

Spire Healthcare Limited

Spire Southampton Hospital

Quality Report

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November 2014

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Southampton Hospital, part of Spire Healthcare, offers comprehensive private hospital treatments, procedures, tests and scans to patients from Hampshire, Dorset, Wiltshire, the Isle of Wight, the south coast of England and the Channel Islands.

The hospital offers a range of surgical procedures, cancer care, rapid access to assessment and investigation and a physiotherapy service for women's health and pain management. Acupuncture, massage and hydrotherapy was also available. Patients are admitted for elective surgery, day case or outpatient care. There are no emergency admissions. Patients requiring an emergency admission are usually triaged through the high dependency unit (HDU) before a decision is taken to manage their care in HDU or if they are safe to move to a ward.

Facilities included 78 beds, of these 59 are en-suite patient bedrooms, 12 beds in day care, and seven in the intensive care unit and high dependency unit. There are five theatres, outpatient facilities, a cancer care suite (The Chalybeate Suite) and the Perform Centre for physiotherapy and pre-assessment.

Services were available to people who held private insurance or to those paying for one-off private treatment. Fixed prices, agreed in advance, were available. The hospital also offered services to NHS patients on behalf of the NHS through local contractual agreements and 30% of its activity was NHS funded care.

Spire Southampton Hospital was selected for a comprehensive inspection as part of the first wave of independent healthcare inspections. The inspection was conducted using the care quality commissions new inspection methodology.

The team of 20 included CQC inspectors and analysts, doctors, nurses, experts by experience and senior managers. The inspection took place on 22 and 23 October 2014, with unannounced visit on 3 November 2014.

The inspection team looked at the following core services: Medical care, surgery, critical care, services for children and young people, outpatient and diagnostic imaging services.

Our key findings were as follows:

Are services safe?

- There was an open culture and learning environment for reporting incidents. The staff reported incidents using an electronic reporting system. Outcomes and learning from incidents was cascaded to staff. The numbers of serious incidents in the hospital compared to patient and bed numbers was low (better than expected). However, the timeliness of investigations following incidents needed to improve in some areas, for example, theatres.
- There were good infection control surveillance procedures to identify and manage infections. However, procedures for infection prevention and control were not always followed, and the fabric of the building and the design of some areas increased the risk of cross infection.
- Patients, other than those receiving critical care, were cared for in single rooms with ensuite facilities. The critical care unit was adjacent to and open to the operating department theatre. The Critical Care Unit was built prior to the present building guidance. This meant the bed spaces and facilities did not meet current guidance. The space was smaller than expected but this did not have an adverse impact on patient outcomes. Some daily equipment checks had not been done on the critical care unit.
- The hospital building was 30 years old and some areas required updating. The outpatients department was undergoing renovation to increase the number of consulting rooms and improve facilities. There was not enough storage space and equipment was in corridors. We observed that this was kept as tidy as possible.

Summary of findings

- Most medicines were stored and managed in safe way. However, there was limited space in the critical care unit and the storage of intravenous infusion fluids did not reflect best practice. The expiry date for liquid medicines was not being appropriately recorded, and intravenous fluids not recommended for use in children were stored on the paediatric resuscitation trolley.
- The pharmacy department had good governance systems to monitor new drugs, off licence drugs, safety and drug alerts and incidents. There was a medicines reconciliation service on admission and audits on prescribing on the wards. Local medicines policies were up to date and the medication error rate was low (0.28%, between January to March 2014). There reporting of near misses was improving but the pharmacy department needed more time to verify medicines. The pharmacy department had limited capacity in terms of staffing levels, and stock control arrangements were limiting the amount of time available to provide a clinical service.
- A single patient record was used by all professionals. These were mainly complete but consultant and nursing staff signatures and dated entries required improvement. The documentation for cardiac patients was incomplete and there was not an appropriate care pathway plan for neuro-surgical patients on the critical care unit. Outpatient records belonged to consultants and were not always consolidated with the hospital's inpatient records. The hospital was working to improve this.
- The early warning score was used to identify and monitor patients whose condition might deteriorate, but there was not an age appropriate paediatric early warning score and this needed to be addressed
- Staff were aware of their responsibility to safeguard adults and children and the action to take if there was a concern. However, not all staff had completed appropriate training. This had been identified as an area for action and there was on-going training.
- Staff had been working flexibly to ensure that safe staffing levels were maintained while a recruitment campaign was underway. To manage costs appropriately, staffing was matched to activity. Many staff worked overtime and as part of a bank to cover vacancies or for example, if theatre lists overran; agency staff were not used. Recruitment was on-going in the hospital but staff in all areas expressed some concern about the need to quickly improve recruitment processes as working long hours was becoming difficult.
- Staffing levels in pre-assessment meant that not all patients could be reviewed prior to admission and, staffing levels in the recovery area of the operating department did not always meet national guidelines.
- The children's service was small and was staffed in line with national guidance for surgical, medical and theatre staff and for nurses on duty for the number of children. The service was not in line with national guidance, however, when only one registered paediatric nurse was on the day care unit and children were inpatients, and there needed to be a paediatric nurse on call. There were paediatric link nurses on the wards but some nursing staff did not feel they had the appropriate training to care for children. Staff training for the care of older children was being developed.
- Consultants were required to be available within 30 minutes when they had patients in the hospital and this on call procedure was adhered to. Intensivists were on call to support patients in the critical care unit. There was a resident medical officer (RMO) in the hospital at all times. In case of an unexpected emergency, the hospital had a resuscitation team consisting of the RMO, a critical care nurse, a senior nurse and an operating department practitioner. Staff in the operating theatre and a general anaesthetist were also on call.

Are services effective?

- Local policies and care pathways to treat patients followed national guidance. Research and the introduction of and new technologies were introduced formally and through appropriate governance arrangements. The policies and procedures in the critical care unit were out of date but these were being reviewed to ensure they were in line with current guidance.
- The hospital did not have an end of life care pathway but appropriate steps were taken for patients, for example, palliative care patients who had requested admission. There were good procedures for when someone died, particularly in terms of responding to the needs of the family, spiritual needs and undertaking procedures for a coroner's inquest.

Summary of findings

- Patient's had appropriate pain relief but the critical care unit needed to develop pain assessments tools for all patients to ensure patient's pain relief was adequate.
- Patients had appropriate nutrition and hydration. They were offered a choice of meals and alternative meals could be provided if required and special diets were catered for. For those patients unable to take food orally there was guidance for patients to receive nutrition through tube feeds or through an infusion. A dietician was available to offer support and guidance
- The hospital reported mortality rates were lower than national average for cardiac surgery, although audit needed to improve to demonstrate compliance with standards overall and patient outcomes.
- There was good multi-disciplinary team working to coordinate care for patients.
- Services were supported by dedicated staff: For example, the weight loss service was supported by a dietician and a specialist nurse. The cancer service had a specialist breast care nurse and there was a cosmetic surgery nurse to support patients undergoing cosmetic procedures.
- Staff had annual appraisals which was linked to personal development plans. The completion of mandatory training did not meet hospital targets in 2013, but the hospital was on track this year (2014). However, the completion of other specialist training and staff supervision needed to improve. The competency assessments and reviews for staff on the critical care unit had not been maintained and this was identified as an area for action. The majority (92.3%) of core staff had immediate life support training for adults but more staff overall needed to do basic and immediate life support training for adults and children.
- Staff did not have an understanding of the Mental Capacity Act 2005 and the deprivation of liberty safeguards. For example, staff did not recognise that sedation and the use of bed rails in the critical care unit were considered types of restraint. This had been identified as an area for action.

Are services caring?

- Staff were caring and compassionate and treated patients with dignity and respect. Patients were positive about services and told us they felt well-cared for.
- Patients told us they were involved in their care plans and were able to make informed decisions and choices
- The hospital had recorded high Friends and Family Tests scores for both privately funded and NHS funded patients who had responded to the survey.
- We received 22 comment cards from patients that were overwhelmingly positive about their experience of care and treatment. Patients reported excellent, professional and caring staff and good information about their care and treatment. Only one patient commented about the need for more support when having flat bed rest.
- The patient led assessment of the care environment (PLACE) conducted in June 2014 was positive. Although no comparative scores were provided, there were no actions identified for the hospital's environment and facilities, cleanliness, food, and privacy, dignity and well-being.

Are services responsive?

- Patient operations and procedures were rarely cancelled.
- The hospital undertakes 30% NHS funded care. There was no differentiation between NHS or private patients, although theatre staff noted that if cancellations were required this would more likely be for NHS patients.
- The majority of MRI and CT scans were not being reported within 48 hours.
- The hospital did not have dedicated facilities for children. When children were treated there was a paediatric nurse and the toys, and appropriate bed linen, were made available in the adult outpatient and inpatient areas"
- Children with a learning disability would be supported by a play specialist at pre-admission. There was no specialist support for adults with a learning disability, and staff had not received any dementia awareness training. The management team were actively addressing the concern about dementia awareness and an e-learning training package had been launched.

Summary of findings

- Patients were positive about the information they received to help them in making decisions. Written information was available to support verbal information, however this was only available in standard English text. There were some information leaflets about children's procedures but these had not been specifically written for children to understand.
- The hospital had received 88 complaints (1 April to 31 August 2014) and 52% were responded to within the hospital's target timescale of 20 days. Patients were informed and kept up to date if their complaints took longer, and this was in line with the hospital's policy. The hospital had not identified any themes in their analysis of complaints, but the number was increasing from previous years and showed higher levels involving clinical care from nurses and doctors. Complaints were taken seriously and investigated with the outcomes shared with the person making the complaint. The majority of complaints had been upheld and patients were reimbursed or compensated appropriately. The learning from complaints was cascaded to staff.

Are services well led?

- There were consultants from each speciality who represented their speciality at the hospital's medical advisory committee (MAC). There were regular meetings held with the hospital management team and there was liaison with other consultants via email, minutes, and meetings where necessary.
- There were heads of departments, and ward and department managers. There were medical leads for each service speciality represented on the hospital MAC.
- Team and department meetings were used to discuss service and governance issues, such as complaints, incidents and audits. However, governance arrangements in the critical care unit and in the paediatric service needed to improve.
- Staff were positive about the hospital as a place of work. There was a supportive and open culture and staff felt that ward and department managers were approachable as were the hospital management team. The hospital was described and felt like a "friendly" place to work. The culture in the theatre department was said to be improving following previous concerns about management arrangements.
- Patient surveys and consultant surveys were conducted and these overall described a good or excellent service. Action was being taken on areas identified for improvement.
- Some nursing staff had specific subject matter lead roles for the hospitals, such as infection prevention and control and venous thromboembolism. Some were working towards gaining national recognition for the service through national "exemplar status" award schemes.
- Staff had been involved in the design and development of services such as the Perform Centre and Chalybeate Suite.

Was the hospital well led?

- The hospital's vision and strategy was that of Spire Healthcare group. Its Compassion in Practice strategy was launched in 2012 and identified key organisational actions, values and behaviours (including the Spire Behaviours) to support staff to deliver compassionate and high quality care, and improve patients outcomes and well-being.
- There were six strategic objectives as part of its clinical strategy: clinical reliability, clinical safety, compliance, patient empowerment, clinical effectiveness and staff empowerment. These were monitored quarterly through a clinical dashboard and defined targets. Hospitals that did not meet these targets were required to demonstrate what actions were being taken to improve.
- Spire Healthcare produced the quality account as a company and the quality targets this year were to improve on the Friends and Family Test results, increase the number of telephone post-operative consultations, and embed the Compassion in Practice strategy.
- Spire Healthcare inspected the hospital as part of its quality assessment programme. The quality assessment report in February 2014 was positive overall. There were areas to improve in medicines management, governance of consultant staff and staff training and development. The hospital had demonstrated some, but not complete progress towards these areas of action. The report in (May 2014) commended the hospital's strong incident reporting culture.

Summary of findings

- In Spire Southampton Hospital, the Hospital Director and Matron were well thought of by staff. Staff reported that they highly visible and took action in response to issues identified and staff concerns. Staff were aware of the 'Spire Behaviours' guidelines.
- The hospital granted practising privileges to doctors who wished to practice and be employed by the hospital. The process included pre-employment checks, induction, training and monitoring of appraisal. The information held by the hospital was not up to date, or was missing. For example on Disclosure and Barring Scheme (DBS) re-checking, Hepatitis B screening, medical indemnity insurance and the approved practice profile of procedures that a consultant could undertake. Approximately 13% of consultants could not demonstrate up to date medical indemnity cover and some had been out of date for several years. There was evidence that these were being followed up, and evidence of suspension of practising privileges but action needed to be more timely.
- The hospital undertook a review of consultants annual appraisals and at the same time reviewed the information they held in relation to the consultants practice. This included review of complaints, incidents, adverse incidents and events and patient outcomes. The hospital asked consultants to provide a copy of their annual NHS appraisal, and had copies from 93% of consultants. There were arrangements to ensure that information on a consultant's private practice was included in their appraisal. The matron/ head of clinical services read all appraisals and followed up where information was incomplete or absent.
- The hospital director and matron met with medical director of the local NHS trust quarterly and the deputy director monthly. Information was shared, for example on clinical practice and incidents. This was in line with national guidance for doctors and responsible officers (the medical director) on The Role of the Responsible Officer, Department of Health, 2013. There was a joint post with the local NHS trust of associate medical director for patient safety.
- There was a clinical committee structure to oversee and monitor the hospital's services. This included the monitoring arrangements for consultants under the MAC.
- Governance arrangements needed to improve overall. Some were effective and the hospital was focused on improvement. There was an open culture and learning environment for incident reporting; the hospital used the clinical dashboard and action was taken when targets were not met, for example, temperature checks had improved in theatre and a risk assessment introduced for falls prevention. Adherence to hospital policies, procedures and care pathways was monitored. The hospital had weekly clinical effectiveness meeting to identify and manage risks. Known risks had been identified as areas for action.
- Some governance arrangements, however, needed to improve. There needed to be better assurance processes and escalation of priorities. Assurance processes, for example, to review practising privileges or to ensure changes following audits were embedded. There were quality governance reports that were comprehensive but were not timely. The most recent report in October 2014, was for the period 1 January to 31 March 2014, and priorities were not analysed and defined so as to effectively be shared across all committees and staff groups. Risks that were identified were appropriately managed but the focus of the risk register was on non-clinical risks and clinical risks were not highlighted and formally reviewed in the same way.
- The hospital held meetings with patients where there had been moderate or severe harm following procedures. These meetings were documented and patients received information and details of action and/or necessary compensation. A corporate policy on Duty of Candour was being developed in readiness for the new legislation in April 2015.
- There were quarterly staff forum meetings that the hospital and matron held. The attendance target was for 80% of staff to attend. Most staff were positive about these meetings and felt comfortable discussing issues and raising concerns. Some staff in lower pay grades, such as administration and clerical staff, cleaners and porters felt less engaged and identified that they needed different opportunities to be listened to and raise concerns.
- Innovation and ideas from staff were actively encouraged. We identified examples where staff were involved in service changes and developments and their achievements were recognised through awards.
- There was also a staff recognition award program. Staff could nominate other staff for awards. This peer recognition process was well received by staff.

Summary of findings

- Patients were surveyed and asked about services, but other than this there was limited evidence of public engagement. The hospital website included information about its services and staff, and was clear about fees and methods of payment.
- Efficiency targets set by Spire Healthcare included reducing the length of stay, over-night conversion rates, non-clinical cancellations, and re-admission rates and minimizing hospital acquired infection and the use of agency staff. The hospital recognised the need to have good working relationships with NHS commissioning groups and to have links with health and social care services, for example for effective discharge planning, if efficiency targets were to be met. Agency staff were not used and staff were rostered to work to meet demand and costs were being reduced in administration. The hospital was clear that clinical quality was the priority. There had not, however, been any quality impact assessments on the overall, approaches to meeting efficiency targets on patient care.

We saw areas of outstanding practice:

- The Chalybeate Suite for patients receiving chemotherapy and palliative care, was designed by nursing staff and patients. The environment was private, calm and relaxing. The unit had received a Macmillan Quality Environmental Mark which indicates that the unit meets national standards to provide a welcoming private and comfortable environment for people with cancer to support and improve their wellbeing.
- The hospital director and matron/head of clinical services met regularly with the Medical Director of the local NHS trust to share information on consultant's clinical practice, performance and services. The hospital had a joint post with the local NHS trust of associate medical director for governance and patient safety.

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

Importantly, the provider must ensure that:

- Procedures for infection prevention and control are followed.
- The environment is in line with recommend guidance to reduce the risk of cross infection. Particular attention needs to be placed on the fabric of the building, and keeping dirty and clean equipment for cleaning and sterilisation processes separate.
- Single use gowns are used appropriately.
- Access and security arrangements are effective and reduce risks to staff and patients.
- Medicines are managed appropriately, so that liquid medicines are stored and labelled correctly and there is adequate storage for intravenous infusions, dialysis and irrigation solutions in the critical care unit. Intravenous fluids not recommended for use in children are not stored on the paediatric resuscitation trolley.
- Cleaning fluids covered by the Control of Substances Hazardous to Health (COSHH) regulations, 2002 are stored securely.
- All equipment in the critical care unit is checked daily where this is required.
- Staffing levels improve in theatre recovery to meet national guidance and improve to ensure appropriate pre-assessment prior to admission.
- Nurse on call arrangements for children in the day care unit are in accordance with national guidance.
- An age appropriate paediatric early warning score system, to identify children whose condition might deteriorate, is introduced in line with current national guidance.
- Staff working in the critical care unit have their competencies reassessed on an annual basis.
- All staff have appropriate safeguarding training and staff who have regular contact with children should complete safeguarding children training at a level suitable to their role.
- Staff attend basic and immediate life support training according to hospital targets.
- Nursing staff have appropriate training to care for medical patients and children.
- Staff must have an understanding, and follow guidance, to ensure they adhere to the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- Imaging reporting times meet service standards of within 48 hours.

Summary of findings

- Appropriate information for consultant's practising privileges are reviewed and kept up to date, and there is evidence that suspension is timely, where required.

In addition the provider should ensure that:

- Improve the timeliness of investigation following an incident in areas where this remains outstanding.
- Recruitment continues to alleviate the pressure of long working hours on staff.
- Information is available in a format other than English and that information is available that is specific for children and young people.
- Clinical staff have an understanding of the needs of people living with dementia and those with a learning disability.
- Care plans are appropriately completed for cardiac patients in critical care and there is appropriate documentation for patients on a neurosurgical pathway.
- The capacity within pharmacy is reviewed to ensure more time is spent on providing a clinical pharmacy service.
- A policy on Duty of Candour is implemented with respect to forthcoming legislation.
- There are better systems to audit and monitor compliance with guidelines and patient outcomes
- Quality impact assessments are undertaken for actions taken to meet efficiency targets, and the annual operating plan.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Why have we given this rating?

Safety procedures were followed. Incidents were reported and the lessons learnt were shared with staff. Medicines and equipment were appropriately managed and infection control procedures were followed. Staffing levels were appropriate and patients were monitored to ensure action was taken if their clinical condition deteriorated. The service was consultant led and national guidance was used to determine patient treatment. The hospital did not have an end of life care pathways for patients receiving palliative care. There were good procedures for when someone died, particularly in terms of responding to the needs of the family, spiritual needs and undertaking procedures for a coroner's inquest. Clinical care was monitored but there needed to be better information on compliance with standards and patient outcomes. Staff were supported in their development but needed more training around caring for medical inpatients. There had not been any dementia awareness training and staff did not have an understanding of the Mental Capacity Act, 2005. This was identified as an area for action. Patients we spoke with said they felt involved in their care and that staff were supportive. Nurses ensured patients were provided with the necessary support to make their hospital stay comfortable and specialist support, for example with breast cancer care, was available. The service was well led and staff worked effectively in their teams. Staff supported the strategy to improve clinical quality indicators and develop the service. Governance arrangements were in place and performance was monitored; there needed to be more formal arrangements around the actions taken to manage clinical risks. Patient feedback was being used to improve the service and staff demonstrated examples of innovative practice.

Surgery

Surgical services were following procedures to provide safe care but there needed to be improvements in incident investigations, infection prevention and control and patient records. Staffing levels and the skill mix of staff were appropriate on the wards. Staffing levels in pre-assessment meant that not all patients could be reviewed prior to admission and, staffing levels in the

Summary of findings

recovery area of the operating department did not always meet national guidelines. Many staff worked long hours to respond to service demands. More formal systems were needed to ensure medical staff who assisted when on call, had appropriate recruitment checks. Staff were using national guidelines to treat patients and performance was being monitored. The hospital reported mortality rates were lower than national average for cardiac surgery, although audit needed to improve to demonstrate compliance with standards overall and patient outcomes. Staff needed to improve their awareness of dementia care and their responsibilities under the Mental Capacity Act, 2005 and action was being taken to address this. Staff were caring and compassionate and treated patients with dignity and respect. Patients were positive about their experience and the care they received. Services were responsive to patient' needs and there was no differentiation in services between private or NHS patients. Operations were very rarely cancelled but staff perceived that cancellations were more likely to happen on NHS patient lists as these sometimes could overrun. Patients living with dementia or who had a learning disability, however, needed better support. Staff were positive about the hospital as place to work and the leadership of the service. Governance arrangements were in place and performance was monitored; there needed to be more formal arrangements around the actions taken to manage clinical risks. Patient feedback was used to improve the service.

