working at the hospital had advanced paediatric life support (APLS) training. The RMO on duty at the time of our inspection showed us evidence of their training in this area. This ensured the hospital always had a member of staff with APLS training on the premises to respond to any paediatric emergencies. The registered children's nurse also planned to undertake a European paediatric advanced life support (EPALS) course in 2016.
- Radiology consultants were on-site during clinic hours to cover urgent work and the reporting requirements for the hospital. In addition, the radiology consortium provided an on-call service that used image-sharing computer software.
- OPD clinics were timetabled to suit each specialist's availability and obligation as part of the consultant's practicing privileges contract. Consultants in clinic could be assisted by the RMO in cases where urgent or additional medical support was required.

Radiology staffing

- There was no staff turnover within this area in the previous 12 months and the manager stated that sickness was low.

Major incident awareness and training

- Staff described participating in regular medical emergency simulations, for example, cardiac arrest, and reported the learning experience in positive terms.
- We were shown an in-date version of the policy for radiation incidents. This indicated that the hospital has considered potential risks to safety and had prepared responses for any such eventuality. Likewise, we noted a current version (issued on November 2015) of the business continuity policy.
- We saw assurance that essential electrical services to the department could be maintained by the use of a specially installed back-up generator. The generator was designed to responds within 20 seconds of a mains outage and we saw evidence that the system was tested monthly in addition to biannual maintenance and servicing by an approved contractor.

Are outpatients and diagnostic imaging services effective?

- There was evidence of good team working in clinics, within the diagnostic imaging department and across the specialities.

Good

Outpatients and diagnostic imaging

- The outpatients and diagnostic imaging departments had undertaken local audits to monitor the quality, safety and effectiveness of care. Care was delivered by a range of skilled staff that participated in annual appraisals and had access to further training as required.
- Staff in all areas had a good awareness of Spire Healthcare policies, which were, based National Institute for Health and Care Excellence (NICE) guidelines. We saw staff demonstrating Royal College of Radiology standards in their imaging practise.

Evidence-based care and treatment

- Policy documents were updated regularly by Spire Healthcare and cascaded to the hospital for implementation. These were available on the hospital intranet as well as in files located in the OPD staff office. We also saw local policies and standard operating procedures such as a laser rules statement.
- We saw how policies were disseminated to staff to read, sign and implement using tracker documents to confirm understanding and their compliance. New NICE guidelines were sent to the hospital monthly by Spire's central governance team. These were assessed within the hospital for their relevance by the medical advisory committee (MAC) and cascaded, including to Consultants.
- The hospital's MAC met quarterly to review clinical performance, incidents and complaints and obtain feedback from the consultant body on new developments and initiatives from within the various specialities.
- Staff followed the National Institute for Health and Care Excellence (NICE) and Royal College of Radiologists standards in the speciality areas we visited. We saw evidence of checks and audits that demonstrated the department monitored compliance with these guidelines.
- Audits included environmental, hand washing and infection control checks and the results of these were shared among staff. We observed examples shared in monthly team meeting notes and on staff notice boards

Pain relief

- The OPD had stocks of "over-the-counter" pain relieving medication, such as paracetamol, which they could give to patients as required. If anything stronger was needed the consultant in clinic wrote a prescription.
- Staff used a pain assessment tool where patients were asked to score discomfort based on a range from 0-10, however we did not observe any instances in clinic where patients complained of pain. The use of a pain scoring system allowed staff to give appropriate medication or support with alternative pain management techniques and review the effectiveness of the intervention.

Patient outcomes

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

Competent staff

- All new staff had an induction package, which included core competencies, and knowledge that was signed off by their line manager. We saw examples of this in the staff files for nurses and radiographers we reviewed.
- Hospital data showed 100% of staff received a performance appraisal between April 2015 - March 2016.
- In addition, staff files contained evidence of regular performance meetings between appraisals. Regular appraisals and reviews allowed the hospital to identify and monitor staff performance and personal development.
- There was a robust performance management system in place. Concerns about staff performance were initially dealt with through informal discussions that were documented in the staff file. If concerns continued, the formal process was triggered in consultation with the HR lead supported by a third party HR support partnership. We were told this had never been necessary.