Critical care

The critical care unit followed safety procedures to provide safe care there were appropriate staffing levels and infection control practices, and patient risks were assessed and acted on appropriately. However, medicines management needed to improve, equipment checks were not completed appropriately and the storage of cleaning equipment was not in line with national guidelines. Patient records were not completed appropriately and neurosurgical patients did not have an appropriate care pathway plan. Local policies and guidelines had not been reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were not implemented. This area had been identified for

Summary of findings

improvement. Data on outcomes was being collected for some, but not for all patients, and outcomes in general, could not be demonstrated. Pain assessment tools needed to be developed. Staff were supported by senior staff to undertake their roles but their competencies were not appropriately assessed. Staff needed support to undertake post registration qualifications in critical care. Staff required an understanding of the Mental Capacity Act, 2005 in order to carry out their responsibilities in relation to consent, informed consent and deprivation of liberty safeguards. Staff were caring and compassionate and treated patients with dignity and respect and patients told us of the good care they had received on the unit and how they were involved in decisions about their care. The critical care services were responsive to the needs of their patients. Patients were appropriately admitted and discharged from the unit and the number of transfers to the local NHS trust for critical care was low. The support required for patients living with dementia and with a learning disability was assessed during pre-operative assessment processes although there was no specific support available on the unit. Staff were not aware of the vision and strategy to expand the service but identified with values and the need to provide excellent care. Quality and patient experience were seen as priorities and everyone's responsibility and staffed worked well together. The unit manager was also the nurse in charge. The nursing leadership of the unit was considered by staff to be supportive but they often worked clinically to cover for staff shortages. There was a lead intensivist for the unit with an additional and lead cardiothoracic intensivist. There was little evidence of quality monitoring processes or monitoring of actions taken on identified risks. This was identified as an area for improvement. Patient feedback to improve the service was obtained although this was not done formally. The service demonstrated good examples of innovation and improvement.

The hospital provided a small paediatric service. Staff were following safety procedures but the service needed to improve areas of medicine management, staffing, safeguarding children and the use of an age appropriate early warning score to identify children whose clinical condition might deteriorate. Children were

Services for children and young people

Summary of findings

appropriately identified to ensure staff used the correct equipment and medicines in an emergency. The hospital was running scenarios to improve the emergency response. There were trained staff to care for children in an emergency although staff, as part of normal procedures, would have to call 999 services for emergency hospital care. National guidelines were being used to treat children and there was evidence of audit but there needed to be better monitoring to assess compliance with standards and evidence of patient outcomes. Older children were cared for by adult nurses, who did not always feel confident in their skills to provide care and support to children and their parents. The environment and facilities did not fully meet the needs of children and children's environments were created by added toys and facilities to adult areas. We only observed a few children in the hospital but from what we observed, staff were caring and compassionate and treated children with dignity and respect. The children and young people that we spoke with told us they were involved in their care. Children's surgery was planned and cancellations were rare. Children and their parents had an initial assessment and pre-admission assessment so appropriate support could be offered. Children were placed first on surgical lists to reduce anxiety in line with best practice. There was support, through play specialist for children with a learning disability and who had mental health condition, although the support was only available pre-admission. There was a strategy to expand the service and for refurbishment to create children's areas, but this needed more formal plans. Staff across the hospital said they received good support from the lead children's nurse when caring for children and young people. A paediatric anaesthetist was the medical lead for the service and access to a paediatrician was via the local NHS trust. Children did not complete surveys themselves to feedback on their care although parents were surveyed. There was a paediatric steering group with representation from across the hospital and this was starting to lead on service and quality standards for children in the hospital. The service had demonstrated innovation and improvement in its development over the last 18 months.

Summary of findings

Outpatients and diagnostic imaging

The outpatient and diagnostic service departments followed procedures to ensure that services were safe and effective. Patients in the outpatients and diagnostic unit were protected from abuse and avoidable harm. Staff reported serious incidents and would challenge poor practice which could harm a person. Learning and good practice were shared. Staffing levels were appropriate. Radiology staff felt the pressures of high demand at times but necessary recruitment was on-going. National guidelines were used to treat patients and these were monitored although more information on patient outcomes was required. Imaging regulations were followed appropriately and standard operating procedures had been developed by staff. There was a collaborative approach to care and treatment and staff had training to do their roles. Staff needed to be more up to date with life support training and with their understanding of the Mental Capacity Act. The Outpatient and Physiotherapy Departments were undergoing development and refurbishment to improve and expand the areas to meet increasing demands for clinical services and to provide more car parking facilities on the hospital site. Staff were caring and compassionate and treated patients with dignity and respect. However, while staff recognised the need for supporting people with complex needs, there was less support for people with a learning disability or of people who lacked capacity. Staff were aware of, and supported, the service strategy to develop more outpatient and diagnostic services. Access to services was good but the majority of MRI and CT scans were not being reported within 48 hours. Governance arrangements were effective to review risks, although clinical risks needed more formal documentation and action and there needed to be more performance and outcome measures. The culture was open and transparent and staff said their departments were well led. Staff reported that the managers ensured they felt respected, valued, and engaged. There were good examples of staff involvement in design and future developments for the outpatient and diagnostic departments. Patients were able to feedback on services and their comments were used to improve the service.

Spire Southampton Hospital

Detailed findings

Services we looked at

Medical care; Surgery; Critical care; Services for children and young people; Outpatients and diagnostic imaging

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Detailed findings

Background to Spire Southampton Hospital

Spire Southampton Hospital, part of Spire Healthcare, offers comprehensive private hospital treatments, procedures, tests and scans to patients from Hampshire, Dorset, Wiltshire, the Isle of Wight, the south coast of England and the Channel Islands. Facilities included 78 beds, of these 59 are en-suite patient bedrooms, 12 beds in day care, and seven in the intensive the care unit and high dependency unit. There are five operating theatres, four of which have laminar flow ventilation systems which ensures cleaner air for more complex surgery. Outpatient facilities include 12 consulting rooms.

There were 345 consultants with practising privileges to work at the hospital. Services offered covered cancer care, cardiac surgery and cardiology investigations, cosmetic and plastic surgery, dermatology, ear nose and throat conditions, gastroenterology, general surgery (eg hernia repair, haemorrhoids and varicose veins), gynaecology, neurology, neurosurgery, ophthalmology, oral and maxillofacial, orthopaedics (e.g hip and knee replacements), spinal surgery, urology, and weight loss (bariatric) surgery. The diagnostic imaging department offered rapid access to MRI scans, CT scans, X-rays, ultrasounds and mammograms.

The physiotherapy team provided a service for neck pain, back pain, upper and lower limb problems and

post-operative orthopaedics as well as a Women's Health Service. Within the physiotherapy department chartered physiotherapists ran a Back Pain Assessment Clinic and the Biomechanical Gait Assessment Lab which offered a full assessment walking and running patterns. Acupuncture, massage and hydrotherapy was also available.

Services were available to people who held private insurance or to those paying for one-off private treatment. Fixed prices, agreed in advance, were available. The hospital also offered services to NHS patients on behalf of the NHS through local contractual agreements and 30% of its activity was NHS funded care.

Spire Southampton Hospital was selected for a comprehensive inspection as part of the first wave of independent healthcare inspections. The inspection was conducted using the care quality commissions new methodology. The inspection team inspected the following core services:

- Medical care
- Surgery
- Critical care
- Children and young people's care
- Outpatients.

Our inspection team

Our inspection team was led by:

Chair: Sandra Brennan, Director of Quality (Executive Nurse) Worcestershire Health and Care NHS Trust

Head of Hospital Inspections: Joyce Frederick, Head of Hospital Inspection, Care Quality Commission (CQC)

The team of 20 included an inspection manager; five CQC inspectors; an analyst, inspection planner; a Consultant

Cardiologist; a theatre specialist.; critical care nurse for adults; a nurse lead for children's services; a registered nurse with a background in medical and palliative care; an infection control nurse; a governance lead, a medical registrar and clinical fellow at the care quality commission; a physiotherapist and an expert by experience.

Detailed findings

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commission group. Patients were invited to contact CQC with their feedback and we received information from 23 patients.

We carried out an announced inspection visit between 22 and 23 October 2014 and unannounced inspections between on 3 November 2014. We held focus groups with a range of staff in the hospital, including theatre nurses, ward staff, other healthcare professionals and administrative and clerical staff. We also spoke with staff individually as requested. We talked with patients and staff from all the wards areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

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

Facts and data about Spire Southampton Hospital

Spire Southampton Hospital offer services to patients in the areas of Hampshire, Dorset, Wiltshire, the Isle of Wight, the south coast of England and the Channel Islands.

The hospital provides a wide-range of treatments and includes the following services:

Surgical services, including cardiac surgery, cosmetic and plastic surgery, surgical treatments for ear nose and throat conditions, gastroenterology, general surgery (eg hernia repair, haemorrhoids and varicose veins), gynaecology, neurology, neurosurgery, ophthalmology, oral and maxillofacial, orthopaedics (eg hip and knee replacements), spinal surgery, urology, and weight loss (bariatric) surgery.

Children's care to children and young people of all ages as outpatients and inpatient services for children aged three years and older.

The specialist health services provided by the hospital include:

Cardiology services: providing a full range of treatment for heart conditions including diagnostic investigations and interventional cardiac procedures.

Oncology services: combining chemotherapy, radiotherapy and surgery all under one roof. The hospital's facilities are equipped to screen and treat breast, bladder, skin, prostate, and lung cancer.

Gastroenterology and Hepatology services: undertaking diagnostic and interventional radiology services along with complex liver surgery and haemofiltration.

Physiotherapy services: Pain service for neck pain, back pain, upper and lower limb problems and post-operative orthopaedics as well as a Women's Health Service. Back Pain Assessment Clinic and the Biomechanical Gait Assessment.

1. Context

- The hospital has 59 inpatient and 12 day case beds, 4 intensive care and 3 high dependency unit beds.
- The number of staff was more than 400, including 50.1 full-time equivalent (FTE) nurses and 11.6 FTE care assistants.

2. Activity

- Adult inpatient admissions – 12,166 (Apr 2013 – Jun 2014)
- Inpatient activity – 18,120 (Jul 2013 – Jun 2014)
 - Discharges: Overnight inpatients – 4,483

Detailed findings

- Discharges: Day case inpatients – 5,237
- Visits to theatre – 8,400

3. Bed Occupancy

- Level 2 critical care (Feb – Jul 2014): 346 bed days were used out of 543 (63.7%). Peak bed occupancy was at 80% in February 2014. This was below England's average at 85.7% (across the NHS and independent healthcare)
- Level 3 intensive care (Feb-Jul 2014): 335 bed days were used out of 724 (46.3%)
- Post anaesthetic extended day care unit (PAECU) - 0 bed days were used out of an available 181

4. Safe

- Never Events reported in past year – 0 (Apr 2013 – Jun 2014)
- Serious injury – 2 cases (Apr 2013 – Jun 2014). The hospital was not an outlier for the number of serious injury notifications
- Clinical incidents:
 - Steadily risen over the last six months of the reporting period but still within expected limits
 - The number of SIRIs (serious incidents requiring investigation) has remained level overall over the reporting period – relatively level between July 2013 and June 2014
- Incidence of hospital acquired venous thromboembolism (VTE) – 5 (Apr 2013 – Jun 2014), where 1 case was recorded between April and June 2014
- Proportion of patients risk assessed for VTE was over 95% (NHS standard). (Apr 2013 - Jun 2014).

Safety thermometer (Jul 2013 – Jul 2014)

- No reported cases relating to falls, pressure ulcers or catheter urinary tract infections

Infection control (Apr 2013 – Jun 2014)

- There has been one reported infection for methicillin-resistant staphylococcus aureus (MRSA) and no reported cases of Clostridium difficile between April 2013 and September 2014.

5. Effective

- Incidence of unexpected mortality – 1 during the reporting period (Apr 2013 – Jun 2014) and subsequently one further case was reported in July 2014
- Rate of unplanned readmissions within 29 days of discharge had fallen over the reporting period and was similar to expected.
- Proportion of unplanned transfers to another hospital (NHS or independent sector) was similar to expected. Overall the rate has fallen for the period Apr 2013 to Jun 2014.

6. Caring

- NHS Friends and Family Test (FFT) for privately funded patients (Apr – Jul 2014): achieved high FFT scores ranging between 79% and 86% , with a response rate around 30% (a low response rate)
- NHS FFT for NHS funded patients (Apr – Jul 2014): achieved high and more consistent FFT scores around 84% and a higher response rate around 75%

7. Responsive

- Most complaints received that are now closed took more than the hospital's own target of 20 days to be resolved. Patients were informed of the progress of their complaint.

8. Well-led

- Turnover – the rate of staff turnover has risen in 2013/14 compared to the previous year for each staff group
- Sickness rate – Overall rates were below 5%. There was a spike in the sickness rate for the nursing this staff group in March 2014 (29%)
- Staff stability - the majority of staff had been employed for a number of years.

9. CQC Inspection history

- Two inspections have taken place at the hospital in November 2013 and December 2012.
- Spire Southampton Hospital was compliant with the outcomes inspected at the last inspection.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	N/A	N/A	N/A	N/A	N/A	N/A
Surgery	N/A	N/A	N/A	N/A	N/A	N/A
Critical care	N/A	N/A	N/A	N/A	N/A	N/A
Services for children and young people	N/A	N/A	N/A	N/A	N/A	N/A
Outpatients and diagnostic imaging	N/A	N/A	N/A	N/A	N/A	N/A
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Notes

Medical care

Information about the service

The majority of patients with medical conditions were treated at the Spire Southampton Hospital either as outpatients or day cases. The hospital did not have a ward dedicated specifically to the care of medical inpatients, but most medical patients were treated on ward 1. There was an oncology service and a palliative care service with a dedicated area within the hospital, the Chalybeate Suite, for patients undergoing chemotherapy. There was a cardiac catheterisation laboratory used largely for electrophysiological procedures and cardiac pacemaker implantation. The catheterisation laboratory was also used for investigation and treatment of patients with a range of non-cardiological disorders.

Approximately 60 patients with medical conditions were admitted to the hospital over a 12 month period. That included around 15 patients admitted through an emergency referral service provided to GPs by a small group of consultant physicians, providing treatment to patients with a range of medical conditions including asthma, COPD, pneumonia, cellulitis and transient ischaemic attacks. There were approximately 48 patient admission for oncology/palliative care in a 12 month period and 1028 patient admissions or chemotherapy in 2014.

We visited the three inpatient wards, the Chalybeate Suite and outpatients. We spoke with 14 members of staff who would care for medical, oncology and end of life care patients in these areas. These included consultants, the resident medical officer, nursing staff, physiotherapist, administrators and 12 patients. Information specific to the inpatient wards (wards 1, 2 and 3) are reported under surgery.

Summary of findings

Safety procedures were followed. Incidents were reported and the lessons learnt were shared with staff. Medicines and equipment were appropriately managed and infection control procedures were followed. Staffing levels were appropriate and patients were monitored to ensure action was taken if their clinical condition deteriorated. The service was consultant led and national guidance was used to determine patient treatment. The hospital did not have an end of life care pathways for patients receiving palliative care. There were good procedures for when someone died, particularly in terms of responding to the needs of the family, spiritual needs and undertaking procedures for a coroner's inquest. Clinical care was monitored but there needed to be better information on compliance with standards and patient outcomes. Staff were supported in their development but needed more training around caring for medical inpatients. There had not been any dementia awareness training and staff did not have an understanding of the Mental Capacity Act, 2005. This was identified as an area for action. Patients we spoke with said they felt involved in their care and that staff were supportive. Nurses ensured patients were provided with the necessary support to make their hospital stay comfortable and specialist support, for example with breast cancer care, was available. The service was well led and staff worked effectively in their teams. Staff supported the strategy to improve clinical quality indicators and develop the service. Governance arrangements were in place and performance was monitored; there needed to be more formal arrangements around the actions taken to manage clinical risks. Patient feedback was being used to improve the service and staff demonstrated examples of innovative practice.

Medical care

Are medical care services safe?

Staff reported incidents and learning was shared at team meetings. Staff followed infection prevention and control procedures, and clinical areas were visibly clean. Medicines and equipment were appropriately managed. Staffing levels and the skill mix of staff were appropriate and patients whose condition might deteriorate were appropriately monitored. All patients were admitted under the care of a named consultant and 24 hour medical cover was provided by a resident medical officer.

Incidents

- Staff were aware of how to report incidents using the hospital's electronic reporting system. An automatic email was sent to the person completing the submission to confirm receipt. The majority of incidents were reported within the hospital target of four days.
- It was not possible from the information provided by the hospital to be specific about the number of incidents that related specifically to medical patients. The oncology service reported one near miss and two adverse events (1 April to 30 September 2014).
- Staff confirmed that they received general feedback through the cascade of information at team meetings and there was an open culture and learning environment for reporting incidents.

Safety thermometer

- Information was collected and reported to commissioners for NHS patients but this was not used as a tool within the hospital.
- Information on falls, infections, venous thromboembolism (blood) clots and pressure ulcers was monitored as part of the hospital's clinical scorecard. The hospital was meeting its targets overall but had a higher rate of falls than defined by its own target (1 July to 30 September 2014). The information was not displayed in ward areas.

Cleanliness, infection control and hygiene

- The oncology unit (The Chalybeate Suite) had an infection prevention and control link nurse who would attend quarterly meetings and cascade information to their colleagues.

- Personal Protective Equipment (PPE) was readily available in all clinical areas visited. In the oncology unit staff were observed to be careful about ensuring that the correct protective equipment was used.
- Infection control training was available to all staff as an e-learning package. Seventy two per cent of staff had completed this training (January to August 2014).
- The patient areas were generally observed to be clean. Cleaning schedules were displayed on the wards and staff knew actions to take if there was a spillage of contaminated items.

Environment and equipment

- Equipment was visibly clean. Items were labelled with the last service date and large green stickers identified when equipment was cleaned.
- All equipment was listed on a corporate computerised maintenance management system. The information included frequency of required maintenance (in line with manufacturer's guidance and best practice) and the details of who held the maintenance contract agreements. The system flagged up when maintenance was required.
- There was a contract for portable appliance testing, these were conducted on an annual basis. A record of checks was maintained.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention. This was undertaken through an electronic reporting system. Records held centrally demonstrated a swift response and work was prioritised according to importance/essential equipment.
- The hospital had received a Macmillan Quality Environmental Mark for the Chalybeate Suite. The Macmillan Quality Environment Mark (MQEM) is a detailed quality framework used for assessing whether cancer care environments meet the recognised national standards required by people living with cancer.

Medicines

- We observed that patient's identification was checked each time medication was administered to assure the correct medication was given to the right patient.
- Medication was safely and securely stored. Refrigerator and room temperatures were monitored and appropriate actions were taken when the refrigerator was outside of the recommended temperature range.

Medical care

- There was an aseptic unit in the pharmacy department used for the preparation of chemotherapy. To ensure that a safe service was maintained, this was audited by an external provider. The audit results for 2013 stated the unit "is clean and functional for the work which is undertaken, with adequate aseptic processes and controls in-place."

Records

- All records were multi-disciplinary and in a paper format. We checked six sets of records and found that all information relevant to the patient's current treatment was recorded.
- Patient allergies were noted in the patient record and in the medical administration record sheet. This would alert practitioners to any contraindication in relations to a patient's allergy.

Safeguarding

- There was an on line safeguarding training package for staff which had been completed by 89.2% of staff (January to August 2014).
- The hospital matron was a member of the local independent safeguarding group and had attended an update training day in July 2014. There was an awareness that as the hospitals client base had changed, staff needed to have an increased awareness of their responsibilities to safeguard patients..
- The hospital had not made any safeguarding or Deprivation of Liberty Safeguard (DoLS) applications. It was acknowledged that this was an area that required further improvement.
- There was an established system, managed by one of the ward sisters, to ensure that all staff who required a professional registration to practice provided current evidence of their registration.
- There was an established recruitment process that included the requirement for two references and a current disclosure and barring scheme (DBS) check prior to a new member of staff commencing employment.

Mandatory training

- There were nine mandatory e-learning modules for staff to complete these included fire safety, manual handling, information governance, infection prevention and control, safeguarding adults and children and equality and diversity.

- There was a mandatory training policy that detailed which training staff were required to attend this also included resuscitation training. The training records showed that attendance at training was monitored.
- At the end of 2013, 83% of staff were up to date with their mandatory training this had been lower than the hospital target of 95%. For the year to date (1 January to 31 August 2014), 58% of staff had completed the mandatory training.
- We did not have separate figures for life support training for oncology staff.

Assessing and responding to patient risk

- The hospital used the national early warning score tool to identify and monitor patients whose clinical condition might deteriorate. There were clear directions for escalation printed on observation charts. Staff were aware of the appropriate action to be taken if patients scored higher than expected. We looked at a sample of completed charts and saw that staff had escalated correctly, and that repeat observations were taken within the necessary time frames.
- Patients were appropriately assessed on admission regarding pressure ulcers, likelihood of falls and on nutrition. This ensured appropriate care was provided to patients throughout their stay.
- Patients often become ill a week to 10 days following chemotherapy. Patients how might become ill would be admitted to the unit. There was patient information available on the risks and patients had a number to call that was available 24 hours a day.
- The hospital had good inter-hospital transfer arrangements. Patients could then easily be transferred to a local hospital in case they needed further specialised care.

Nursing staffing

- Staff told us that there were enough nurses on the wards and in clinical areas. Staff shortages were covered by bank nurses.
- We observed a nursing handover and found staff were provided with good quality information about the patients and their conditions.

Medical staffing

- There were nine consultants with practising privileges in general medicine at Spire Southampton Hospital. Two of these consultants worked in geriatric medicine. There were 14 consultants in oncology.

Medical care

- All patients were admitted under the care of a named consultant. Consultants were expected to visit and review their patients on a daily basis. They were also expected to be available to be contacted throughout the time they had patients resident in the hospital.
- There was a resident medical officer (RMO) present in the hospital at all times. There were five RMO doctors at specialist registrar level and all were trained in advance life support. They worked a roster of 24 hours on a week day and 48 hours on a weekend. When on duty they were resident on site for the duration of their shift.

Major incident awareness and training

- Staff understood what action to take, if for example there was a major incident such as fire or extreme weather conditions.

Are medical care services effective?

National guidelines were used to determine treatment and there were care pathways for common medical conditions. Oncology patients had a detailed plan of care. The hospital, however, did not have an end of life care pathway. Clinical care was monitored but there needed to be better information on compliance with standards and patient outcomes. Patients receiving treatment for cancer had their pain managed effectively and patients felt they had adequate meal choices and that special diets could be catered for. The staff were supported with training but some staff on the wards told us they did not have sufficient training and experience to deal with medical inpatients. Staff had not received training in dementia awareness and had limited awareness of the Mental Capacity Act. This was recognised as an area for action. Staff worked in multi-disciplinary teams to coordinate care for discharge when necessary and for patients receiving palliative care. Do not attempt cardio-pulmonary resuscitation forms were used appropriately.

Evidence-based care and treatment

- A combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines was used to determine the treatment for medical patients. There were care pathways for common medical conditions such as diabetes and heart failure to standardise and improve the care for patients.

- There were care pathways and guidelines for oncology patients, such as neutropenic sepsis which could occur after cytotoxic chemotherapy.
- The hospital did not have a care pathway for patients who might need end of life care. It was therefore not possible to assess if the care provided would be in line with current guidance. This had been recognised as an area requiring improvement and staff were reviewing how this pathway could be implemented.
- There was an audit plan, which covered for example record audits, health and safety audits, however there was limited information that related to clinical outcomes.

Pain relief

- The oncology department used the World Health Organisation "pain ladder" a recognised tool for the management of pain for patients with cancer.
- When providing palliative care appropriate syringe drivers were used to provide pain relief.
- Patients told us that the nurses were very responsive and ensured they received the pain relief they required.

Nutrition and hydration

- Patients told us there was choice and variety in the hospital food menu. If they wanted something that was not available, the kitchen staff were most helpful in responding to their needs.
- Patients with special diets were catered for and there were arrangements to provide "gluten free diet" and other special diets.

Patient outcomes

- The hospital used Systemic Anti-Cancer therapy audit tool (SACT) and collected the data on how patients were responding to the biological and cytotoxic chemotherapies. However, the data from the hospital were neither shared nationally, nor compared with other Spire hospitals to see whether there were any trends emerging.
- There was no outcome data collected for medical patients.

Competent staff

- Clinical staff we spoke with told us that appraisals were undertaken regularly; 95% of nurses who would see medical patients had had an appraisal. Staff also spoke positively about the process. Nursing staff were supported through clinical supervision.

Medical care

- All medical patients were admitted to ward 1. The staff on ward 1 nursed a mix of surgical and medical patients including post-operative cardiac, cardiology, thoracic, neurosurgery and medical patients.
- Some staff on ward one had completed appropriate training to care for medical patients, for example, training in diabetes care, cardiac rhythm, and chronic obstructive pulmonary disease, and this had been cascaded to colleagues. However, some ward 1 staff told us they did not have the experience or training to deal with medical patients. Training needs had been identified in staff personal development plans and a new training programme, that would include respiratory and high dependency training, was planned to start in 2015.
- The hospital had a breast care nurse had specialist qualifications in oncology and was supported to undertake further training.
- There was no specific training for staff in understanding dementia. This had the potential to impact on the care of patients living with dementia. The hospital was aware of this and an e-learning training package was being implemented.
- There was a physiotherapy service available seven days a week.
- A dietician was available to assess and care for patients requiring nutritional treatment Monday to Friday. There was no cover for the dietician, and they told us that they would be contacted during days off and during leave to provide dietetic advice. The dietician told us that they were trying to set up a bank dietetic service to help resolve this issue.
- The pharmacy was open 8.30am to 5.30pm Mondays to Friday and 9am to 1pm on Saturday mornings. Out of hours there was an on call service that was shared with Portsmouth Spire Hospital.
- The radiology department operated from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service. MRI scans were also available between 8am and 3pm on Saturdays.
- Pathology services were available from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service.

Multidisciplinary working

- Nursing staff worked with social services on discharge arrangements when the patient required additional support once discharged.
- Where appropriate, staff contacted the palliative care team or end of life team for support in the needs of patients. There were also good links with community palliative care teams and the hospital had direct access to specialised palliative care team based at the local NHS trust. We found contact had been made for one patient and this was recorded in their notes.
- There was a breast care nurse, who supported patients undergoing treatment for breast cancer. They would meet the patient at their first consultation and then support them throughout their treatment.

Seven-day services

- Consultants who had inpatients were expected to conduct a daily ward round.
- Consultants provided 24 hour on-call (off site) cover for their patients. If they were unavailable at any time they organised a consultant colleague with admitting rights to provide cover in their absence.
- A Resident Medical Officer (RMO) was available and onsite 24 hours a day 365 days a year.

Access to information

- The hospital was actively working with consultants' secretaries to ensure that the required information was available when a patient was admitted to the hospital, either through the provision of a copy of notes or a summary letter.
- For oncology patients there was a detailed plan of care for those receiving chemotherapy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- At the end of June 2014, 48% of all staff had completed the Spire Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) training. However, many of the staff we spoke with were not well informed about the Mental Capacity Act or DoLS. The hospital recognised this as an area for improvement and had an action plan address this.
- We saw two Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms that had been appropriately completed.

Medical care

Are medical care services caring?

Staff were caring and compassionate and patients were treated with dignity and respect. Patients said they felt involved in their care and that staff were supportive. Nursing staff ensured patients were provided with the necessary support to make their hospital stay comfortable.

Compassionate care

- We observed staff to be caring, compassionate and polite when dealing with patients. The staff treated patients with dignity and respect and calls bells were answered promptly.
- Patients were well cared for and looked comfortable.
- Doctors and nurses introduced themselves appropriately and that doors were closed to maintain patient privacy.

Understanding and involvement of patients and those close to them

- Patients said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- One patient told us: "I like coming in (to oncology unit) it's like taking to a friend, they know me and how I tick."

Emotional support

- Patients told us staff were supportive. Nurses ensured patients were provided with the necessary support to make their hospital stay comfortable. We spoke to five patients who told us they were very well supported. One relative told us how during the time of her mother's death in the hospital, the family was well supported with food and drink.
- One patient told us that the emotional support and encouragement given to them was invaluable. It helped them cope with their condition.
- There were clear procedures for staff to follow when a patient died in the hospital. The deceased was cared for in the room so as to enable family member's to come and pay their respect. The deceased was then transferred by their chosen funeral director.
- A nun visited the hospital every Wednesday and would visit patients to discuss their spiritual needs. Patients own ministers were also welcomed.

Are medical care services responsive?

The hospital provided a consultant led service, the majority of patients were planned admission though there was an emergency referral service for GP access on behalf of patients. There was good support for oncology patients who had rapid access to the service and to specialist advice. There was no specific support available for patients with a learning disability or those living with dementia. Information leaflets were available, these were all written in English but could be translated if required. Patients were clear about how to make a complaint and staff were clear about their responsibilities to ensure complaints were investigated.

Service planning and delivery to meet the needs of local people

- Most medical patients were planned admissions for day care or outpatients. For access to rapid assessment and investigation, and there was an emergency referral service.
- All patients were admitted under the care of a named consultant. GPs could make a direct referral to a consultant through the emergency medicine service.
- The hospital did not have a dedicated medical ward, patients admitted under the care of a medical consultant would be admitted to the surgical wards.
- There was a dedicated oncology unit that had been specifically designed and built to meet the needs of these patients. Patients had direct access to an out of hours telephone line to gain advice and support.

Access and flow

- There were no waiting times for investigation; cancellation and do not attend rates were low.
- All inpatient discharges were planned and did not take place out of hours. While there was not a dedicated discharge team staff worked with local social services, the district nurse team and the local NHS trust's 'hospital at home' team to ensure safe discharges took place. NHS funded patients with complex needs that may have a lengthy discharge process could be transferred to an NHS facility.
- Oncology patients told us they had direct access to the unit. For example, one patient told us they called the out of hours telephone line was put through to an

Medical care

appropriate senior nurse. Another patient spoke to the oncology nurse and was immediately asked to come in for an assessment to ensure medication was working appropriately.

- Discharge summaries were sent out on the same day that the patient left the hospital in a timely manner.

Meeting people's individual needs

- There was flexible visiting times in all patient areas.
- There was no specific support available for patients with a learning disability or those living with dementia.
- All the written information for patients was in English. There were no leaflets in other languages although staff told us if a patient required information in another language that arrangements would be made for the information to be translated.
- Relatives of the deceased patients were provided with information leaflets on bereavement which included information on the next steps.

Learning from complaints and concerns

- Complaints were handled in line with hospital policy. Members of staff told us they would deal with any complaints on the wards.
- Complaints leaflets were available throughout the hospital. We observed these on the wards and in clinical areas.
- Patients we spoke with told us they would be confident to raise concerns with staff. We spoke with one patient who told us they had raised concerns about their hospital care and they were visited by a senior manager who had resolved their concerns.

Are medical care services well-led?

There were strategic objectives for medical and oncology services and these had been shared with consultants and staff who supported the vision. Staff were positive about the leadership of the service and felt valued and supported. Governance arrangements were effective but required improvement at hospital level around the management of clinical risks and to monitor consultant practising privileges. Patients feedback was used to improve the service and staff demonstrated innovation in practice.

Vision and strategy for this service

- The hospital's strategic objectives for 2014 were to improve on clinical performance quality indicators and

there were also some specific service improvements. For medical and oncology patients, for example, these included developing a minor injuries unit, increasing dermatology minor procedures, ensuring counselling for all patients having their first cycle of oncology treatment.

- Senior staff had shared this vision with staff, including consultant staff, and they were supportive.
- All staff were clear about the hospital's vision and values that encompassed key elements of care such as compassion, dignity, respect, and equality with quality a key priority.

Governance, risk management and quality measurement

- Wards and departments had team meetings and there was feedback and learning from complaints, incidents, and quality monitoring indicators which was included on the hospital's clinical dashboard.
- The risk register included non-clinical risks; there were no clinical risks identified for medical or oncology patients.
- The hospital used a corporate clinical quality metric to monitor performance. Reports were published quarterly. There were 32 clinical items that were monitored but the majority were for surgery. The hospital were meeting targets for indicators that may apply to medical patients, for example, pain assessment and effective discharge but the number of falls had increased.
- Hospital clinical indicators and outcomes were discussed at the medical advisory committee (MAC) to ensure they were informed and to engage consultants in improvements were required. There was a set agenda for each of these meetings with standing items such as incidents, practising privileges, complaint and any new national initiatives.
- The monitoring of consultants to ensure they all had current medical indemnity insurance, appraisals and professional registration was not robust. Two consultants had a notice to suspend but others had out of date indemnity insurance.

Leadership of service

- Each ward or department was led by a ward sister or manager. The lead nursing staff were supported by a deputy matron and a matron. The hospital director and matron were highly regarded by staff throughout the hospital.

Medical care

- There were consultant leads who represented their speciality at the hospital's medical advisory committee (MAC).
- There were avenues for staff to raise concerns. The hospital director held a monthly forum where all levels of staff could attend to share their concerns. These were well attended and staff told us that the senior management team listened to them and took their opinions on service improvements.
- The hospital director and matron were visible throughout the hospital and were seen acknowledging all staff by name and clearly knew who staff were.

Culture within the service

- The matron and hospital director were highly regarded by the staff who felt that they had strengthened the importance of quality and had made a positive impact on the culture of the hospital.
- Staff felt valued and supported and were positive about the hospital as a place to work.
- Staff in the Oncology Unit worked effectively as a team and had a collective responsibility to ensure quality care for patients.

Staff engagement

- Staff surveys were undertaken on an annual basis. The information was published and available for staff to read along with any actions being taken to make improvements. The action plans were developed by department. Staff felt that they could raise concerns and that the hospital management was accessible.

Public engagement

- Patients were regularly surveyed and results were discussed at ward meetings. Information was used to improve the service.
- Patients in the oncology unit were also invited to visit the hospital for afternoon tea to meet with the management team.

Innovation, improvement and sustainability

- The Chalybeate Suite for patients receiving chemotherapy and palliative care, was designed by nursing staff and patients. The environment was private, calm and relaxing. The unit had received a Macmillan Quality Environmental Mark which indicates that the unit meets national standards to provide a welcoming private and comfortable environment for people with cancer to support and improve their wellbeing.
- The oncology unit was piloting a new method of unequivocal patient identification to ensure patients received appropriate chemotherapy. A map of the patient's finger vein pattern was taken. When this was used via a connection to a tablet, the patients photo was displayed. The vein mapping technique was developed because for some patients on chemotherapy, their finger prints become less defined due to rapid surface skin loss.

Surgery

Information about the service

The hospital offered cardiac surgery, cosmetic and plastic surgery, surgical treatments for ear nose and throat conditions, gastroenterology, general surgery (e.g. hernia repair, haemorrhoids and varicose veins), gynaecology, neurology, neurosurgery, ophthalmology, oral and maxillofacial, orthopaedics (eg hip and knee replacements), spinal surgery, urology, and weight loss (bariatric) surgery.

There were five operating theatres, four of which had laminar flow ventilation systems which ensured clean air for more complex surgery. There was one dedicated endoscopy unit. There were 59 inpatient beds and an 12 bedded day care unit, all were single rooms with ensuite facilities. In 2013-14, the hospital had approximately 4500 overnight inpatients, 5,200 day patients and 8,400 visits to the operating theatre.

We spoke with 13 members of staff from the operating department; four consultants; the resident medical officer, three ward administrators; 11 members of nursing staff from the wards and day care unit; two nurses from the pre assessment team; a dietician, physiotherapist and ten patients. We visited the three in patient wards the surgical day care unit, the pre assessment clinic, the endoscopy unit and the operating theatre.

Summary of findings

Surgical services were following procedures to provide safe care but there needed to be improvements in incident investigations, infection prevention and control, and patient records. Staffing levels and the skill mix of staff were appropriate on the wards. Staffing levels in pre-assessment meant that not all patients could be reviewed prior to admission and, staffing levels in the recovery area of the operating department did not always meet national guidelines. Many staff worked long hours to respond to service demands. More formal systems were needed to ensure medical staff who assisted when on call, had appropriate recruitment checks. Staff were using national guidelines to treat patients and performance was being monitored. The hospital reported mortality rates were lower than national average for cardiac surgery, although audit needed to improve to demonstrate compliance with standards overall and patient outcomes. Staff needed to improve their awareness of dementia care and their responsibilities under the Mental Capacity Act, 2005 and action was being taken to address this.

Staff were caring and compassionate and treated patients with dignity and respect. Patients were positive about their experience and the care they received. Services were responsive to patient' needs and there was no differentiation in services between private or NHS patients. Operations were very rarely cancelled but staff perceived that cancellations were more likely to happen on NHS patient lists as these sometimes could overrun. Patients living with dementia or who had a learning disability, however, needed better support. Staff were positive about the hospital as place to work and the leadership of the service. Governance arrangements were in place and performance was monitored; there needed to be more formal arrangements around the actions taken to manage clinical risks. Patient feedback was used to improve the service.

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Are surgery services safe?

Staff were clear about their responsibility to report incidents. The timeliness of investigation following incidents needed to improve but lessons learnt were cascaded to staff. There was a good infection control surveillance programme and prompt action was taken to identify and isolate infections. Staff however did not always observe infection control procedures and the environment did not segregate clean and dirty areas appropriately. Damage to the fabric of the building also increased the risk of cross infection. Equipment was available and maintained. Medicines were well managed. Patients records contained appropriate information but were not always completed as information from outpatient appointments and other providers might not be present. Safeguarding procedures needed to improve and action was being taken to address this. Patients whose clinical condition might deteriorate were identified and monitored appropriately. Staff had completed immediate life support training, but more staff needed to complete annual training in basic and paediatric life support. Staffing levels and the skill mix of staff were appropriate on the wards. Staffing levels in pre-assessment meant that not all patients could be reviewed prior to admission and, staffing levels in the recovery area of the operating department did not always meet national guidelines. Many staff worked long hours to respond to service demands. More formal systems were needed to ensure medical staff who assisted when on call, had appropriate recruitment checks.

Incidents

- Over the 12 month period July 2013 to June 2014 there had been 183 clinical incidents reported. Twelve of these had been classified as serious incidents, the majority in surgery. There had been 134 near misses reported and 40 adverse events reported in surgery (April 2014 to October 2014).
- Staff were aware of how to report an incident using the hospital's electronic reporting system. An automatic email was sent to the person completing the submission to confirm receipt. The majority of incidents were reported within the hospital target of four days.

- The hospital had an incident log which categorised incidents under clinical, non-clinical, drug related, infection control, manual handling and medical devices headings. The information also included the outcomes to any investigation.
- It was not always clear what action was taken following incidents. For example, following an incident it was noted that there were no emergency call bells in the anaesthetic rooms. This had been placed on the hospital's risk register and the investigation and the course of action was being decided. The hospital's health and safety report in June 2014, identified that theatres had 45 outstanding incidents where action had not been taken or issues resolved.
- Staff on the wards and in the operating department confirmed that they received general feedback through the cascade of information at team meetings.
- Patient safety alerts, for example, from the Medicines and Healthcare Products Regulatory Agency or the central alert system, were reviewed by the hospital. These were reviewed and appropriate action was taken if required.
- Nursing staff and the dietician told us that bariatric case studies were discussed at quarterly mortality and morbidity meeting.

Safety thermometer

- Information was collected and reported to commissioners for NHS patients but this was not used as a tool within the hospital.
- Information on falls, infections, venous thromboembolism (blood) clots and pressure ulcers was monitored as part of the hospital's clinical scorecard. The hospital was meeting its targets overall but had a higher rate of falls than its own target (1 July to 30 September 2014). The information was not displayed in ward areas, and the staff on the wards were not always aware of these quality indicators and how they performed as a ward.

Cleanliness, infection control and hygiene

- There had been one reported infection for methicillin-resistant staphylococcus aureus (MRSA) and no reported infections for Clostridium difficile between April 2013 to September 2014.
- There was a lead infection prevention and control (IPC) nurse who worked 30 hours a week supported by a microbiologist. The hospital matron was the hospital lead for infection prevention and control. All wards had

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a IPC link nurse who would attend quarterly meetings and cascade information to their colleagues. These positions were vacant on wards one and three where they were actively looking for volunteers to ensure information was effectively cascaded and to reduce the burden on the lead nurse.

- There was an IPC committee, which met quarterly, with representatives from estates, pharmacy, operating department and pathology. Minutes from the meeting demonstrated that policies were reviewed as were national alerts and adverse events relating to IPC were discussed and action taken.
- There were good surveillance practices to identify and treat infections in a timely manner this included support from a microbiologist. People with a known or suspected infection were isolated. It was not possible, however, to immediately identify that a patient may have an infection that required isolation. Trolleys with the personal protective equipment were placed outside rooms but this did not indicate the isolation room. Most clinical staff did know which patient was affected but others would not know and this was a potential infection risk.
- The hospital target for surgical site infections as a percentage of total hip replacement and total knee replacement procedures for a rolling 12 months was less than 0.6%. The hospital was above (worse than) this target for hip surgery 0.93% and for knee surgery 1.05%. Action was being taken to improve this and the hospital had introduced a surgical infection prevention and control care bundle. The last known compliance level with the care bundle was 100% but this data was for March 2013.
- Personal protective equipment (PPE) was readily available in all clinical areas visited however; this was not always being used. We observed nursing staff carrying contaminated items such as used urinals without the use of gloves or aprons.
- Infection control training was available to all staff as an e-learning package. Seventy two percent of staff had completed this training for the year to date.
- There were notices on each ward to remind consultants that they should be bare below the elbow when delivering direct patient care with reference to the National Institute for Health and Care Excellence (NICE), guidance Infection: Prevention and control of healthcare-associated infections in primary and community care (2012).
- Clean and dirty items were not always segregated. On ward two, access to the area where clean equipment was stored was via an area where bags of dirty linen and bags of rubbish were stored while waiting collection. There was also open access to the dirty utility room through the same area. In the operating department (theatre), the theatre trolleys were cleaned in the area referred to as the dirty corridor and then returned to the theatre clean passing by a cleaner's cupboard (which was open) and clinical waste bins. There was clean equipment stored directly outside theatre five in the designated dirty corridor.
- The clinical waste bins in theatres were overfilled and the bin bags were falling out.
- There was a process in place for labelling items as ready for use after cleaning however in the store area on ward two we found that items labelled as clean were dirty.
- The fabric of the walls had been damaged in the dirty corridor in the operating department. There was also damage to the walls in the cleaner's cupboard where there was visual discolouration to the walls. There was an access door to this area that was not for general use but staff were frequently observed using this door to access the department. Therefore passing through a dirty area to gain access to a clean area.
- The shared setting up area for theatre two and three could be accessed directly from the main theatre corridor which could compromise the sterility of any instrument sets, laid out ready for use. There was no instruction on the door to advise staff not to enter this area.
- There was not a hand wash sink in the cleaning area of the endoscopy unit, this had been acknowledged and there were plans for a sink to be installed. There was also open shelving that had been covered with plastic sheets, this was a potential infection risk and there were plans to fit permanent covers.
- There was a dedicated cleaner for the operating department who had received additional training to clean this area. Daily cleaning check lists were also in use and the cleanliness was being monitored through audit.
- The hospital had its own dedicated sterilisation and disinfection unit. There was a clear dirty to clean flow process, with clearly defined areas for each part of the process. However, single use gowns used in the

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packing room had been used more than once on the same day. We observed staff hanging them on hooks when they left the area and reusing them when they returned.