- Staff had training in the newly implemented dementia care policy.
- There were processes in place for confirmation of practicing privileges. Consultants were offered privileges by the MAC only after HR had received the necessary assurance documentation.
- All appraisals were shared by the consultant following their appraisal with the NHS trust in which they worked. Where the hospital director provided information for NHS appraisals, this routinely included data relating to that particular consultants practice such as surgical site infections, complaints and morbidity and mortality, which also reflected outcomes collected by the Hospital as part of their biennial practising privilege reviews.

Multidisciplinary working (related to this core service)

- We also saw effective multi-disciplinary working between all professions and grades of staff. This included housekeeping and pharmacy staff.
- There was consistent evidence of close collaboration across different services within outpatients and diagnostic imaging. Staff told us they felt well supported by other staff groups and there was good communication within the teams.
- We heard positive feedback from staff at all grades about the excellent teamwork within the hospital generally.

Seven-day services

- The MRI facility operated seven days a week and diagnostic imaging department provided a 24-hour on-call service for urgent examination requests. In addition, the hospital contracted with a consortium of local radiologists to provide on-call specialist support. The radiologists were also employed by the local NHS trust which, according to the specialist we spoke to enabled the hospital to quickly access support and assistance in a variety of specialist radiology topics. This allowed staff to access diagnostic services in a timely way to support clinical decision-making.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw "Spire Healthcare parental agreement to investigation or treatment for a child or young person" forms. Parents or legal guardians signed these consents on behalf of young children who were not competent to provide consent. We saw that these forms also had a space for children to sign as well as the parent to show their involvement in decisions about their treatment. The associated guidance stated, "It is good practice when a person with parental responsibility signs the consent form to involve the child in the decision making and to allow them to countersign the consent form where the child's level of development allows".
- Consultants took consent, and assessed Gillick competence for young people under the age of 16. This was the statutory process for assessing that children under the age of 16 were competent to make decisions about their own care and treatment. We saw clear guidelines available to staff in the paediatrics folder in outpatients.
- We saw clear documentation of parental verbal consent in the paediatric risk register for children who had minor interventional procedures such as blood taking in outpatients.
- We saw examples of verbal consent demonstrated in the x-ray room.
- The provider had a policy to guide staff in the correct interpretation and implementation of the Mental Capacity Act 2005 (MCA). Nursing staff we spoke to demonstrated awareness of how the Mental Capacity Act 2005 related to their practise and were aware of who to contact if they required guidance.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good

We rated the outpatient and diagnostic services at Spire Tunbridge Wells Hospital as good for caring. This was because:

- People were treated with kindness, dignity, respect and compassion whilst they received care and treatment.
- Consulting and clinical treatment room doors were kept closed, and staff knocked before entering clinic rooms to maintain patients' privacy. All clinic room doors had "free/engaged" signs and we observed staff using these consistently.
- Patients and relatives commented very positively about the care provided to them by the staff from the clinics we visited.
- All comment cards were positive with comments on helpfulness, kindness, standard of care and the cleanliness of the environment.

Compassionate care

- We received 15 comment cards from patients at the hospital. The comments were very positive and praised the hospital staff and environment. Patients talked about staff being "excellent, efficient and courteous". An x-ray patient stated "Care has been excellent. Extremely friendly and helpful staff including surgeon, x-ray people, chef. I've been here a lot over the last six months and had excellent care throughout."
- These comments were consistent with patient satisfaction data we reviewed, which detailed the responses of 1,198 patients from all areas of the hospital over the last year. For example, monthly satisfaction rates for "care and attention from the nurses" was higher than the Spire target of 98% 10 times in the last 13 months and reached 100% on separate months.
- A patient told us that staff and their consultant explained things in detail and allowed time for any questions. Patients also reported feeling part of the decision-making about their treatment and care.
- Again, these aspects were highly rated in the satisfaction data, with consultants being scored above 98% on 11 out of 13 months, and OPD nurses scoring above 97% 12 out of 13 months. Physiotherapy also scored highly although imaging/x-ray patient satisfaction scores dipped below the Spire target of 97% for the last five months. The only reason that the department found for this were the recent changes in staffing. The current manager had only been in post for six weeks.
- In the imaging suite, we saw staff ensuring that patients' dignity was maintained despite the need to wear examination gowns during the process.
- We saw posters displayed informing patients of their right to request a chaperone for any consultation, examination or treatment. Staff told us they offered patients a chaperone before any intimate examination or procedure and were able to anticipate requests based on the clinic schedule. We saw the OPD log, which recorded whether each patient used or declined a chaperone.