- Bed mattress were cleaned between patients and a more detailed checked by an external company took place annually. We inspected three mattresses, they had check dates recorded as 2012, 2013 and 2014 and it was not clear if they had been checked annually. Two were heavily stained on the inside.

Environment and equipment

- Equipment was visibly clean. Items were labelled with the last service date and large green stickers identified when equipment was cleaned.
- All equipment was listed on a corporate computerised maintenance management system. The information included frequency of required maintenance (in line with manufacturer's guidance and best practice) and the details of who held the maintenance contract agreements. The system flagged up when maintenance was required.
- There was a contract for portable appliance testing, these were conducted on an annual basis. A record of checks were maintained.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention. This was undertaken through an electronic reporting system. Records held centrally demonstrated a swiftly response and work was prioritised according to importance/essential equipment.
- Equipment for bariatric patients was available on the wards. The need for mobility aids for bariatric patients were assessed during pre-assessment and patients who already had equipment to aid their mobility brought this with them on admission. Staff informed us that they rarely ran out of appropriate equipment and that equipment could be ordered and delivered to the hospital within two days.
- Equipment to be used in an emergency was available in all areas and was being checked on a daily basis or when the department was being used.
- Anaesthetic machines were checked daily. Pre and postoperative instrument checks were taking place to ensure that the correct items were present.
- All areas of the hospital were open and accessible to all, there was no restrictive access. This was of particular

concern in the operating theatre where anyone could enter the department without reporting to the reception area. The cleaners cupboards were also unlocked and could be accessed by any one even though they contained fluids that came under the Control of Substances Hazardous to Health (COSHH) regulations (2002) which identifies the need for the area to be locked.

- In the operating department the new post of loan coordinator had been introduced. They had responsibility for management of stock control and of loan kits for orthopaedic surgery.
- The washers and sterilisers in the endoscopy unit were checked and serviced on an on-going basis with a check run taking place at the beginning of each day to ensure that there were fit to be used that day.
- The patient led assessment of the care environment (PLACE) conducted in June 2014 was positive about the ward environments.

Medicines

- Medicines were securely stored. The temperature of the fridges used for the storage of medicines was monitored on a daily basis. Appropriate actions were taken if the temperature was outside of the recommended temperature range.
- Control drugs were stored securely in the endoscopy unit and the stock was checked daily. Records of administration were completed.
- The pharmacy provided a medicines reconciliation service on admission and prior to discharge to ensure that medicines prescribed in hospital correspond to those that the patient was taking before admission.
- The pharmacy was registered with the General Pharmaceutical Council to allow the sale of pharmacy only medicines and to dispense private prescriptions from prescribers outside of the service.
- There were systems in place to ensure the safe storage of spare keys to medicines cupboards and control drug safes.
- The size of the pharmacy limited the amount of stock held. This in turn led to frequent small orders. As a consequence more pharmacy staff time was spent on ordering and stock management reducing the amount of time available for pharmacy staff to visit the wards.
- The pharmacy did quarterly drug chart audits to review prescribing, completion and verification of medicines.

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The results of the audit showed high compliance (100%) overall. There needed to be improvements in the documentation of weight, previous medications and pharmacy verification.

- Patients told us that they knew what medication they had and why it was prescribed and this had been explained to them by the staff.
- Discharge medication profiles of all discharge medicines were provided to the patient, GP, physiotherapy and consultant's secretary.

Records

- Records for planned admissions were received on the ward and reviewed by the ward administrator to ensure there were fully prepared the evening before admission.
- We reviewed nine surgical records. We found that the documentation in all the surgical records and on assessment and theatre forms was not always fully completed, and there were missing dates and signatures. Three surgical records did not have a signature of the nurse receiving handover from theatre staff. This meant that a named nurse was not identified as accountable for the handover.
- Anaesthetic records were completed inter operatively.
- Patients were sent a pre assessment medical questionnaire to complete and return, these were not always available when patients was admitted particular for day case surgery, in these cases the form would be completed again.
- Outpatient records and in patient records were not always consolidated into one. This was because for private patients the outpatient records would be the property of the consultant. The hospital was working with the consultants to ensure that summaries were provided for the hospital records.
- All hospital staff were required to write in the one patient record and medical staff were encouraged to record their visit. The last records audit conducted in October 2014 demonstrated that 93% of consultants had written in the records.

Safeguarding

- There was an on line safeguarding training package for staff which had been completed by 89.2% of staff.
- The hospital matron was a member of the local independent safeguarding group and had attended an

update training day in July 2014. There was an awareness that as the hospitals client base had changed there needed to be an increased awareness of the staff's responsibilities to ensure that the patients were safe.

- A ward sister managed the hospital process to ensure that all staff, who required a professional registration, to practice provided current evidence of their registration.
- There was an established recruitment process that included the requirement for two references and a current disclosure and barring scheme check prior to a new member of staff commencing employment.

Mandatory training

- There were nine mandatory elearning modules for staff to complete these included fire safety, manual handling, information governance, infection prevention and control, safeguarding adults and children and equality and diversity
- There was a mandatory training policy that detailed which training staff were required to attend this also included resuscitation training. The training records showed that attendance at training was monitored
- At the end of 2013, 83% of staff were up to date with their mandatory training this had been lower than the hospital target of 95%. For the year to date (1 January to 31 August 2014), 58% of staff had completed the mandatory training. For surgery, 63% of nursing staff and nursing support staff, 63% of theatre staff and 71% of theatre support staff had completed this training.
- More staff needed to complete life support training. The hospital training figures for the end of year demonstrated what training was outstanding for 2014. The hospital identified that 87.6% of ward staff had completed adult and paediatric basic support training; 96% had completed adult immediate life support and 52% paediatric immediate life support. Approximately, 64.7% of theatre staff had completed adult basic life support training and 62.75% had completed paediatric basic life support training; 76% had completed adult immediate life support and 50% paediatric immediate life support.

Assessing and responding to patient risk

- The Five Steps to Safer Surgery Checklist was being used. The process was audited monthly through an observation audit. The outcomes from audit demonstrated compliance was 96% (October 2014). We

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observed two cases and all staff were present and participated in the time out and sign out process. Team briefings across all five theatres were well embedded and documented.

- In line with national sepsis bundle guidelines patient's temperatures were monitored throughout the perioperative period at 30 minute intervals. The hospital compliance had improved from 60% (1 January to 31 March 2014) to 90% (1 April to 30 June 2014).
- There was a pre-assessment process. All patients were asked to complete a medical questionnaire. The completed questionnaires were reviewed by the pre assessment team of nurses and a decision made as to whether a face to face assessment or telephone assessment was required. There was a written criteria as to which patients should have a face to face assessment but from discussion with staff, this was not always followed.
- There were no clear protocols for pre assessment staff to follow though patients were referred to an anaesthetist if there were concerns about the patient's fitness for surgery. We saw examples of concerns that had been escalated for review by the matron before a patient was admitted.
- Venous thromboembolism (VTE) risk assessments were completed on all patients. Compliance was 95% and compliance with VTE prophylaxis was 100% (1 April to 30 June). There was an on line training video for staff to watch on the management of the risk of VTEs. When incidence did occur a root cause analysis was undertaken. Findings were presented at the clinical effectiveness meeting and at ward hand overs. The information was also shared with the named consultant responsible for the patient to ensure that learning took place.
- The National Early Warning Score (NEWS) system was being used to identify early and respond to patients who presented with an acute illness or whose condition might deteriorate.
- There was an ortho-geriatrician (a doctor who specialises in the care of elderly orthopaedic surgery patients, most often following a fractured hip) who had practising privileges and who would provide advice for patients with complex needs.
- Nursing staff and the dietician caring for bariatric patients assessed patients prior to surgery to ensure that they were medically fit and to reduce the risk of post-surgical complications. Each multidisciplinary

team member completed assessment tools. We reviewed three pre assessment records and they included documentation to support assessments such as VTE and falls.

- Physiotherapists risk assessed the mobility of bariatric patients. They had made changes following this, for example, physiotherapists no longer took bariatric patients on to stairs as if patients fell it would be difficult for staff to get patients back onto their feet.

Nursing staffing and theatre staffing

- Staffing in the operating theatres was in line with national guidance from the Association for Perioperative Practice. There was an operating department practitioner, two people to scrub and a support person in each theatre. If there was an unexpected shortage the situation was risk assessed and adjustments made. There was an on call team available from 9pm. There were occasions when theatre list over ran and staff worked later into the night. This meant that staff could be on duty the next day without an eight hour break. This had been acknowledged as an issue by the managers of the department and a solution to the issues was being consulted on.
- The current vacancy rate for theatre staff was 6% and the hospital was actively recruiting to these posts but the process was deemed by staff to be taking a long time.
- A theatre coordinator handover check sheet was being used in the operating theatre. Information captured included changes to planned activity, sickness summary and outstanding shifts. For a mid-day hand over a summary of activity was also included.
- On the wards at each shift change staff received a verbal hand over for each patient which included diagnosis, treatment, progress to date and outstanding work to be completed that day or required moving forward.
- The current vacancy rate for ward staff was 4% and recruitment was on-going.
- Ward staffing levels were set taking into account patient acuity. The expected base line was one nurse to five patients in the day and one nurse to seven patients at night. Staff were based on a ward area relevant to their skill and an experience and the three wards were for cardiac, orthopaedic and general surgery. Staff were expected to be flexible and when required to help in other areas.

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- At times the nurse to patient ratio was higher than anticipated with 1 to 7 in the day time. It had been acknowledged that additional staff were required and a recruitment campaign was on going. Staff had worked flexibly and bank staff were used to ensure that wards were covered. Agency staff were not being used.
- Any concerns were raised with senior management. Staff would be moved to ensure that as far as possible a safe environment was maintained. Health Care Assistants who had completed additional training would take a case load of their own of patients that they had the skills and knowledge to care for .
- There was a nurse who took a lead responsibility for VTE and was the blood transfusion coordinator for the hospital. However, they had no protected time to undertake these roles and would come in on their day off to complete work.
- The pre assessment team reported that they did not have enough staff to be able to review all patient's prior to admission, this had been recognised by the hospital.
- Staff working in the operating department recovery area felt that they were not supported. There were six main recovery bays and two additional bays. There was two or three staff per shift in line with the Association of Anaesthetists of Great Britain and Ireland. Immediate Post-anaesthesia Recovery 2013 guidelines. However, there could be two patients per recovery nurse which would not be line with national guidelines if patients had not regained airway control, respiratory and cardiovascular stability, and were unable to communicate.

Surgical staffing

- There were 100 consultant surgeons with practising privileges at Spire Southampton Hospital
- All patients were admitted under the care of a named consultant. Consultants were expected to visit and review their patients on a daily basis. They were also expected to be available to be contacted throughout the time they had patients resident in the hospital or to arrange cover by a peer. Staff and the Resident Medical Officer (RMO) were all positive about the support from consultants and their availability.
- Surgeons were able to bring a first assistance to support them in the operating theatre. The clinical policy number 25 issue 2 (April 2010) clinical support specialist handbook stated that external assistance must provide a curriculum vitae; evidence of an occupational health

check; criminal records bureau check (now Disclosure and Barring Scheme); indemnity insurance; evidence of register with General Medical Council (GMC); identification ie passport. This information was held in the operating department to manage. However we were told by the department manager, that the information was to be provided as soon as possible and a person may assist when the surgeon vouched for them without this information being available. While there was a risk assessment in place, the process was not robust and was being applied flexibly.

- Fifty percent of the hospital's own staff were able to act as a first assistant having completed either an advanced scrub practitioner course or in house competency based training signed off by a consultant equipping the member of staff with general assisting skills only. Staff assisted in their preferred speciality and were not expected to take on a dual role of scrub nurse and direct assistant.
- There was a RMO present in the hospital at all times. There were five RMO- doctors at specialist registrar level working on a rota. They worked a rota of 24 hours on a week day and 48 hours on a weekend. When on duty they were resident on site for the duration of their shift.

Major incident awareness and training

- Staff reported that they were required to understand their role if there was a fire and described the evacuation to a place of safety process.
- Staff were aware that if a major incident occurred they may take patients from the local NHS hospital in order to free up beds.
- Consideration had been given to situations that may occur, for example, extreme weather conditions such as snow and how this could be managed.

Are surgery services effective?

National guidance was considered and implemented to inform care practices in the hospital. Staff had access to information on the wards on procedures and guidelines. Mortality rates for cardiac surgery were lower than the national average. Other information on patient outcomes was being collected, but was not produced to demonstrate results locally. Patients reported that their pain was well managed and they had appropriate nutrition. There was a choice of meals available and special diets could be catered for; a dietician was available to give advice and

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support. Patients undergoing surgery were fasting longer than the recommend times but action was being taken to address this. Nurses reviewed patients with consultants and therapy, dietetic and specialist advice was available. There was an established induction program that supported staff to understand the hospital structure and the expectations of their role. Staff were supported through appraisals and competency assessment were used to support staff in developing new skills. Staff had a limited understanding of the Mental Capacity Act.

Evidence-based care and treatment

- A combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided.
- There was a local policy for nutrition and enteral feeding based upon the NICE guidelines 2006 (Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition). There were protocols for the prescription of nutrition support and supplements.
- There was National Patient Safety Agency (2011) guidance on 'Decision tree for nasogastric tube placement checks in adults'. The hospital had a nasogastric and naso-jejunal tube variance tracking sheet which staff were prompt to complete to ensure the tube was safely used.
- Venous thromboembolism (VTE) risk assessments were conducted in line with NICE guidelines and the hospital was using the department of health risk assessment tool.
- Patients care was planned by following corporate care pathways. Where national guidance was available this was referenced in the care plans, for example, management of insertion of a system to enable the delivery of high dose anti-cancer drugs to a specific area.
- There was an audit plan, which covered for example record audits, health and safety audits, however there was limited information that related to clinical outcomes.

Pain relief

- Patients reported that they were asked about their pain and that when required they were offered pain relief.
- Some patient's had their pain controlled using an epidural, a controlled infusion of medication into the spinal area, or patient controlled analgesia via an infusion pump. The effectiveness of these was monitored by the nursing staff.

- The hospital audit demonstrated 100% of patients had, had their pain assessed.

Nutrition and hydration

- Compliance with current fasting guidelines was monitored. Between 1 January to 31 March 2014, 65% of patients had gone without fluids between 3 and 12 hours prior to surgery. Action was being taken to increase staff and patients awareness of the importance of having fluids pre-operatively and this figure had reduced to 25% of patients (1 April to 30 June 2014).
- A dietician was available to assess and care for patients requiring nutritional treatment Monday to Friday. All staff we spoke with were aware that a dietician was available for patients requiring advice and treatment and all staff knew how to refer patients to the dietician.
- Patients were assessed for malnutrition using the Malnutrition Universal Screening Tool (MUST). However, when we asked nursing staff about the tool, not all staff could describe how it should be used correctly and one nurse did not know how the ward screened for malnutrition.
- Total parenteral nutrition (TPN) was available from the Southampton General Hospital and the Spire Southampton Hospital ordered and administered TPN in line with Southampton General Hospital's protocols. This was ordered on a daily basis before 10am and delivered by 5pm. If the dietician was unavailable the pharmacist would order this.
- Patients had a choice of meals and could order lunch and evening meals on the day. Out of hours cold food was available for patients who had missed a hot meal. Patients had access to hot and cold drinks at all times. Special diets were catered for. Patients were positive about the food. For example, one patient told us "the food is good and they will get you anything you want."

Patient outcomes

- Surgeons contributed outcome data from the hospital to the national adult cardiac surgical database, the national joint registry and the National Confidential Enquiry into Peri-operative deaths (NCEPOD). Outcome data for the hospital was not provided.
- The cardiothoracic surgeons reported data about survival rates following surgery undertaken at the hospital. This was required by the Society of

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Cardiothoracic Surgeons in Great Britain & Ireland. Between April 2010 - March 2013, the hospital reported mortality rates of less than 1%. The national average was 2.5%.

- Surgeons performing bariatric surgery on NHS patients were collecting data for a gastric bypass versus gastric band audit. Bariatric surgery data was submitted to the International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) and the British Obesity & Metabolic Surgery Society (BOMSS) for research purposes. Outcome data for the hospital was not provided.
- The number of readmission within 29 days of discharge was similar than expected.
- The rate of unplanned transfer to another hospital was similar to expected. Overall the rate of unplanned transfers of inpatients to other hospitals had fallen over the period April 2013 to June 2014.
- From 1 April to 30 September 2014, approximately 85% of patient with hip and knee replacements over 70 year of age had a cemented prosthesis in line with best practice.

Competent staff

- New staff were supported through an induction process which included some supernumery time and competency assessments. Staff were also supported by a mentor.
- All the employed staff we spoke to had had a six month and annual enabling excellence review, a type of appraisal. This included discussion about performance and development. Ninety six percent of staff had, had an appraisal.
- Training courses were accessed through a provider in London, locally through the NHS trust and internally through the Spire Healthcare group.
- Staff were positive about the support their received to gain additional skills, such as venepuncture, through a competency assessment framework.
- The hospital was working to ensure that all information held about consultants with practising privileges was current and accurate. This included evidence of current registration with the general medical council, relevant insurance and evidence of an appraisal that included evidence of review of work for all areas of their private practice. The hospital had taken action to improve infection rates for one surgeon who was an

outlier. Improvement was demonstrated but this information had not been added to the consultants personal file or NHS file at the time of this inspection. Some consultant practising privileges were out of date.

- The RMO was trained in Advance Life Support (ALS) and European Paediatric Life Support (EPLS) to be able offer to support in an emergency if a patient collapsed. If additional airway support was required then the on call anaesthetist would be called in.
- The dietician told us that they provided on ward training for staff as required. They also allowed new nursing staff and student nurses to shadow dietetic practice to enable understanding of the dietician's role. There were staff nutrition workbooks and self-assessment tools for staff to use available in the wards nutrition support manuals.
- The dietician told us that they were able to attend national study days to ensure that they continued to develop their knowledge and skills.
- Health care assistants (HCA) in the operating theatre had been or were being supported to complete training to become a scrub practitioner; others were being support to go to college to compete the operating department practitioner training. HCA on the wards were being supported to complete further training to enable them to undertake additional roles.
- Staff had not received any training in caring for patients living with dementia, this had been acknowledged by the provider and an e- learning awareness training package was being introduced.

Multidisciplinary working

- Nurses worked with consultants to review their patients. Physiotherapist and dieticians saw patients pre and postoperatively and wrote in the patient records
- Consultants felt that there was a good working relationship with hospital management team and the staff.
- Patient records demonstrated that there was communication between the bariatric surgical team and the patients GP, practice nurse and the local NHS trust if applicable, to explain the procedure patients had planned, or had received and the care that they would require from each service.
- There was a dedicate nurse with a special interest in cosmetic surgery who was available to speak to patients and to offer guidance and support during the decision making process.

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Seven-day services

- Theatres were open 8.30pm to 9pm Monday to Friday and from 8.30pm to 4pm on Saturdays there was a 24/7 on call service.
- Consultants who had inpatients were expected to conduct a daily ward round.
- Consultants provided 24 hour on-call (off site) cover for their patients. If they were unavailable at any time they organise a consultant colleague with admitting rights to provide cover in their absence.
- A Resident Medical Officer (RMO) was available and onsite 24 hours a day 365 days a year. Consultants who had inpatients were expected to conduct a daily ward round.
- There was a physiotherapy service available seven days a week.
- A dietician was available to assess and care for patients requiring nutritional treatment Monday to Friday. There was no cover for the dietician, and they told us that they would be contacted during days off and during leave to provide dietetic advice. The dietician told us that they were trying to set up a bank dietetic service to help resolve this issue.
- The pharmacy was open 8.30am to 5.30pm Mondays to Friday and 9am to 1pm on Saturday mornings. Out of hours there was an on call service that was shared with Portsmouth Spire Hospitals.
- The radiology department operated from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service. MRI scans were also available between 8am and 3pm on Saturdays.
- Pathology services were available from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service.