Understanding and involvement of patients and those close to them

- Staff photographs and names were clearly and legibly displayed on the waiting room wall, which helped patients and visitors identify key staff encountered during their visit.
- A range of literature and health education leaflets was also on display in the waiting area.
- The radiology suite had safety notices in several languages.
- Between 88% and 95% of patients surveyed by the hospital felt they were involved as much as they wanted to be in decisions about their care, exceeding the target of 91% on 11 occasions in the last 13 months.

Emotional support

- Patients told us that staff and consultants working in the outpatient clinics were approachable and "had the time to explain everything". Information such as side effects of medicine was also made clear.
- We saw relatives being invited to accompany patients into consultation rooms, which indicated that the hospital encouraged a friend or partner to attend the appointment in order to provide emotional support.
- Again, our observation was consistent with the hospital's own survey, which showed that between 85% and 100% of patients found someone on the hospital staff to talk to about their worries and fears. This exceeded the target of 88% on 11 occasions over the last 13 months.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated the outpatient and diagnostic services at Spire Tunbridge Wells Hospital as good for responsive. This was because:

- For NHS patients, referral to treatment times was better than the England average for the last year.
- Patients were kept well informed of waiting times in some clinics and delays rarely occurred.
- Services had been planned and were being delivered to meet the needs of the client group.
- People's concerns and complaints were listened and responded to and feedback was used to improve the quality of care.

Service planning and delivery to meet the needs of local people

- A range of outpatient clinics were made available to meet the needs of the client group. According to data provided by the hospital, this included: Orthopaedics, General surgery, ENT, Cosmetic surgery, Urology, Neurology, Ophthalmology, Gynaecology, Physiotherapy, Breast surgery, Medicine, Gastroenterology, Cardiology, Pain management, Dermatology, Rheumatology , Paediatrician, Oral surgery, Endocrinology, Dietetics or Nutrition, Oncology, Vascular, Psychiatry, and podiatry and respiratory medicine. Orthopaedics and ENT being the highest percentage of attendances,
- These outpatient clinics were supported by diagnostic services including Magnetic Resonance Imaging (MRI) scans, x-ray, Computerised Tomography (CT) scans and ultrasound scans. These facilities supported clinical decision-making by the treating specialists.
- Outpatients and imaging departments coordinated activities to provide a 'one stop breast clinic', which enabled patients to undergo breast assessment, specialised breast scanning including mammography and feedback in one convenient appointment.
- Evening and Saturday outpatient clinics were routinely offered, which afforded additional choice and convenience to patients and particularly those that worked or had childcare commitments during the week.
- The environment provided by the hospital met the needs of the patient, with comfortable and sufficient seating, toilets and refreshment facilities. Free car parking was also provided on-site.

Access and flow

- GPs referred the majority of new patients attending the department. We were told that physiotherapy and referrals from other registered practitioners were also accepted by insurers.
- The hospital exceeded the target of 92% for NHS patients beginning treatment within 18 weeks of referral for each month in the reporting period (April 2015 - Mar 2016). During the same period, no patients waited six weeks or longer from referral to test for MRI, CT or non-obstetric ultrasound.
- Follow up appointments were arranged according to the request of consultants and the needs of patients.
- Opening hours for outpatient clinics varied and specific clinics were held on different days and at variable times to ensure that there was provision for patients with restricted availability.
- We were told that delays in Outpatients did not happen often and we were shown appointment lists that supported this. Staff and managers expressed strong commitment to the efficiency of the departments and gave examples of their responses when clinics ran late. Patients were kept informed and personal apologies made when there were delays.
- If a clinic ran behind schedule staff provided refreshments including light meals.

Meeting people's individual needs

- Hearing loops were available in the waiting area, which helped those who used hearing aids to access services on an equal basis to others.
- We were shown details of a telephone translation service used by the hospital. The staff we spoke to were aware of the facility.
- We observed the waiting room and clinic areas to be accessible to all including wheelchair users. This included level access from the car park set down area and automatic entry doors at the main entry as well as entrances to the departments.