Access to information

- There were resource folders on the wards to provide staff with information about procedures and treatments, including on ward 3, bariatric surgery.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of consent and consent was appropriate prior to surgery. Consent audits undertaken (January to May 2014) identified the need

for consultants to clearly provide their name, signature and date of procedures and for the patients name and signature to be clear. There was an action plan to address this.

- The two week cooling off consent period for cosmetic surgery was audited in 2013. This demonstrated that the guidance was adhered to and any breaches had been risk assessed and agreed. The audit was to be repeated in September 2014 but results were not available yet.
- An e-learning training course was available for staff based on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). At the end of June 2014, 48% of all staff had completed this training. However, many of the staff we spoke with were however staff were not clear of their responsibilities under the Act. The hospital had acknowledged that more work was required following an incident when a patient living with dementia was admitted for surgery. Issues were identified at the patient's pre-assessment and action was taken to ensure correct procedures were followed, their capacity to consent assessed and the patient had appropriate support during their admission.
- The hospital has not made any DoLS application. The matron was able to describe an incident when they had deprived a patient of their liberty and how they now understood that an application should have been made. It was acknowledged that this was an area where staff required further education.

Are surgery services caring?

Staff were caring and compassionate and treated patients with dignity and respect. Patients felt they were well treated. Patients were kept informed and involved in the decision making process and received support for their emotional needs.

Compassionate care

- We observed staff to be caring, compassionate and polite when dealing with patients. The staff treated patients with dignity and respect and calls bells were answered promptly.
- Patients in the operating theatre and the recovery area were treated in a kind, caring, unhurried manner. We observed wards staff to be caring and polite.

Surgery

- Patients had been asked how they wished to be addressed and staff introduced themselves and asked permission to enter their room and to give care.
- People were positive about the way they were treated they said “I am being treated well” and I am being treated with dignity and respect.”
- There was clear rapport between bariatric patients and the dietician when we observed an outpatient clinic.
- The hospital had recorded high Friends and Family Test scores for both privately funded and NHS funded patients who had responded to the survey. The response rates for privately funded patients was low in terms of absolute numbers and also compared to the response rates for NHS funded patients.
- We received 19 comment cards from patients using the service. Patients were overwhelmingly positive about the service and told us about excellent, professional and caring staff. Patients identified that staff regularly checked on their health needs and wellbeing. Only one patient identified the need for support to eat when they were on flat bed rest.

Understanding and involvement of patients and those close to them

- Patients reported that they were given the opportunity to ask questions and felt involved in the decision making process. Patients said “I am well involved with decisions about my care. I am informed about what is happening and I get the opportunity to ask questions.”
- Patients were given the choice of which pre bariatric surgery diet they would like to follow. The dietician explained the treatment options to patients in the outpatient clinic.
- We received 19 comment cards from patients using the service. Patients told us that throughout their admission, including pre-admission, they were given clear explanation of their procedures and what would happen during their hospital stay.

Emotional support

- A nun visited the hospital once a week and would meet with people to address their spiritual needs and additional ministerial support would be provided if required.
- A patient liaison person visited all patients every day and worked with the deputy matron to ensure that patients’ emotional needs were met.

- NHS patients who received tier 3 support for weight management received psychological support prior to bariatric surgery. Private patients who received bariatric surgery could be referred for psychological support if required but this was not provided as standard.

Are surgery services responsive?

The majority of patients were admitted on a planned basis for elective surgery this included private patients and NHS patients. The hospital provided timely hip and knee surgery and cardiac surgery for NHS patients. It was rare for operations to be cancelled due to the lack of beds or theatre time, if this did occur they would be rescheduled at the earliest opportunity. There was no differentiation between private and NHS patients in terms of services received. There were very few cancelled operations, although staff said cancellations were more likely to be on NHS patient lists which could overrun. The number of NHS patients that were transferred back to an NHS hospital was low and was being done according to contracts with commissioners for ongoing or further care. Discharge was supported, and there were arrangements for patients with complex needs. There was no specific support available for patients with a learning disability or those living with dementia. Patient information was available but it was not documented that these had been given to, and discussed with, patients. Complaints were investigated and learning was shared.

Service planning and delivery to meet the needs of local people

- All admissions for surgery were planned in advance this included private patients and NHS patients.
- The hospital only accepted patients for planned or semi planned (patients who are inpatients in the NHS and unable to be discharged home until treatment is undertaken) for elective surgery. There were no facilities for emergency patient admissions.
- The hospital had contractual agreement with the local clinical commissioning group to undertake orthopaedic and cardiac surgery for NHS patients.

Surgery

Access and flow

- Consultant surgeons had allocated theatre time to plan their lists, extra theatre time when available could be accessed. Admissions were planned according to available theatre time and bed availability and patient requirements.
- If a patient was fit for bariatric surgery and were able to follow the liver reduction two week diet, then surgery could be within two weeks of assessment. This was a diet designed to be followed for the two weeks before surgery to help shrink the liver so the surgeon can operate more easily and increases the chances of surgery being performed by keyhole surgery.
- The Matron reviewed the records of all NHS patients, acting as a gate keeper to ensure that the hospital was able to meet the person's individual needs. More information was requested if required before the decision to accept the patient was made.
- Cancellations of operations were reported by the department manager to be rare. There was a policy that no planned procedure should commence after 8pm. In discussion with the consultant the procedure would be postponed and the next available slot offered for re scheduling. Cancellations and procedures after 8pm were monitored and the findings showed that these were low. Theatre staff noted that if cancellations were required this would more likely be for NHS patient lists as these sometimes could overrun.
- There was no differentiation between NHS or private patients in terms of services received.
- Between April to September 2014, there had been six transfers to the local NHS Trust for ward care. These had been for contractual reason where patients who had received NHS funded care were transferred for on-going or further care. This represented approximate 2% of the total number of NHS patient discharges.

Meeting people's individual needs

- The dietician had access to a bioelectrical impedance analysis (BIA) to measure patient's body composition. We saw this in use and the dietician explained to the patient the need and result of the test.
- The dietician had an 'open door' policy for patients who had received bariatric surgery. They had planned pre and post-surgical consultations but patients could contact the dietician and receive telephone and email advice as well as additional consultations if required.

- The hospital had a contract with Homeward, a home enteral feeding company, to facilitate discharge for patients who required training to use their feeding tube and feeding pump at home.
- The hospital would contact the local social service hub to gain support to enable the discharge of patients with complex needs. They would also work with family's and district nurses to facilitate a safe and timely discharge. For NHS patients who had undergone orthopaedic surgery the hospital was working with the local NHS trust to enable them to use the healthcare at home team.
- The hospital had an orthogeriatrician (a doctor who specialises in elderly people who undergo surgery after a fall) who helps in discharge planning to ensure patients have adequate support at home
- There were no dedicated facilities for patients living with dementia or with a learning or physical disability. All rooms were single rooms with ensuite facilities, rooms were available with walk in showers, for people who required assistance.
- Patients said that the pre-assessment clinics provided them with good information about the hospital stay and expectations of to expect through recovery and discharge preparation.
- Patient information had been reviewed, and this included updates to make it clear when patients should take their last drink of clear fluids prior to surgery.
- The dietician had detailed patient information booklets for patients to read information regarding their surgical procedure, and optimum dietary and medication advice. This included information for pre and post bariatric surgery, Nissen fundoplication surgery and the management of Chyle leaks post-surgery.
- We reviewed nine surgical notes. Five of these reviewed did not have a patient signature to confirm that they had "Received a written copy of the patient information booklet and had the opportunity to discuss it" or that, "My operation, progress and how long I am expected to stay in hospital following the operation " had been discussed.
- A discharge letter was completed by the nursing staff and given to the patients on discharge from the ward.

Learning from complaints and concerns

- Complaints were handled in line with hospital policy. Members of staff told us they would deal with any complaints on the wards.

Surgery

- Complaints leaflets were available throughout the hospital. We observed these on the wards and in clinical areas.
- All of the patients we spoke with said they were either aware of how to make a complaint or where to find the information.
- The outcome of complaints was shared with staff.

Are surgery services well-led?

Staff were aware of the vision and strategy to expand the service. Staff were positive about the leadership of the service and improvements were being taken to improve the management of theatres. Clinical governance arrangements were effective to monitor performance but needed to improve so that the actions taken on clinical risks were formally documented and reviewed. There needed to be better processes to monitor consultants practising privileges. Staff were effectively engaged and action was being taken in areas of concern but some staff identified the need to have further opportunities to raise issues and concerns. Patient feedback was used to improve the service.

Vision and strategy for this service

- The hospital's strategic objectives for 2014 were to improve on clinical performance quality indicators and there were also some specific service improvements. For surgical service, for example, these included increasing the range of cardiac services and opening a sixth theatre and increasing the number of inpatient beds by six.
- Senior staff had shared this vision with staff, including consultant staff, and they were supportive.
- All staff were clear about the hospital's vision and values that encompassed key elements of care such as compassion, dignity, respect, and equality with quality a key priority.

Governance, risk management and quality measurement

- Ward and department meetings took place and staff were updated on information from the hospital clinical governance meetings. This included information on complaints, incidents, and audit. For staff who were unable to attend notes were taken and made available.
- The hospital risk register was focused on environmental and equipment risks rather than clinical risks. In surgery

the risks identified were a lack of emergency call bells in anaesthetic rooms; Autoclaves and washers unreliable and endoscope room ventilation issues, not compliant with regulation. These were being monitored action was being taken. Clinical risks were not identified and monitored in the same way.

- The hospital used a corporate clinical quality metric to monitor performance. There were 32 clinical items that were monitored. For surgery, these included theatre starving times and monitoring of patients pain; infection rates; compliance with reporting and recording of incidents and complaints; the incidence of venous thromboembolism (blood clots) and pressures sores. There was an escalation process and if the hospital was under performing, and an exception report with details of the actions being taken had to be submitted corporately. Reports were published and reviewed quarterly.
- The hospital's score for patients fasting times had improved (July to September 2014 2014). The hospital, however, continued to under achieve in three areas, two of these related to surgery these were the percentage of eligible patients undergoing hip& knee surgery where chemical VTE prophylaxis is given within the recommended timescale and surgical site infections as percentage of total knee procedures. The hospital had been required to submit an action plan to their corporate team (Spire Healthcare).
- Hospital clinical indicators and outcomes were discussed at the medical advisory committee to ensure they were informed and to engage consultants in improvements were required. There was a set agenda for each of these meetings with standing items such incidents, practising privileges, complaint and any new national initiatives.
- The monitoring of consultants to ensure they all had current medical indemnity insurance, appraisals and professional registration was not robust. Information on medical indemnity insurance was not appropriately acted upon to suspend surgeons in a timely way when this was not up to date.

Leadership of service

- Each ward or department was led by a ward sister or manager. Staff were positive about the local leadership at ward and department level.

Surgery

- Staff felt that they were kept informed and that the local managers, the ward sisters and theatre manager, were approachable.
- The lead nursing staff were supported by a deputy matron and a matron. The hospital director and matron was highly regarded by staff. Staff in all areas were positive about the opportunities to meet and speak to the hospital director and matron through the staff forum.
- In the operating theatre staff were positive about the visibility of the hospital management team. The matron attended the operating theatre on a monthly basis to meet with staff. Concerns had been raised about the theatre management team and a new theatre management team had been recruited.
- In response to feedback that it was sometimes difficult to identify the person in charge senior staff now wear different colour theatre attire.
- There were consultant leads who represented their speciality at the hospital's medical advisory committee.

Culture within the service

- Staff told us that they felt there was good team working and that they were able to challenge practice.
- There was a collective responsibility to deliver a quality service.

Staff engagement

- Staff in all areas were positive about the opportunities to meet and speak to the hospital director and matron through the staff forum. Staff felt that they could raise concerns and that the hospital management was

accessible. Some staff in lower pay grades, such as administrative staff, cleaners and porters and operating assistances wanted further opportunities to raise concerns, perhaps even anonymously.

- Staff surveys were undertaken on an annual basis. The information was published and available for staff to read along with any actions being taken to make improvements. The action plans were developed by department.
- A consultant survey had been conducted in February 2014. Where concerns had been identified action had been taken. For the operating theatre results for effectiveness of working relationships with theatre staff was rated as 89% very good or excellent. Concerns were raised about the theatre management team and a new theatre management team had been recruited.

Public engagement

- Patients were regularly surveyed and results were discussed at ward meetings. Information was used to improve the service.

Innovation, improvement and sustainability

- The nurse with lead responsibility for the hospital approach to management of venous thromboembolism (blood clots) was working through the process to gain 'exemplar status' for this service. This was a national award and would mean that the service was meeting an agreed set of national standards and was providing a high level of service.
- The hospital had an orthogeriatrician (a doctor who specialises in the care of elderly orthopaedic surgery patients, most often following a fractured hip) who helps in discharge planning to ensure patients have adequate support at home.

Critical care

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The critical care service has seven beds (four critical care and three high dependency) on the critical care unit and two high dependency beds on a separate ward area. The two ward based high dependency beds have no staffing establishment. The majority of patients to the critical care unit are elective patients with a planned admission (some may be unplanned following surgery or patients who have deteriorated on the wards); the unit does not undertake emergency care.

The unit is able to provide up to level 3 critical care and 80% of patients to the unit are cardiothoracic surgery patients. The remaining 20% of patients had had neurosurgery, spinal surgery, general surgery and bariatric surgery. The critical care unit had approximately 400 cardiothoracic patients a year (that is between 8 – 10 patients per week). Two thirds of these patients are NHS patients.

During the inspection we visited the critical care areas that consisted of the critical care unit and the high dependency unit. We also visited ward areas to assess how critical care services, which included how the outreach service, worked with the rest of the hospital. We spoke with one physiotherapist, the critical care unit manager, two ward sisters, four staff nurses, one administrator, one patient services assistant (with a housekeeping and hostess role), two anaesthetists, the lead intensivist, six patients and four relatives of patients being cared for in the unit. We looked at records for four patients.

Summary of findings

The critical care unit followed safety procedures to provide safe care there were appropriate staffing levels and infection control practices, and patient risks were assessed and acted on appropriately. However, medicines management needed to improve, equipment checks were not completed appropriately and the storage of cleaning equipment was not in line with national guidelines. Patient records were not completed appropriately and neurosurgical patients did not have an appropriate care pathway plan. Local policies and guidelines had not been reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were not implemented. This area had been identified for improvement. Data on outcomes was being collected for some, but not for all patients, and outcomes in general, could not be demonstrated. Pain assessment tools needed to be developed. Staff were supported by senior staff to undertake their roles but their competencies were not appropriately assessed. Staff needed support to undertake post registration qualifications in critical care. Staff required an understanding of the Mental Capacity Act, 2005 in order to carry out their responsibilities in relation to consent, informed consent and deprivation of liberty safeguards.

Staff were caring and compassionate and treated patients with dignity and respect and patients told us of the good care they had received on the unit and how they were involved in decisions about their care. The critical care services were responsive to the needs of their patients. Patients were appropriately admitted and discharged from the unit and the number of

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transfers to the local NHS trust for critical care was low. The support required for patients living with dementia and with a learning disability was assessed during pre-operative assessment processes although there was no specific support available on the unit.

Staff were not aware of the vision and strategy to expand the service but identified with values and the need to provide excellent care. Quality and patient experience were seen as priorities and everyone's responsibility and staffed worked well together. The unit manager was also the nurse in charge. The nursing leadership of the unit was considered by staff to be supportive but they often worked clinically to cover for staff shortages. There was a lead intensivist for the unit with an additional and lead cardiothoracic intensivist. There was little evidence of quality monitoring processes or monitoring of actions taken on identified risks. This was identified as an area for improvement. Patient feedback to improve the service was obtained although this was not done formally. The service demonstrated good examples of innovation and improvement.

Are critical care services safe?

Staff were reporting incidents and there was evidence of feedback and learning as a result. The environment was clean and staff followed infection prevention and control practices. Bed spaces in the unit were smaller than guidelines but this had not affected patient outcomes. However, critical care services needed to improve safety procedures. Cleaning arrangements needed to improve so that cupboards were more secure and dirty and clean items were not in the same area. Equipment checklists were inaccurate and staff could not demonstrate equipment was fit for purpose especially emergency. Medicines were managed appropriately but the expiry date of liquid medicines needed to be identified for safe use and there needed to be better assurance processes. There was a single patient record that all professionals used. However, documentation was not completed appropriately for cardiac patients and there was not appropriate documentation for neurosurgical patients. Patient clinical risks were assessed and acted on appropriately but patient handovers to the ward needed to be more formal. There was a flexible approach to nurse staffing levels which meant there were appropriate numbers of staff on duty to meet the needs of patients. Medical staffing was coordinated to provide adequate cover for patients and mitigate risks. The unit manager was also the nurse in charge but often worked clinically to cover for staff shortages.

Incidents

- There had been 11 clinical adverse events and one non clinical incident reported in the critical care unit (October 2013 to October 2014). The clinical incidents involved post surgical complications The non clinical incident was related to a visitor who fainted on the unit. Records show that incidents were investigated and appropriate action was taken.
- Staff were aware of how to report an incident using the hospitals electronic reporting system. An automatic email was sent to the person completing the submission to confirm receipt. The majority of incidents were reported within the hospital target of four days.
- Staff told us they were not always informed of the outcome of specific investigations on the unit. There was a summary of incidents provided as feedback and learning was cascaded at departmental meetings.

Critical care

Safety Thermometer

- Information was submitted for NHS patients but this was not used as a tool within the hospital.
- Information on falls, infections, venous thromboembolism (blood) clots and pressure ulcers was monitored as part of the hospital's clinical scorecard. The hospital was meeting its targets overall but had a higher rate of falls than its own target (1 July to 30 September 2014). The information was not displayed in the unit. Staff were aware of how the unit had performed.

Cleanliness, infection control and hygiene

- There were good surveillance practices to ensure that infections were identified and treated in a timely manner this included support from a microbiologist. Staff reported they received good and prompt support from the microbiology team in relation to managing and preventing infections.
- We observed staff wearing protective equipment such as gloves and aprons and disposing of them after completing a task of patient care to reduce risks of cross contamination. However, colour coded aprons for specific tasks were not used, and this is recommended.
- The bedside curtains were disposed and were routinely changed every six months. Staff and the cleaner said that curtains would be changed more frequently if they were soiled. Curtains had labels on them detailing they had last been changed on 14 September 2014.
- There was a cleaner who was dedicated to the critical care unit and the recovery area. There was not a cleaning schedule on display, but a cleaning audit folder detailed and evidenced the cleaning required on a daily and weekly basis. Bed spaces had a full clean when a patient was discharged from the unit and before a new patient was admitted. This included cleaning the bed, floor, equipment and curtain rails in the bed area. Records showed that this full clean occurred for a bed space every two to three days, dependant on the length of stay in the unit for each patient.
- To reduce risks of cross infection cleaning equipment had been moved from the dirty utility area on the unit to a store cupboard on a different floor. Access to the new cupboard was through a toilet room. We were told that the toilet was not used; however there was no assurance of this. There was no assessment of the risk the position of the cupboard might have with regard to cross infection from use of the toilet room.

- The cleaners cupboards were unlocked and could be accessed by any one even though they contained fluids that came under the Control of Substances Hazardous to Health (COSHH) regulations (2002) which identifies the need for the area to be locked.
- The cleaner told us that the position of the cupboard meant that it took longer to clean the unit as she had to spend time going up and down the stairs to collect cleaning equipment. The bucket for cleaning floors was however, still stored in the dirty utility room in the unit, which posed a risk of cross contamination when cleaning floors. The dirty utility was used for disposal of bodily fluids and storage of dirty/soiled linen prior to laundering. If bodily fluids and dirty linen came into contact with cleaning buckets there was a risk that cross contamination could occur when floors were being cleaned.
- The unit was visibly clean with the exception of one portable suction machine that was covered in dust.
- Hand washing facilities were available throughout the unit. This included two wash basins on the open ward, a wash basin in the isolation room and hand gel/sanitizers by every bed side and at strategic points throughout the unit. We observed hand washing facilities being used by all staff.
- The unit did not submit data to benchmark its activity, for example to the Intensive care National Audit and Research Centre (ICNARC). There was no data on how well the unit was doing on infection prevention and control in comparison to other critical care units.

Environment and equipment

- Equipment was visibly clean. Items were labelled with the last service date and large green stickers identified when equipment was cleaned.
- All equipment was listed on a corporate computerised maintenance management system. The information included frequency of required maintenance (in line with manufacturer's guidance and best practice) and the details of who held the maintenance contract agreements. The system flagged up when maintenance was required.
- There was a contract for portable appliance testing, these were conducted on an annual basis. A record of checks were maintained.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues

Critical care

that needed attention. This was undertaken through an electronic reporting system. Records held centrally demonstrated that broken equipment or environmental issues that needed attention were recorded and responded to. However, staff on the unit reported they were not kept informed of the progress of maintenance requests

- The critical care unit had seven beds, six beds in an open ward setting and one bed in an isolation room. There was an additional two bedded high dependency area on ward three which was used when required and staffed by a nurse, using their flexible staffing approach, with support from staff on ward three
- Bed spaces and facilities did not fully comply with current Department of Health building note 04-02 for Critical Care Units published in March 2013. Bed spaces did not have individual wash-hand basins, there was no ceiling hoist and bed spaces did not meet the recommended minimum space of 25.5meters squared. The bed space size had the potential to make access to the patient difficult in an emergency. The staff, however, reported no concerns with the bed space available, there were no reported incidents of cross infection relating to the closeness of bed spaces, patients reported privacy and dignity was maintained and there was appropriate equipment available for each bed space.
- Support jackets (referred to as post-thoracic jackets) were available if required, for patients following cardiac surgery to support the healing of the chest (thoracic) area.
- The critical care unit had ready assembled trolleys, containing all the stores and equipment supplies to turn around a bed space once a bed became vacant. The checklists used for checking and stocking up these trolleys were completed but these did not always correspond to the supplies on the trolleys.
- A Continuous Positive Airway Pressure (CPAP) device lacked an oxygen sensor which had been reported as faulty on 26 September 2014. At the unannounced inspection new saw that a new sensor had been delivered and was in use.
- Resuscitation equipment was available on the unit and a difficult airway trolley was present in the adjacent theatres.
- The unit manager was responsible for developing an equipment replacement programme and bidding each year for required equipment.

Medicines

- Medicines were administered appropriately and two members of staff checked medication and fluids.
- There were three different drug charts used on the unit. A Day Zero pre-operative drug chart, a Day 1 post-operative ward drug chart and a photocopied critical care drug chart, with a review date of 2010. This later drug chart was used for inotropes, intravenous fluids and colloid, blood, Insulin and sedation. It was practice for the anaesthetist in theatres to fully prescribe these with parameters for when and how much of the drug should be administered. When a patient was discharged to the wards, medicines were transcribed onto the ward medication chart. There were no reported incidents and the risk of transcribing errors, that had the potential to result required medicines being missed or not administered appropriately, were considered. The potential for transcribing errors was from non-cardiac drugs and the hospital ensured that the patient's own medications followed the patient to theatre, critical care and returned with the patient to the ward.
- Medicines including controlled drugs were stored securely, though there was a lack of capacity for the storage of intravenous fluids and dialysis solution. Dialysis solutions were stored securely in theatres next to the critical care unit. This meant there would be a delay in accessing these items if required urgently and there was a lack of space to rotate stock.
- Refrigerator and room temperatures were monitored and appropriate actions were taken when the refrigerator was outside of the recommended temperature range.
- Emergency medicines including oxygen were available for use within critical care and expiry dates were checked on a weekly basis.
- Written guidance to support the administration of injectable medicines was available and used on the unit. A copy of the Critical Care Intravenous Infusion Drug Handbook 3rd edition was available.
- Most open liquid medicines lacked a date of opening this meant it was not possible to track how long they had been in use to ensure they were used within the manufactures recommend timeframe. There was also out of date medication in the medicines fridge.
- The nursing staff took responsibility for the stock control and the ordering and receipt of medication the pharmacist would visit the unit as required.

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- Patient Group Directions (PGD) provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. The PGD should be used in situations that offer an advantage to patient care, without compromising patient safety. The critical care unit had PGD for the use of intravenous and nebuliser saline and oxygen by nursing staff agreed in July and September 2014. These were appropriately authorised, within date and working copies had been signed by staff working from them. We did not have evidence, however, that these were locally monitored in line with National Institute for Health and Care Excellence (NICE) guidelines. Medicines Practice Guidelines: Patient Group Directions (updated February 2014).

Records

- Patients had one set of records and all staff, including consultants, wrote in the same set of records while the patient was an inpatient. Although all surgeons dated their entries in the notes, not all recorded the time of their entry. For the cardiac patient records we reviewed there was no patient assessment or treatment plan during the admission to Critical Care
- Pre-printed protocols and pathway of care were added as required. Patients had appropriate pathways in their notes with the exception of neuro surgical patients who were placed on a spinal surgery pathway. While there were some similarities in the patients care needs, risks specific to patients undergoing neurosurgery, such as risks of seizures and cerebral oedema (swelling of the brain), were not identified on the pathway. However, staff confirmed they were aware of this shortfall and told us they knew how to assess patients for the risk of neurological deterioration. Records we looked at confirmed that patients were assessed for risk of neurological deterioration
- Nursing staff did not record conversations/communications with relatives. Nursing staff told us this should be recorded by the medical staff.

Safeguarding

- There was an on line safeguarding training package for staff which had been completed by 89.2% of staff.
- The hospital matron was a member of the local independent safeguarding group and had attended an

update training day in July 2014. There was an awareness that as the hospitals client base had changed there needed to be an increased awareness of the staff's responsibilities to ensure that the patients were safe.

- There was an established system managed by one of the ward sisters in the hospital to ensure that all staff working in the hospital who required a professional registration to practice provided current evidence of their registration.
- There was an established recruitment process that included the requirement for two references and a current disclosure and barring scheme (DBS) check prior to a new member of staff commencing employment.
- We did not find further safeguarding systems in the critical care unit.

Mandatory training

- There were nine mandatory elearning modules for staff to complete these included fire safety, manual handling, information governance, infection prevention and control, safeguarding adults and children and equality and diversity
- There was a mandatory training policy that detailed which training staff were required to attend this also included resuscitation training. The training records showed that attendance at training was monitored
- At the end of 2013, 83% of staff were up to date with their mandatory training this had been lower than the hospital target of 95%. For the year to date (1 January to 31 August 2014), 58% of staff had completed the mandatory training. All staff in the critical care unit confirmed they had completed the required mandatory training.
- All nursing staff who were in charge of shifts completed an intermediate life support course annually and an advanced life support course every four years. This meant there was always a member of staff on duty who could provide immediate care for patients in emergency situations. Approximately, 100% of critical care staff had completed adult and paediatric basic life support training adult; 100% had completed adult immediate life support training and 85.7% had completed paediatric immediate life support training.

Critical care

Assessing and responding to patient risk

- Risk assessments were undertaken that related to the risk of falls, pressure ulcers; Venous thromboembolism (blood clots) and use of bed rails. Where risks were identified the tools identified the action to be taken to reduce or manage the risk.
- There was a separate folder of risk assessments that were pertinent to the equipment, practices and conditions of patients on the unit. However, most of these referred the reader to further policies and procedures rather than detailing clear actions to be taken to reduce the occurrence of the risks.
- Critical care used observation charts that were specific to the unit. Medical staff provided guidance regarding the parameters that each patient's observations should be within and provided information about the actions staff should take if the observations were outside these parameters. This included increasing medication and contacting medical staff.
- An outreach service was provided by the senior person on duty in the critical care unit. They would visit patients on wards who had been discharged from the unit within 24 hours of their discharge, evidenced through their paper filing system. They would also review patients with a raised NEWS score (National Early Warning Score system) and escalate care as required. The outreach team could give oxygen and fluids in an emergency. They were able to admit patients to the critical care unit if required. Staff on the wards considered the outreach to be a good and invaluable service supporting the care and a sick patient and ward staff through education and support.
- Staff said critically ill and emergency patients were transferred to the local NHS provider if deemed necessary by the consultant. Some patients had a contractual referral back to the NHS if their condition meant they required critical care. Staff told us that approximately 10 to 15 patients had to be transferred in a year.
- The hospital resuscitation team consisted of the RMO, critical care nurse, sister or staff nurse holding the hospital bleep, a porter and an operating department practitioner. The hospital undertook adult cardiac arrest scenario audits, which were simulation exercises to assess the emergency response for a collapsed patient in clinical areas.

Nursing staffing

- Patients requiring level three care were cared for a one to one basis, patients requiring level two care were cared for a two to one ratio
- There was one nurse manager; two full time senior sisters working nights; 3.6 whole time equivalent (WTE) sisters; seven WTE staff nurses and 4 WTE part time staff nurses. There was a minimum staffing requirement of two nurses in the critical unit. For the high dependency unit there could be one nurse with additional support from the ward.
- The nursing establishment had been calculated on a unit occupancy of four patients requiring level three care and three requiring level two care with reduced weekend activity. The critical care unit was responsible for staffing the two bedded High Dependency Unit (HDU) that was located on the ward the floor above the critical care unit. We were told that the beds in HDU were rarely used. The nursing establishment had been calculated for the critical care unit and did not include the additional two high dependency beds on the ward. The nature of staffing the unit was flexible which meant if extra staff were required because there were more than four level three patients or there were patients in the HDU staff would work extra hours and take time back when the unit was not busy. If needed the hospital used bank nurses in order to maintain adequate staffing levels. Staff also worked flexibly to ensure the unit was staffed, working on the wards when not busy or taking time back or banking hours owed to the hospital.
- At the time of the announced inspection the unit manager, who was also the nurse in charge of the shift, was working clinically. When we returned to the unit during the unannounced inspection she told us that she was not rostered to work clinically. She only worked clinically at times of staff shortages or if there was an increased work load on the unit, as there had been at the time of our announced inspection. This meant she had opportunity to complete administrative and supervisory roles. The nurse who was rostered to be in charge of the shift had a supernumery role to coordinate the shift and provide support to the staff team in line with recommendations of the British Association of Critical Care Nurses for Nurse staffing in Critical Care(2009). They also carried the hospital arrest bleep, acted as the outreach nurse for the hospital and field calls at night that would have otherwise gone straight to the RMO

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- Nursing staff were supported five days a week by an administrator and a patient services assistant who undertook housekeeping and hostess duties.
- Physiotherapists told us that they reviewed and treated patients and discussed patients with the nursing staff as there was no formal multi-disciplinary ward round.
- There was a transfer information sheet that was completed by the nursing staff for patients who were transferred to the ward. The sheet was intended as an aid to handover, however, we observed a handover that was unstructured in that it did not follow the format of the handover sheet.

Medical staffing

- All patients were admitted under the care of a named consultant. Patients who had undergone cardio thoracic surgery were discharged from the critical care unit by the surgical consultant.
- Anaesthetist with a special interest in critical care known as intensivist, supported the consultants in caring for the patients. There were 10 consultant cardiac anaesthetist (intensivists) and five general anaesthetists (intensivists) with practising privileges at Spire Southampton Hospital.
- There was an anaesthetist on call within 20 minutes of the hospital. When on call for the Spire Southampton Hospital they were not on call at the local trust. The cardiothoracic medical team cared for their patients and arranged their own out of hours cover for cardiothoracic patients. The out of hours cover arrangements for non-cardiothoracic patients were less clear and individual consultants provided out of hours cover for their own patients.
- Intensivists had active involvement in the management of patients considered to be in need of level three critical care, that is, for advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. Patients requiring level two care, that is, patients requiring detailed observation or intervention, single failing organ system or postoperative care, and higher levels of care, would be cared for by their consultant with advice being available from the intensivist if required
- There was a resident medical officer (RMO) present in the hospital at all times. There were five RMO doctors at specialist registrar level and all were trained in advance life support. They worked a roster of 24 hours on a week day and 48 hours on a weekend. When on duty they were resident on site for the duration of their shift.
- The hospital did not strictly following the Intensive Care Society guidelines, which state “There must be immediate access to a practitioner who is skilled with advanced airway techniques”. They were however, mitigating this risk. They had divided their patients into two broad categories: general surgical patients requiring intensive care looked after by the general intensivists and cardiothoracic patients looked after by cardiothoracic intensivists.
- The general intensivists did not keep any patients requiring level 3 care in the critical care unit overnight. If they did have a patient who had been intubated, and needed to remain intubated overnight, they were transferred to Southampton General Hospital . This had been agreed amongst the general intensivists. Their patients were reviewed by the RMO overnight.
- The cardiac intensivists “occasionally” had patients intubated overnight who would required level 3 support. Most patients were extubated by 5pm but we did not get an accurate number of how often patients may be intubated overnight. There were occasions that patients were stable and remained intubated overnight in hospital. In these cases the intensivist would come in from home if there was problem. If there was a cardiothoracic patients who was unstable at the end of the day, the intensivist would stay onsite overnight. There was evidence of strong teamworking amongst the cardiothoracic intensivists and this was a policy jointly agreed amongst them.
- The RMOs had “basic” airway skills (for example, bag, valve and mask) and not advanced airway skills (ability to intubate). However, if there was a problem with the airway, the consultant's had agreed they would rather have someone who was doing the basic airway skills correctly, rather than have a registrar equivalent attempting to intubate patient in a “stressful environment”, as this was more prone to error. We spoke to two RMOs and they told us they never felt that they were being placed in an unsafe situation, or being asked to do something, which was above their level of competency.

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Major incident awareness and training

- Staff reported that they were required to understand their role if there was a fire and described the evacuation to a place of safety..
- If a major incident occurred the unit would take patients from the NHS trust to ensure that beds were available in the acute sector where emergencies would be treated.

Are critical care services effective?

Local policies and guidelines had not been reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were not implemented. This area had been identified for improvement. Data on outcomes was being collected for some, but not for all patients, and outcomes in general, were not demonstrated. Patients received pain relief but did not always have an adequate assessment of their pain relief. Patient received appropriate nutrition and hydration. Staff were supported by senior staff to undertake their roles but their competencies had not been appropriately reviewed. More staff needed post registration qualifications in critical care and educational supervision. Staff required an understanding of the Mental Capacity Act in order to carry out their responsibilities in relation to consent, informed consent and deprivation of liberty safeguards. Practices such as sedation and the use of bed rails were a type of restraint but were not considered as a deprivation of liberty by staff and patients best interests needed to be assessed. Multi-disciplinary working was not coordinated with all disciplines but staff communication was effective.

Evidence-based care and treatment

- There were local critical care standards but these had not been reviewed and many were not up to date. The critical care manager told us that they were in the process of reviewing the standards and competencies were being revised to ensure they were in line with national guidelines and National Institute for Health and Care Excellence (NICE) guidance.
- NICE guidelines for critical care rehabilitation were not used as patients rarely stayed on the critical care unit more than a few days and were only ventilated for a short period of time.

- The ward manager told us they monitored practice on the unit through observation but there was a lack of formal audit to evidence care was being given in line with national guidelines

Pain relief

- Patient's did not always have their pain controlled. Three patients we spoke with told us their pain had been well controlled. However, two patients reported that they had been uncomfortable and in pain overnight. While pain relief medication had been administered there was no evidence that a pain assessment score had been used to monitor its effectiveness.
- There was no pain assessment tool on the critical care observation charts used for patients requiring level 3 care. There was a tool used for patients requiring level 2 care.
- During our unannounced inspection, the ward manager confirmed that a pain scoring assessment tool was going to be included in the observational chart for level 3 patients.

Nutrition and hydration

- Patients on the unit were usually only ventilated for a short period of time and required minimal support with meeting nutritional needs. However, if patients were ventilated for longer periods of time, enteral feeding commenced after 24 hours. Strict protocols were followed and the dietician provided guidance for staff to follow with regard to feeding regimes
- While patients were not eating and drinking post operatively, they received intravenous infusions to ensure they were hydrated. Fluid intake and output records were maintained for all patients on the unit as well as food intake charts where required.
- Patients that we spoke with, who had been patients on the unit, commented that they felt they received sufficient food and fluid while being nursed on the unit.
- We observed patients making choices about their forthcoming meals and being supported to take their meals.

Patient outcomes

- The average length of stay for cardiothoracic patients on the critical care unit was less than 2 days, the national average was 3 days.
- Critical care transfers level 2 and 3 patients were monitored quarterly. Between April to September 2014,

Critical care

there had been five transfers to the local NHS Trust for critical care. This represented less than 0.1% of the total number of discharges from critical care. All patients were transferred for clinical reasons only one patient was transferred because the hospital was unable to find an available general surgeon to treat the patient.

- The unit did not participate in a benchmark system to review its outcomes, for example, the Intensive care National Audit and Research Centre (ICNARC).

Competent staff

- The average bed occupancy rate in critical care was below the England average for patients requiring level 2 care and this could impact on staff competencies. However, the hospital focused mainly on cardiothoracic surgery and the actual number of these patients was similar to the England average. This meant that staff had sufficient exposure to cardiothoracic patients to retain their competencies and skills. However for neuro, spinal, bariatric and general surgery and newly introduced renal replacement therapy, which was undertaken in fewer numbers, there was a risk that this could negatively impact on staff competencies in caring for these patients. There was no clear assessment of competencies to ensure that this was being monitored.
- Staff were supported to complete training and competency assessments to undertake their role. Topics covered included aseptic technique, management of arterial line, management of chest drain, ventilation, enteral feeding, pain management and inotropic management. However, records we looked at showed that competencies were not regularly reviewed. The ward manager told us competencies should be reviewed annually but the formal documentation of these reviews was not happening. The current competency documents did not fully reflect current care practice on the unit and were being developed in line with national guidance and NICE standards. Staff competencies were observed and assessed on a daily basis and extra support was provided if required. The unit did not have a clinical educator to supervise and assess the educational needs of staff
- Staff we spoke with confirmed they had their competencies assessed by one of the senior members of staff and that if they personally did not feel

competent about a particular care practice they could approach senior staff for help and support. Staff confirmed they received regular supervision sessions and annual appraisals.

- The nurse in charge of the shift was a critical care trained nurse. The manager told us it was sometimes difficult to support staff to do post registration courses in critical care nursing because of funding issues. Ten out of 22 staff employed on the unit had completed specialised training in the care of the critically ill patient.

Multidisciplinary working

- Consultants with inpatients conducted a daily ward round of their patients with the nurse caring for that patient.
- The unit did not have a formal multi-disciplinary ward round. Physiotherapists told us that they reviewed and treated patients and discussed patients with the nursing staff as and when required. Support from a speech and language therapist could be sourced from the local NHS trust.
- Because patients only stayed for a short period of time on the unit and did not require critical care rehabilitation, the unit did not have occupational therapy support.

Seven-day services

- There was an expectation that a consultant would review patients within 4 hours of admission to the critical care unit and on a daily basis including weekends.
- Consultants provided 24 hour on-call (off site) cover for their patients. If they were unavailable at any time they organise a consultant colleague with admitting rights to provide cover in their absence. General and Cardiac Consultant Intensivist provided 24 hour on-call (off site) cover.
- A Resident Medical Officer (RMO) was available and onsite 24 hours a day 365 days a year. Consultants who had inpatients were expected to conduct a daily ward round.
- There was an Intensive Care Technician Service to support haemofiltration available 24/7.
- There was a physiotherapy service available seven days a week.
- A dietician was available to assess and care for patients requiring nutritional treatment Monday to Friday.

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- The pharmacy was open 8.30am to 5.30pm Mondays to Friday and 9am to 1pm on Saturday mornings. Out of hours there was an on call service that was shared with Portsmouth Spire Hospitals.
- The radiology department operated from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service. MRI scans were also available between 8am and 3pm on Saturdays.
- Pathology services were available from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service.

Access to information

- Staff did not have access to up to date information on current procedures and guidance. These were under review.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Whenever possible, patients were asked for their consent before receiving any care or treatment, and staff acted in accordance with their wishes.
- An e-learning training course was available for staff based on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). At the end of June 2014, 48% of all staff had completed this training. Nursing staff, however, had limited understanding of the Mental Capacity Act or their responsibility under the Act. Treatment was deemed to be in a person's best interest or they could refuse.
- The unit had not made any DoLS applications and it was acknowledged that this was an area that required further education for staff. .
- Patients could be chemically restrained through the use of sedation medication. The hospital had a section on restraint in its consent policy, however staff were not aware that there was a restraint policy to follow. Patients were sedated on ventilation for up to four to six hours after cardiac surgery. The treatment was deemed to be in a person's best interest, but there was no process or written policy that staff followed. There was no documentary evidence to demonstrate that staff had recognised this as a type of restraint and had discussed and agreed this to be in the best interest of the patient.
- All beds on the unit had bed side rails that we saw were being used. Risk assessments were in place for the use

of bed sides. However, there was no indication that the views of patients had been sought prior or during the use of bed rails. Staff had not considered that the use of bedrails could be classified as a type of restraint.

Are critical care services caring?

Patients and relatives were given good emotional support, and throughout our inspection, we saw patients being treated with compassion, dignity and respect. Patients we spoke with told us about the good care they had received in the unit and said that they had been involved in decisions about their care.

Compassionate care

- Patients were very complimentary about the care and support they received. They were also positive about the staff approach to promoting their dignity. Patients and relatives told us they received excellent care and that their "views were taken into account."
- We observed staff speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.

Understanding and involvement of patients and those close to them

- Patients felt they were well informed and involved in the decision making process.
- We observed staff explaining to patients and their relatives the care and treatment that was being provided, in order to reduce any anxiety. Patients and relatives that we spoke with told us that staff on the unit were very supportive and explanations about equipment and what was happening helped to reduce their anxiety.

Emotional support

- Emotional support was provided to patients at their pre-admission assessment so they had a good understanding about how the treatment would affect them emotionally. This was confirmed in conversations we had with patients and their relatives.
- The deputy matron visited all patients on the unit daily to assess if they had any concerns with their stay in the hospital.
- Spiritual or religious support would be sourced from the local community to meet individual patient's needs if required.

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Are critical care services responsive?

The critical care services were responsive to the needs of their patients. Patients were appropriately admitted and discharged from the unit and the number of transfers to the local NHS trust for critical care was low. The support required for patients living with dementia and with a learning disability was assessed during pre-operative assessment processes although there was no specific support available on the unit. Patients had received information prior to admission but information was not available on the unit. Staff understood how to manage complaints but there had been none on the unit in the last six months.