Good

Outpatients and diagnostic imaging

- The outpatients department had toy boxes available to provide distraction and comfort to child patients. We saw two different toy boxes for different age groups. One contained age-appropriate toys for toddlers, and the other had toys suitable for slightly older children.
- There was also a small children's area in the waiting room. On the day of our visit, this area only contained four stools, abacus beads on a table, and two books. However, the hospital told us that during children's clinics, and on request at any other time, the service provided additional toys and colouring sheets.Staff did not leave these items out continuously so as to keep the area clear and tidy, but regularly offered them when a child attended with their parent during an adult clinic.
- The Matron told us all seats and sofas in the waiting area were suitable for bariatric patients. We saw that the seats appeared to be very sturdy. This allowed bariatric patients to sit anywhere they chose.
- According to the dementia lead, the hospital did not treat many patients living with dementia. Approximately one every 2-3 months. These patients were mainly those with mild confusion. The hospital was keen to expand their service for this client group. Dementia information folders had been prepared to help inform staff in every department of the hospital and we saw these located in the nurses' office. The service used dementia passports, which were given to patients and carers at the pre-assessment clinic. We were shown activity boxes available to patients living with dementia. These contained materials to help occupy patients while they were in hospital and help reduce any anxieties. The boxes included adult-appropriate colouring books and pencils, stress balls, 1950s memorabilia and flashcards to aid communication.

Learning from complaints and concerns

- The hospital received 33 complaints between April 2015 and March 2016. These were all resolved at a local level and were not escalated to the Ombudsman. Staff at all levels described an open and honest culture and a willingness to accept responsibility for any shortcomings.
- There was a robust system in place for capturing learning from complaints and incidents. The senior management team "signed off" every complaint, which was logged onto the incident reporting software. Anonymised complaint logs were used to help inform all staff and changes were fed back through the heads of departments to frontline staff.
- Concerns picked up through surveys and comment cards were acted upon. The matron discussed any concerns or complaints received with the departmental manager as soon as possible. The OPD manager told us they "couldn't recall" a recent complaint relating to the department.
- All written complaints were acknowledged within two days of receipt or within five days if a full answer could be provided. If more investigation was required, this was within a 20-day timescale in accordance with the hospitals policy. The hospital used a corporate "Please talk to us leaflet" that was sent with the acknowledgement to help inform the complainant of the process and their rights.
- Where complaints involved clinical care, the consultant responsible for the patient's care was contacted and involved in the investigation.
- All complaints were reported to the Spire Healthcare head office via the regional reporting structure. This enabled all Spire Healthcare hospitals to learn from complaints within the group.
- We saw child feedback forms in the outpatients department. These were simple and child-friendly, and used pictures as well as words for children unable to read. Children gave feedback by ticking an appropriate box to show how they felt about the hospital. This enabled the hospital to receive feedback from its youngest patients who may not be able to write.

Are outpatients and diagnostic imaging services well-led?

Good

We rated the outpatient and diagnostic services at Spire Tunbridge Wells Hospital as good for well led. This was because:

- There were high levels of staff satisfaction across all areas in OPD. Staff expressed pride in the organisation

as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff and staff at all levels were actively encouraged to raise concerns.
- We saw strong collaboration and support across all functions and a common focus on improving quality of care and people's experiences.
- The governance framework ensured staff responsibilities were clear and that quality, performance and risks were all understood and managed.
- The leadership and culture reflected the vision and values of the organisation, and encouraged openness and transparency that promoted good quality care.
- The senior management team were highly visible and engaged with staff and patients on a frequent basis.

Vision and strategy for this core service

- Staff we spoke to were clear about the values of the organisation and were committed to working towards achieving the broad vision and strategy.

Governance, risk management and quality measurement for this core service

- Nursing and radiology leads reported to the matron who, as part of the hospital senior management team was accountable to the hospital director.
- There were good structures for reporting against the governance framework in place for all Spire Healthcare hospitals with regional and national benchmarking against other Spire Healthcare hospitals.
- The provider had an electronic incident reporting system that fully linked complaints, incidents and risk reporting. This assisted managers in monitoring processes and identify any developing trends or patterns.
- The safety records were monitored monthly by the executive team. Lessons learned were discussed and disseminated across the organisation.
- There were very clear lines of accountability and responsibility with explicit and effective information flow pathways.
- The Senior Management Team (SMT) also received information from the monthly heads of departments meetings. Once the SMT had reviewed and considered the information, they produced an integrated governance report that was fed upwards to the Provider's central Clinical Governance and Quality Committee for central review and feedback.
- The SMT explained that updates to NICE guidance or safety alerts were sent monthly from corporate level and shared via the heads of department meetings. We saw examples of this in the meeting notes we reviewed.