Service planning and delivery to meet the needs of local people

- The unit provided care and treatment for patient's undergoing elective surgery. The majority of this work was cardiothoracic surgery, but also included neurosurgery, spinal, bariatric and general surgery. The unit did not have emergency admissions, although would admit patients who had unexpected complications following planned surgery.
- The planning of the service was dependant on surgeons informing the unit about their operating lists and who would be required to be nursed on the unit post operatively. The unit administrator said this information was provided two weeks in advance. However, she also reported some consultant secretary's had failed to inform the unit about patients. This meant staff had to be called in to provide the care for patients and sometimes patients were transferred to the high dependency area on the floor above. The situation was improving as the secretary's had been advised about the essential need to inform the unit about operating lists.
- The average bed occupancy rate in critical care (February to July 2014) were for patients requiring Level 3 care was 46.3% (peaking at 56% in May). For patients requiring level 2 care the average occupancy was 63.7% (peaking at 80% in February). This was below the national established bed occupancy rate of 85% required to ensure functional efficiency of the critical care unit. The nature of staffing the unit was flexible to meet demands at busy times, with staff working extra hours and taking time back when the unit was not busy

Access and flow

- The service had few patients staying more than 1 to 2 days and patients were rarely ventilated overnight. This was because of the elective nature of the work and pre-assessment process that patients were required to undertake prior to admission to the hospital."
- Most patients were admitted from the operating theatre following an elective procedure. This meant the four hour decision to admit was not an issue for the unit
- Patients were managed in a planned way and were not discharged from the unit at night.
- Patients were only admitted to the unit as an emergency from the wards following a decision that would be taken by the medical staff and the nurse in charge of the unit. The nurse in charge of the unit could make the decision to admit for more intensive monitoring. The need to admit a patient in emergency was reported to be a rare occasion. Between July to September 2014 there had been four unplanned admissions (2% of total admissions) to the HDU. All unplanned admissions were monitored and reported as an incident.
- Between April to September 2014, there had been five transfers to the local NHS Trust for critical care. This represented less than 0.1% of the total number of discharges from critical care. All patients were transferred for clinical reasons only one patient was transferred because the hospital was unable to find an available general surgeon to treat the patient.
- The nurse in charge who acted as the critical outreach nurse followed up patients when they were discharged to the wards in the hospital.

Meeting people's individual needs

- Interpretation services were available by phone.
- Staff reported that they rarely had to care for patients who were living with dementia or who had a learning disability. In the situation of having a patient with dementia or a learning disability, their specific care needs and communication strategies would have been discussed in the pre assessment process, and information would have been made available so that staff knew how to support them. There was no specific support available on the unit, however, staff were not able to provide any examples of where they had needed to provide care and support to such patients.

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- Patients were seen in a pre-assessment clinic prior to surgery and were given verbal and written information and where given the opportunity to ask questions. The information was written in a format that was easily understood.
- There was no written literature available on the unit for patients and their relatives to view.
- Information about Spire Southampton Hospital was available on the Spire website. However the information on the website was not easily accessible to people who had any difficulties with reading written literature. There was no process to enlarge the writing for people who had visual difficulties. There was no process to change the background colour for people who have dyslexia. This meant that some people might not be able to fully access the information.

Learning from complaints and concerns

- Staff we spoke with understood the hospital's complaints policy and knew how to manage any complaints they received. They all said they would try to resolve any concerns or complaint's that a patient might have before it escalated into a formal complaint
- The critical care unit had not received any complaints in the last six months.
- Patients and relatives that we spoke with would voice concerns or complaints directly to the nurse in charge of the shift and were confident that the concerns and complaints would be treated seriously and dealt with promptly.

Are critical care services well-led?

Staff were not aware of the vision and strategy to expand the service but identified with values and the need to provide excellent care. Quality and patient experience were seen as priorities and everyone's responsibility and staffed worked well together. The local leadership of the unit was considered to be supportive, but there was little evidence of quality monitoring processes or monitoring of actions taken on identified risks. The unit had a lead intensivist and a cardiothoracic lead. Patient feedback to improve the service was not done formally, and service innovation demonstrated good examples of innovation and improvement.

Vision and strategy for this service

- The hospital's strategic objectives for 2014 were to improve on clinical performance quality indicators and there were also some specific service improvements. For critical care this included the implementation of Haemofiltration for single organ failure, enhancing the resuscitation service with a view to the hospital becoming a training centre.
- Staff were not specific about the vision and strategy for the service but saw their role and purpose of the unit as providing excellent and compassionate care to patients.

Governance, risk management and quality measurement

- The unit had meetings where staff were updated on information from the hospital clinical governance meetings. This included information on complaints, incidents, and audit.
- There was limited formal evidence to provide assurance around the quality of the service delivered on the critical care unit. The unit gained reassurance and this was mainly through personal observation by the manager, the positive feedback from medical staff, the thank you letters from patients, the competencies and the low turnover of staff. A stable work force indicated a high level of satisfaction, including support from the leader of the service.
- There was one item on the hospital's risk register that related to the critical care unit and this was in relation to the lack of storage. A solution was being investigated. The risk register was not used to detail clinical issues, for example, the need to update guidelines and formally assess nurse competencies.
- The hospital used a corporate clinical quality metric to monitor performance. There were 32 clinical items that were monitored. For critical care, these included for example, monitoring of patients pain; infection rates; compliance with reporting and recording of incidents and complaints; the incidence of venous thromboembolism (blood clots) and pressures sores. There was an escalation process and if the hospital was under performing, and an exception report with details of the actions being taken had to be submitted corporately. Reports were published and reviewed quarterly.
- Staff were aware of the hospital's clinical dashboard and were involved in data collection. There were no issues identified for escalation in the critical care unit.

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- The monitoring of consultants to ensure they all had current medical indemnity insurance, appraisals and professional registration was not robust. Information on medical indemnity insurance was not up to date and the professional registration of some doctors needed to be verified.

Leadership of service

- There was a lead intensivist to oversee the clinical management of the critical care unit. There was also a lead cardiothoracic intensivist. The leads represented the consultant staff on the hospital's Medical Advisory Committee.
- The critical care manager was highly visible on the unit. In the event of staff shortages, or the increased number or acuity of patients, they prioritised clinical care over management and non-clinical duties.
- All staff spoke highly of the support the manager provided to themselves and to patients. All staff said they were supported to report concerns to the manager who would act on their concerns. They said that the manager updated them on issues that affected the unit and the whole hospital.
- Staff forums were held by the hospital director and these were open to all staff. Staff felt that these were positive and that they felt listened to.

Culture within the service

- Staff within the unit spoke positively about the service they provided for patients. They worked well together and there was obvious respect for each other.
- Quality and patient experience were seen as priorities and everyone's responsibility. Staff spoke about their responsibility for ensuring patients received high a quality service from the critical care unit. We observed shift and unit leaders who were compassionate and led by example.
- Staff were encouraged to complete incident forms and raise concerns.
- Staff worked well together and there was obvious respect

Staff engagement

- Staff told us that the use of staff meetings and handover sessions meant they were fully informed and involved in the running of the critical care unit and the hospital.
- Staff surveys were undertaken on an annual basis. The information was published and available for staff to read along with any actions being taken to make improvements. The action plans were developed by department. Staff felt that they could raise concerns and that the hospital management was accessible.

Public engagement

- Patient feedback was obtained informally, for example through discussion and thank you letters and cards from patients and their relatives. There were no other formal processes for seeking feedback.

Innovation, improvement and sustainability

- The critical care lead ran a monthly critical care delivery meeting for staff. The lead and manager was a member of the local Wessex critical care network. This provided opportunities to network and learn about innovations.
- The team deliver resuscitation training for the hospital, they also offer IV training and other courses internally to ensure the ongoing professional development of clinical teams.
- The critical care unit won the Spire Healthcare Group 2013 inspiring people award. The award covered innovation, excellent customer service and leadership and performance.
- The December 2013, the team introduced a new innovative procedure for two patients who chemotherapy directly into their liver over a four hour period whilst the patient was anaesthetised.
- The team were introducing further developments, such as the management of pulmonary artery catheters and the were developing a haemofiltration service as part of renal replacement therapy.

Services for children and young people

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

The children and young person service at the Spire Hospital Southampton provided elective surgery for children between the ages of three to 18 years. Surgery provided included dental surgery, ENT, general surgery, ophthalmology, orthopaedic, urology and some cosmetic surgery. Outpatient's services were provided for children aged from 0 up to 18 years. Outpatient services included consultations, dressings, ECG and ECHO tests, eye tests, microsuction, plaster cast application and venepuncture. The hospital saw approximately 200 to 250 children a year for surgery. The hospital did not have a dedicated children's ward, and children were cared for in adult single rooms but with age appropriate bed linen and toys provided. The outpatients departments did not have a dedicated children's waiting area but toys were provided for children's clinics.

During the inspection we spoke with the lead children's nurse, three parents, three older children (one inpatient and two outpatients), a paediatric anaesthetist and four general nurses. We looked at records for three patients.

Summary of findings

The hospital provided a small paediatric service. Staff were following safety procedures but the service needed to improve areas of medicine management, staffing, safeguarding children and the use of an age appropriate early warning score to identify children whose clinical condition might deteriorate. Children were appropriately identified to ensure staff used the correct equipment and medicines in an emergency. The hospital was running scenarios to improve the emergency response. There were appropriately trained staff to treat children in an emergency although staff, as part of normal procedures, would have to call 999 services for emergency hospital care. National guidelines were being used to treat children and there was evidence of audit but there needed to be better monitoring to assess compliance with standards and evidence of patient outcomes. Older children were cared for by adult nurses, who did not always feel confident in their skills to provide care and support to children and their parents. More staff needed to complete paediatric basic and immediate life support training. The environment and facilities did not fully meet the needs of children and children's environments were created by added toys and facilities to adult areas.

We only observed a few children in the hospital but from what we observed, staff were caring and compassionate and treated children with dignity and respect. The children and young people that we spoke with told us they were involved in their care. Children's surgery was planned and cancellations were rare. Children and their parents had an initial assessment and pre-admission assessment so appropriate support could be offered. Children were placed first on surgical lists to reduce

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anxiety in line with best practice. There was support for children with a learning disability and who had mental health condition, although the support of play specialists was only available pre-admission.

There was a strategy to expand the service and for refurbishment to create children's areas, but this needed more formal plans. Staff across the hospital said they received good support from the lead children's nurse when caring for children and young people. A paediatric anaesthetist was the medical lead for the service and access to a paediatrician was via the local NHS trust. Children did not complete surveys themselves to feedback on their care although parents were surveyed. There was a paediatric steering group with representation from across the hospital and this was starting to lead on service and quality standards for children in the hospital. The service had demonstrated innovation and improvement in its development over the last 18 months.

Are services for children and young people safe?

Incidents were reported and changes in practice occurred and learning was shared. Infection control procedures were followed. However, services for children and young people needed to improve safety procedures. Medicines were appropriately stored and administered, however intravenous fluids not recommended for use in children were stored on the paediatric resuscitation trolley. Equipment was appropriate but children used facilities in adult areas. Staffing was planned around expected admissions and needs of children. Medical and nurse staffing followed national guidance with the exception of on call nursing arrangements. A paediatric anaesthetist was the medical lead for the service and access to a paediatrician was via the local NHS trust. All staff that had contact with children had not completed safeguarding training to the required level although this was being addressed. More staff needed to complete annual training in paediatric basic and immediate life support. The hospital did not use an age appropriate paediatric early warning score to identify and monitor children whose clinical condition might deteriorate. The hospital used a nationally recognised system for using equipment and medicines in a paediatric emergency. This had been tested in a scenario and resuscitation was appropriate but some areas required action. There were appropriately trained staff to treat children in an emergency although staff, as part of normal procedures, would have to call 999 services for emergency hospital care.

Incidents

- There had been one serious clinical incident and two clinical incidents and near misses reported in the paediatric service (July 2013 to June 2014).
- Staff were aware of how to report an incident using the hospital's electronic reporting system. An automatic email was sent to the person completing the submission to confirm receipt. The majority of incidents were reported within the hospital target of four days.
- Staff confirmed that they received general feedback through the cascade of information at team meetings.
- The paediatric sister demonstrated that learning and changes in practice occurred as a result of serious incidents. There had been a surgical incident which had resulted in a poor outcome for the patient. A root

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cause analysis had been completed which had demonstrated that the surgery had been appropriate but risk assessments should have been improved. Learning had happened and practice had changed: There were stricter criteria for operating on children with certain conditions, for example, a child with a learning disability.

Cleanliness, infection control and hygiene

- Infection control policies and procedures were available and all staff had completed infection control training as part of their mandatory training.
- Hand washing facilities and hand sanitizers were available throughout the hospital and staff were observed using them.
- Pre-admission assessment included checking whether children had been in contact with any infectious diseases recently and their inoculation history.
- An infection control nurse attended the children's and young people steering group to support the children's department with infection control practices.

Environment and equipment

- The recovery area for children was a two bedded bay area opposite the main recovery area. One side of the bay was used as storage for the intensive care bedside trolleys. The other side was free to recover a child post operatively. There were only able to have one child in recovery, there was no reports of this being a problem. The paediatric resuscitation trolley was located in this two bedded bay and was easily accessible in an emergency
- There was dedicated children's resuscitation equipment. The hospital used a nationally recognised colour coded system on the ward, and this was checked daily.
- The outpatients department did not have a children's waiting area and children would have to wait with adults. This issue was being addressed, and building work that was being undertaken at the time of our inspection. The department also did not have dedicated clinic rooms for children and young people. There was a baby changing area.
- In the radiology department there were two seats to be used for children and these were slightly separate from the rest of the department.

Medicines

- All staff were required to complete a medication work book on induction that included medicines administration for children and younger people.
- Children's medication was administered appropriately. Oral medication was checked by one member of staff, and intravenous medication and controlled drugs was checked by two nurses which was in line with guidelines from the Nursing and Midwifery Council.
- In the recovery area there was an in date anaphylaxis kit.
- Intravenous fluids to support children's whose condition might deteriorate did not reflect the printed documents used by the hospital or national best practice guidelines. The printed document required Glucose 5% and 0.45% Sodium Chloride but the medicines on the trolley and held as stock were Glucose 4% and 0.18% Sodium Chloride. This was contrary to the National Patient Safety Alert (2007): reducing the risk of hyponatremia when administering intravenous infusions to children, and has been identified as a risk to children's health.
- Patient Group Directions (PGD) provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. The PGD should be used in situations that offer an advantage to patient care, without compromising patient safety. The paediatric service had PGD for the use of Ametop and EMLA. These had been agreed in July 2012 and February 2014. These were appropriately authorised, within date, and working copies had been signed by staff working from them. We did not have evidence, however, that these were monitored in line with National Institute for Health and Care Excellence (NICE) guidelines. Medicines Practice Guidelines: Patient Group Directions (updated February 2014).

Records

- We reviewed the records for three children who had undergone surgery at the hospital. One was a young child, aged eight, and two were over the age of 13.
- A care pathway titled "Spire Healthcare care pathway Child/day case/overnight stay" was completed for the children, which included risk assessments and plans for

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discharge. The pathway was clinical and did not include an assessment of how the child and/or parents were coping emotionally with the being admitted to hospital and undergoing surgery.

- The five steps to safer surgery surgical check list was completed appropriately.
- Surgeons wrote in the notes and dated their entries but did not record the time of their entries.

Safeguarding

- The hospital had safeguarding policy and procedures. All staff could access the current policy electronically although in some clinical areas the printed copies of the safeguarding children's procedures was out of date.
- There was a level 1 children's safeguarding training available on line for staff and 88.3% of all staff working at the hospital had completed this training. Only 8% of staff who were required to complete safeguarding training at level 2 had completed the training and 50% of staff had completed training at level 3. The hospital was addressing the issue of training at level 2 forthcoming training dates had been arranged and published for staff. The paediatric lead was planning to undertake level three training.
- The hospital had open visiting times and parents could visit their child at any time of the day or night and could stay overnight. There was open access to all areas and the hospital was therefore not a secure environment for children. Children, young people and their families were asked to record on the pre-assessment form who would be visiting them during their hospital stay; this was intended to help control those visiting a child or young person.
- The hospital had not made any safeguarding referrals for children or young people and had not produced an annual safeguarding report. The lead nurse attended the local children's safeguarding board.
- The hospital did not have a process to inform staff about a child or young person who may have a protection plan. The Staff would only know this if it was verbally disclosed or recorded on the pre assessment form

Mandatory training

- There were nine mandatory elearning modules for staff to complete these included fire safety, manual handling, information governance, infection prevention and control, safeguarding adults and children and equality and diversity.

- There was a mandatory training policy that detailed which training staff were required to attend this also included resuscitation training. The training records showed that attendance at training was monitored.
- At the end of 2013, 83% of staff were up to date with their mandatory training modules this had not met the hospital target of 95%. As of August 2014, 58% of the total staff had completed the mandatory training for the year so far.
- More staff needed to complete their life support training for children. The hospital training figures for the end of year demonstrated what training was outstanding for 2014. Approximately, 81.9% of relevant staff had completed paediatric basic life support training. This included 100% of paediatric staff, 62.75% of theatre staff, 100% of critical care staff, 87% of ward staff and 87.5% of outpatient staff. Approximately 62.5% of relevant staff had completed paediatric immediate life support training. This included 80% of paediatric staff, 50% of theatre staff, 85.7% of critical care staff, 52% of ward staff and 100% of outpatient staff.

Assessing and responding to patient risk

- Royal College of Anaesthetists (2013) states that infants and pre-pubertal children (below eight-12 years) have anatomical and physiological differences, requiring careful fluid and drug calculation and specialist equipment. Therefore, where children are managed, appropriate equipment and staff with the appropriate skills are required (Royal College of Surgeons of England 2010).
- Pre assessment clinics or telephone pre-assessment was undertaken. At these clinics a medical questionnaire was reviewed and any concerns or issues discussed. If a child had special needs, for example, autism or a learning disability, the play specialist would be involved in the planning process
- A paediatric early warning score was used to enable the early indication of children whose condition might deteriorate. However, the system used did not reflect the different scoring scales for different age groups. This meant that for some children their score could indicate they were at risk but in fact, the observations were acceptable for their stage of development. It was clear from the records we reviewed and discussions with members of staff, that the staff had adapted the scoring to the needs of the individual child and refrained from seeking medical advice when it was not required.

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However, this also meant staff were not following the guidance on the charts with regard to escalating observations, because they did not consider they were relevant to the child.

- Children whose clinical condition might deteriorate and required more intensive treatment care were transferred to NHS providers promptly to optimise the chances of a positive outcome. This was done as an emergency 999 call, while the child was having their condition stabilised by a paediatric anaesthetist or the RMO, who had the appropriate qualifications and training, if this happened out of hours.
- The hospital used the colour coded system to treat children in an emergency. This was a nationally recognised system for using equipment and medicines in a paediatric emergency system. A tape was used to compare a child's height to their weight and children were assigned a coloured wrist band on admission to the hospital. This wrist band corresponded to a similarly coloured bag that contained the appropriate sized equipment and dose of medicines, and defibrillator information that was to be used in an emergency.
- The hospital undertook a paediatric cardiac arrest scenario in October 2014. The arrest was deemed to be managed appropriately but some key staff did not attend, the coloured bag did not arrive, and staff were unfamiliar with the defibrillator. The hospital had an action plan for improvement and intended to repeat the scenario.

Nursing staffing

- There was one full time lead nurse whose nursing registration included caring for sick children. The lead nurse was supported by two part time children's nurses one working 15 hours a week and one seven hours a week. There was a bank of four children's trained nurses that were used to provide care to younger children when the hospital's permanent children's nurses were not available. A play specialist was available when required.
- There were set operating dates for children to be admitted for surgery. These dates were planned a year in advance which enabled forward planning of the staff rota to ensure that there was a children's nurse on duty.
- The hospital could treat up to six children in on one day. The children's service was staffed in line with national guidance for nursing staff. The registered children nurse

cared for up to four patients at any time. This was in line with national guidelines for independent healthcare as children were elective, planned, admissions. The children's nurse was supported during the day by the general nurses working on the day care unit until 8pm. After this time there would be one nurse on the unit to care for any children staying overnight. They were supported by the staff from the critical care unit which was on the same floor but not directly linked to the ward. Nursing staff in theatre recovery were trained with appropriate airway management competencies relevant to the age group of children and had paediatric life support competencies.

- The service was not in line with national guidance, however, when only one registered paediatric nurse was on the day care unit and children were inpatients as there needed to be a paediatric nurse on call. The Clinical Guideline on the Care of Children in the Independent Healthcare Sector, October 2014 states: As a minimum there should be at least one registered children's nurse on duty at all times and one registered children's nurse on call when children under the age of 12 are being treated and cared for as day cases and inpatients. If this cannot be achieved then the child's admission to hospital should be delayed until there is a children's nurse available. Additional staffing requirements should be assessed on a volumes basis.
- A nurse who had completed paediatric intermediate life support training was on duty in the operating department area when children were undergoing surgery. There were no nursing staff working in the recovery area with a registration in the care of a sick child, which was not in line with the RCN's guidance.
- The outpatient sister held a dual qualification meaning that they were registered to care for adults and children.
- Young people, over the age of 13 were treated as adults and could be cared for on the adult wards by registered general nurses. Some staff on the inpatient wards felt that it was not appropriate for them to be asked to care for young people. When staff were allocated a young person to care for they were supposed to have less patients but we were told that this was not always the case. Senior staff said they would allocated such a patient to a nurse who felt comfortable with caring for them

Services for children and young people

- There was not a formal system for nurses to obtain advice from a registered children's nurse out of hours. The lead nurse would provide support if called when not at work.