Leadership / culture of service

- All staff we spoke to felt managers and the hospital SMT were open and approachable. At the staff focus group, we heard that staff felt established at the hospital and had worked there for many years. They described the senior management as being very visible and they felt able to discuss any issues on a daily basis. The SMT had an open door approach and during busy days, they visited at least twice daily to "ensure the day was going smoothly".
- We saw excellent examples of local leadership in the nursing and physiotherapy areas. For instance, a health care assistant (HCA) told us about the support she received when a consultant "demanded a trained nurse" instead of an HCA to run his clinic. The nurse manager intervened and explained that the HCA was assessed as competent to run the clinic, the consultant apologised to the HCA.
- Staff said that they enjoyed coming to work and that they were passionate about the care they gave to patients.

Public and staff engagement

- At all levels, the staff we spoke to expressed pride in their teams and the services they provided. As part of the inspection process, comment cards were circulated to all departments. There were five cards returned by staff that worked in the outpatient department. All were very positive about the open culture and teamwork at the Hospital.
- The hospital had recently commenced staff forums, where staff from all departments could attend to discuss any issues or concerns and share ideas and learning. This was advertised in the June 2016 newsletter.
- Senior nursing and radiology staff were particularly proud of the positive relationships with consultants. In the last Spire Healthcare consultant survey (2015), the OPD Manager, OPD Sisters and OPD staff all scored 97-100% overall consultant satisfaction. These were the highest scores in the Spire network in this survey out of 38 hospitals.

Innovation, improvement and sustainability

Good

Outpatients and diagnostic imaging

- There was good internal promotion and opportunities to undertake further training and education.
- The hospital Matron was a key individual in the development of Spire Healthcare's corporate policy for Children and Young People, which reflected the latest best practice and national guidance.
- The hospital had an "Inspiring People" programme where staff were encouraged to identify innovative ideas to enhance services for patients and their colleagues and regular awards were given for the best ideas. The scheme was also used to recognise staff who had gone "above and beyond" for a patient, visitor or colleague. Exceptional ideas or performance were nominated for the Spire group national annual awards ceremony.
- The senior management team told us that the hospital's activity volue had increased by 11% in 2016, which was better than the target of 5%. The hospital provided MRI services to NHS patients through a contract with the local trust that was contributing to this increase.
- The hospital used a corporate clinical benchmarking system, which ensured the hospital regularly reviewed its clinical performance and benchmarked this against other hospitals. This helped the service work towards continuous improvement.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital had systems and processes in place that supported staff in providing a good service.
- The catering department met both patients and staff individual requirements, and visited with patients daily.
- The leadership from the senior management team was described as approachable, available and visible.
- Patients and their families were cared for by kind and compassionate staff who went out of their way to support them.
- Two-hourly patient "quality rounds" on the ward, led by the nurse-in-charge.
- Regular scenario-based training to ensure staff responded appropriately to emergency situations was undertaken.

Areas for improvement

Action the provider SHOULD take to improve
Action the hospital SHOULD take to improve

- Provide written information such as leaflets in other languages for patients whose first language is not English.
- Ensure that if a patient declines a chaperone this is recorded in the patient's notes for inpatients, in line with hospital policy.
- Consider making the layout of some rooms on the ward more accessible for wheelchair users.
- Consider providing training to ward staff to help them better meet the needs of physically disabled patients.
- In order to monitor and assure staff equality, the provider should ensure that they comply with reporting requirements for the Workforce Race Equality Standard.
- Consider using observational hand hygiene audits to monitor hand washing.
- Ensure dedicated hand hygiene sinks in patient bedrooms are included when carrying out refurbishment in accordance with the Department of Health's Health Building Note 00-09.
- The hospital should progress Joint Advisory Group (JAG) accreditation for endoscopy services.