Medical staffing

- The children's service was staffed in line with national guidance for surgical and medical staff. Only paediatric surgeons - or surgeons that have paediatrics as a substantial part of their NHS practice - could operate on children in the hospital. There were four consultant paediatric surgeons with practising privileges and one consultant paediatric anaesthetist at Spire Southampton Hospital. One ear nose and throat (ENT) surgeon also operated on children.
- All children and young people were planned admissions for surgery and they were admitted under the care of a named consultant surgeon and a paediatric anaesthetist.
- When children were in hospital they did not have a named paediatrician in charge of their care. The children's lead nurse told us that there were plans for this role to be developed, but at the time of the inspection these were not detailed. However, the hospital had access to the paediatric surgeon, the paediatric anaesthetist on call and through the paediatric anaesthetist a paediatrician from the local NHS Trust
- There was a resident medical officer (RMO) present in the hospital at all times. There were five RMO doctors at specialist registrar level and all were trained in advance life support. They worked a roster of 24 hours on a week day and 48 hours on a weekend. When on duty they were resident on site for the duration of their shift. The RMOs had completed the European paediatric advance life support course and had a least six months paediatric experience. This was required to ensure they had sufficient knowledge and experience to care for children.
- When children were in hospital there was an on call paediatric anaesthetist for the hospital who would attend if there were concerns about a child. The surgeon who performed the surgery was on call to respond to any concerns that might arise after a child had undergone a surgical procedure.

Major incident awareness and training

- The hospital had a major incident plan which staff working in children's services were aware of and understood their role.

Are services for children and young people effective?

Children were treated according to national guidance and an audit programme for children services was being developed. Currently there was limited evidence on patient outcomes. The hospital used a recognised pain assessment tool but staff requested more training on managing pain in children and required more training on paediatric basic and immediate life support. The lead nurse coordinated care with ward staff. Older children were cared for by adult nurses: some adult nurses were not confident in their skills to provide care and support to older children and their parents. Where appropriate, children were enabled to sign consent to their own treatment.

Evidence-based care and treatment

- Children were treated according to national guidance including those from the National Institute of Health and Clinical Excellence (NICE) and Royal College of Paediatrics and Child Health (RCPCH).
- Local policies and procedures used in caring and treating children were based on national guidelines and were up to date.
- The lead nurse was developing an audit programme for the children's service. Audits already completed included a safeguarding children audit and they were in the process of developing an MRSA audit.

Pain relief

- The hospital used a recognised child pain assessment tool to assess a child's pain. However staff training on pain management for children was not available. The lead nurse commented that she was trying to source training for all staff, including general staff who looked after the older children.

Nutrition and hydration

- A private place would be found in the out patients department if a mother was breast feeding.
- Snack boxes were provided for children post operatively.
- Children and young people could choose meals from either the adult menus or special children's menus.

Services for children and young people

- Staff provided parents with hot drinks and they could use the hospital canteen for buying refreshments. One parent/carer was provided with all meals free of charge for the duration of the child's stay.

Patient outcomes

- The hospital did not have processes to measure patient outcomes for children and young people.

Competent staff

- The lead nurse maintained a link with the local NHS trust children's service and attended the clinical practice group held there. They fed back relevant information to staff at Spire Southampton Hospital.
- Emergency scenarios were undertaken on a monthly basis these could be adult or child orientated and were used to help staff maintain their skills.
- The small team of children's trained nurses cared for children under the age of 13. Staff on the general wards commented that the paediatric lead was always available for support and advice when they were caring for children. Some staff on the general wards expressed they did not feel they had the skills to provide care and support to older children and their parents.
- The hospital did not provide specific training for general staff who were not trained in the care of the sick child. The paediatric lead nurse had identified that general staff on the wards needed training about caring for older children. This training was being planned but was not yet available.

Multidisciplinary working

- There were two play specialists who worked on the hospital bank and supported pre assessment clinics for children.
- The paediatric lead nurse communicated with nurses on the ward regarding the care of children.

Seven-day services

- Consultants who had inpatients were expected to conduct a daily ward round.
- Consultants provided 24 hour on-call (off site) cover for their patients. If they were unavailable at any time they organise a consultant colleague with admitting rights to provide cover in their absence.
- A Resident Medical Officer (RMO) was available and onsite 24 hours a day 365 days a year.
- There was a physiotherapy service available seven days a week.

- A dietician was available to assess and care for patients requiring nutritional treatment Monday to Friday.
- The pharmacy was open 8.30am to 5.30pm Mondays to Friday and 9am to 1pm on Saturday mornings. Out of hours there was an on call service that was shared with Portsmouth Spire Hospitals.
- The radiology department operated from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service. MRI scans were also available between 8am and 3pm on Saturdays.
- Pathology services were available from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service.

Access to information

- The paediatric lead would go through relevant guidance with staff when children were on adult wards.
- Most staff told us they would contact the paediatric lead for information and advice. Staff also had access to guidance that was available on the hospital intranet.

Consent

- Children, young people and their parents were involved in the consent process. We observed that older children were given the opportunity to sign their consent forms. For one child both the child and their parent had signed the consent form.

Are services for children and young people caring?

We only observed a few children and young people in the hospital at the time of our inspection. We did find that staff were caring and compassionate when providing care and treatment. The children and young people we spoke with felt that they had the information they required to make an informed decision. Emotional support was provided by nursing staff; specialist support from a play specialist was only available pre-admission.

Compassionate care

- There were very few children and young people in the hospital at the time of our announced and unannounced inspection. We were therefore unable to observe many interactions between staff and patients to assess how compassionate and caring staff were.
- A young person who had been admitted for surgery spoke positively of the experience.

Services for children and young people

- Feedback from parents and children in the form of cards and letters expressed the view that staff were very caring.
- Through observations in the outpatients department and observation of the interaction between staff and the one child who was an inpatient at the time of our inspection, we saw that staff were caring and compassionate toward the children and their parents.

Understanding and involvement of patients and those close to them

- Two young people (and their families) who were attending their first appointment were positive about the process and the information they had been given. Both young people commented they were involved in the discussions about treatment.
- The lead nurse described that all children were involved in the discussions and decision making processes about their treatment and care.

Emotional support

- Support from play specialists was provided to children and their parents prior to their admission. This helped children and their parents have good understanding about how the treatment would affect them emotionally. Where required extra support was provided by play specialists during pre-admission clinics.
- There was no specialist provision for the emotional support for children while they were an inpatient. This was provided by the nursing staff supported by the paediatric lead nurse.

Are services for children and young people responsive?

Children attended the hospital for planned surgical procedures. The inpatient service was only offered to children age three and above in line with national guidance. All patients had an initial assessment that involved discussion with both the child and their parent or carer. Children attended pre-admission clinics and would not be accepted for procedures if they had complex needs. Children were placed first on operating lists, in line with best practice, to reduce their anxiety. There was support for children with a learning disability and with a mental health condition. There were limited facilities for adolescents and no educational support for children who had a longer hospital stay. The environment and facilities

did not fully meet the needs of children and children's environments were created by added toys and facilities to adult areas. There were some information leaflets about children's procedures but these had not been specifically written for children.

Service planning and delivery to meet the needs of local people

- In line with national guidance, children under three years old were not admitted to the hospital as they should only be admitted to a specialist paediatric unit, due to the increased risk of anaesthetic problems.
- The hospital provided elective surgery for children between the ages of three and 18 years and an outpatients service for children of all ages. The service was provided to privately funded patients and to NHS patients for orthopaedic surgery.
- Following an incident, and to ensure patient safety, the hospital no longer provided spinal surgery for children who had a learning disability that compromised their ability to communicate.
- The paediatric lead had plans to develop the service provided to children and young people to better meet their needs. This included increased support and training for general nursing staff looking after older children and increasing the numbers of children being treated in the hospital. However, there were no detailed plans to describe how the service was going to be developed.

Access and flow

- The specific operating dates for children's surgery were scheduled a year in advance and surgical rotas for paediatric staff were planned based on these dates.
- All patients had an initial assessment that involved discussion with both the child and their parent or carer.
- Children and young people were only admitted in a planned way and would not be accepted for surgery/admission if there were concerns about the complexity of their needs.
- Pre-admission clinics were held on alternative Saturdays and were supported by a play specialist to help prepare children for their admission to hospital. If a child had special needs, for example, autism or a learning disability, the play specialist would be involved in the planning process.
- Children were scheduled to be first on operating lists to reduce their anxiety and in line with best practice.

Services for children and young people

- Cancellations of surgical procedures were rare.

Meeting people's individual needs

- The hospital would access psychiatric support for children and young people with a mental health condition.
- Children being admitted with a learning disability were seen by the play specialist prior to their admission in order to reduce their anxiety about admission and to plan how to best support the child and their parents during the admission.
- The hospital did not provide educational support even though young people who may undergo major surgery required a longer hospital stay. If the child's condition was such that school work could be undertaken, work would be bought in for them to do according to the child's and parent's wishes.
- The hospital did not have dedicated areas to care for children. Rooms were made available on the inpatient wards or day care unit. Bed linen and toys were used to make the environment more inviting to this age group. Children under the age of 13 were cared for on the day care unit; children over the age of 13 were generally cared for on the general wards. An additional "put up" bed would be placed in the room for the parents to stay.
- The environment and facilities did not fully meet the needs of children and children's environments were created by added toys and facilities to adult areas. For example, toys were made available on the wards, and in the outpatient and radiology departments. However, there was a lack of adolescent entertainment equipment such as electronic games.
- There was a lack of specific literature for children. Some information leaflets were available in the outpatient department, to inform parents about procedures their child might undergo, for example, for grommets and removal of tonsils.

Learning from complaints and concerns

- Children's services received very few complaints and most were resolved locally.

Are services for children and young people well-led?

There was a strategy to expand the paediatric service and for refurbishment to create children's areas, but this was

not developed into a detailed plan. There was a new paediatric steering group in the hospital to ensure standards of care for children and young people were in line with national guidance. There was representation from all wards and departments. Governance arrangements were developing and performance was monitored but there needed to be improvements in the audit and the management of risks. The children's lead nurse communicated well with staff across the hospital. Children's experiences were seen as the main priority but staff had mixed views about caring for older children as some staff felt supported but others did not. A paediatric anaesthetist was the medical lead for the service. Children did not complete surveys themselves to feedback on their care although parents were surveyed. The service had demonstrated innovation and improvement in its development over the last 18 months.

Vision and strategy for this service

- The hospital's strategic objectives for 2014 were to improve on clinical performance quality indicators and there were also some specific service improvements. For the paediatric service this including, improving the environments for paediatric care, developing the skills and knowledge of staff, developing the paediatric orthopaedic service as a centre of excellence and learning from audit and feedback to shape the service.
- The lead children's nurse and senior management spoke about a vision to expand and improve service provided to children and young people. This, however, was not formalised in a written plan.
- Staff throughout the hospital were aware that there was a vision to expand the paediatric service.

Governance, risk management and quality measurement

- The children's service fed into the hospital governance structure by submitting their own governance reports. There was evidence of incident reporting and audit, although monitoring of performance and patient outcomes needed to improve.
- There was one entry on the risk register relating to this service which related to the lack of provision of level 2 safeguarding training. The risk register did not include all identified risks, such as the lack of appropriate training, and the concern of general nurses in caring for older children.
- All wards and departments had a paediatric link nurse that attended a children's and young person's steering

Services for children and young people

group. The purpose of this group was to ensure there was a safe quality service for children in line with national and local guidance and standards. Information from this group would feed into the governance report for the children's and young person's services. The steering group was a recent development, and changes in practice as a result of this group had yet to be demonstrated.

Leadership of service

- The children and young people service was managed by a lead nurse with a qualification in the care of sick children. They told us they received good support from the matron and hospital director.
- Staff throughout the hospital told us that the paediatric lead nurse was approachable and they could approach her at any time of day or night for advice and support if they were caring for children or young people.
- A paediatric anaesthetist was the lead for the service and represented the medical staff on the hospital's Medical Advisory Committee.

Culture within the service

- The lead nurse was communicated well with members of staff throughout the rest of the hospital about the children's service.
- There were mixed views from general nurses about caring for older children. Some felt well supported and had no concerns, whereas others felt unsupported and did not feel they had the skills to care for older children.
- Some staff felt their views about caring for children were not considered and they were given no choice about whether they were involved in the care of older children.

Staff engagement

- The children's lead engaged with staff when children were being treated in the hospital.
- The paediatric steering group was a recent development and had representation from all wards and departments. The group was disseminating and sharing information and guidance on children's care to all staff groups.

Public engagement

- The hospital did not have a satisfaction survey for children to complete. Surveys were completed by parents and it was presumed that parents would consider the views of their children. There was a plan to develop surveys for children and young people to complete, but this process had not yet started.

Innovation, improvement and sustainability

- The children's service has developed over the last 18 months. This has included expanding nursing team from one to three members, recruiting two hospital play specialists, creating a steering group, introducing parent surveys and having a separate hospital governance report for the service. The service has increased the number of patients seen and provided more information for admissions. The children's service had further plans to develop and expand, however, these had not been formalised to evidence how this was going to happen.

Outpatients and diagnostic imaging

Safe	
Effective	
Caring	
Responsive	
Well-led	
Overall	

Information about the service

Outpatients includes all areas where patients undergo diagnostic testing, receive diagnostic test results, are given advice or are provided care and treatment without being admitted as an inpatient. This includes clinics where specialist advice and/or treatment are provided. Spire Southampton Hospital treats adults, children and young people of all ages in the outpatient departments.

There were 12 consulting rooms on the hospital site with additional physiotherapy and sports injury facilities at the perform centre. The hospital has a dedicated separate radiology (imaging) department which included a site Magnetic resonance imaging (MRI) and computerised tomography (CT) suite.

During our inspection; we spoke with 57 staff and 20 patients. We visited the outpatient department which was being refurbished and expanded to increase the size to 17 clinic rooms. We visited the radiology department which included a fixed site MRI and CT Scanner and a cardiac catheter laboratory.

We also visited the new off-site development known as Perform Southampton, which is situated approximately two miles away from the hospital. The new facility predominantly hosts the out-patient physiotherapy department and pre assessment clinics.

Summary of findings

The outpatient and diagnostic service departments followed procedures to ensure that services were safe and effective. Patients in the outpatients and diagnostic unit were protected from abuse and avoidable harm. Staff reported serious incidents and would challenge poor practice which could harm a person. Learning and good practice were shared. Staffing levels were appropriate. Radiology staff felt the pressures of high demand at times but necessary recruitment was on-going. National guidelines were used to treat patients and these were monitored although more information on patient outcomes was required. Imaging regulations were followed appropriately and standard operating procedures had been developed by staff. There was a collaborative approach to care and treatment and staff had training to do their roles. Staff needed to be more up to date with life support training and with their understanding of the Mental Capacity Act. The Outpatient and Physiotherapy Departments were undergoing development and refurbishment to improve and expand the areas to meet increasing demands for clinical services and to provide more car parking facilities on the hospital site.

Staff were caring and compassionate and treated patients with dignity and respect. However, while staff recognised the need for supporting people with complex needs, there was less support for people with a learning disability or of people who lacked capacity. Staff were aware of, and supported, the service strategy to develop more outpatient and diagnostic services. Access to services was good but the majority of MRI and CT scans were not being reported within 48 hours. Governance arrangements were effective to review risks,

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although clinical risks needed more formal documentation and action and there needed to be more performance and outcome measures. The culture was open and transparent and staff said their departments were well led. Staff reported that the managers ensured they felt respected, valued, and engaged. There were good examples of staff involvement in design and future developments for the outpatient and diagnostic departments. Patients were able to feedback on services and their comments were used to improve the service.

Are outpatients and diagnostic imaging services safe?

Patients in the outpatients and diagnostic unit were protected from the risk of abuse and avoidable harm. Staff had a good understanding of safeguarding procedures and where to report serious incidents, whistle blow or challenge if they suspected poor practice which could harm a person. Staff and patients we spoke with were satisfied with the cleanliness levels throughout the departments we visited. The current refurbishment and extension in the outpatient department would significantly improve confidentiality and privacy for patients and provide additional equipment storage facilities which were needed. Staff worked flexible as a team and the staffing levels and skill mix of staff was appropriate for patient attendances. Staff in radiology felt the pressure of demand at times, but there was on-going recruitment to fill vacant posts. There were arrangements to implement good practice, learning from any untoward incidents and an open culture to encourage a focus on patient safety and risk management practices. Patient records were available for clinics although sometimes delayed. Patients who did not have a GP referral letter for their outpatient appointment were risk assessed to decide if the appointment could go ahead or should be rescheduled. More staff needed to complete annual training on basic life support. Simulation exercises tested the emergency team response times if a patient collapsed, and this was reported as good.

Incidents

- There had been 10 adverse events and near misses reported in the outpatient department (July 2013 to June 2014). There had been no serious incidents since June 2014 up to the inspection.
- Staff were aware of how to report an incident using the hospital's electronic reporting system. An automatic email was sent to the person completing the submission to confirm receipt. The majority of incidents were reported within the hospital target of four days. However, the outpatient administration team had taken an average of 18 days to report incidents based on data in June 2014

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- Staff said there was an open approach to reporting and learning. Staff we spoke with were confident to report serious incidents, whistle blow or challenge if they suspected poor practice which could harm a person.
- Incidents were investigated and action was taken. For example, one serious event regarding patient identification had been reported in the radiology department in the last year. The incident had been investigated and actions taken to reduce the risk of reoccurrence. Another example was patients were coming to theatre from a CT Scan had a white swab taped to their back. This caused confusion with swab counts and action was taken to avoid reoccurrence to safeguard patients.
- Staff were aware of the lessons learnt from reporting incidents. Hospital wide information was shared through a newsletter and discussed at team meetings. Issues such as the checking processes for patient identification and the lack of high resolution x-ray viewer screens on wards had been discussed at team meetings.

Cleanliness, infection control and hygiene

- The majority of equipment in the outpatient and diagnostic departments was single use only and this equipment was not reused.
- Decontamination practices for reusable instruments for minor operation procedures were compliant with national guidelines.
- A new higher grade minor operation room was to be built as part of the on-going renovation work. This would include air changes and scrub facilities to improve infection prevention controls which were noted as good practice.
- Staff and patients we spoke with were satisfied with the cleanliness levels throughout the departments we visited. A recent patient led assessment of the care environment (PLACE) June 2014 found satisfactory infection control practices.
- The current refurbishment and extension in the outpatient department was creating dust in corridors. Not all of the areas where building work was taking place were sealed and cross contamination of areas was a possibility. The Infection prevention and control nurse had not been involved in advising the contractors of their responsibilities.
- Staff regularly washed their hands and used hand gel between patients. Bare below the elbow policies were adhered to.
- Infection prevention and control training via e learning for all clinical and non-clinical staff was provided. Training records showed 49.3% of outpatient staff had attended (1 January to 31 August 2014).

Environment and equipment

- Equipment was visibly clean. Items were labelled with the last service date and large green stickers identified when equipment was cleaned.
- All equipment was listed on a corporate computerised maintenance management system. The information included frequency of required maintenance (in line with manufacturer's guidance and best practice) and the details of who held the maintenance contract agreements. The system flagged up when maintenance was required.
- There was a contract for portable appliance testing, these were conducted on an annual basis. A record of checks were maintained.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention. This was undertaken through an electronic reporting system. Records a swift response and work was prioritised according to importance/essential equipment.
- Resuscitation equipment was in line with national guidance and was checked daily.
- The hospital was aware that there was not enough storage for the large volume of equipment and stock. Moving the physiotherapy and pre-assessment services to the external Southampton Perform Centre had freed up some space. The extensions and refurbishment in outpatients would improve this further and provide office space for the nursing staff which was welcomed.
- It had been recognised by the hospital management team that the outpatient waiting areas did not support confidentiality and there was a lack of offices or quiet areas to support distressed patients or relatives. The architect and managers we spoke with demonstrated that the current expansion and refurbishment of outpatients would significantly improve confidentiality and privacy for patients.

Outpatients and diagnostic imaging

Medicines

- Staff were aware of medicine management policies for reference purposes and there were appropriate systems to monitor stock control and report medication errors.
- In the outpatients and diagnostic departments there were appropriate security arrangements to manage medicines safely.
- Contrast media and medicines required during diagnostic imaging were administered appropriately using approved patient group direction to enable staff to carry out the procedure without an individual patient prescription.
- Patient Group Directions (PGD) provide a legal framework that allows some registered health professionals to supply and/or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. The PGD should be used in situations that offer an advantage to patient care, without compromising patient safety. The diagnostic imaging department had PGD that had been agreed in April 2013 and February 2014. These were appropriately authorised, within date, and working copies had been signed by staff working from them. We did not have evidence, however, that these were monitored in line with National Institute for Health and Care Excellence (NICE) guidelines. Medicines Practice Guidelines: Patient Group Directions (updated February 2014).

Records

- The hospital had a policy that records could not be taken off site. This was adhered to.
- The medical records for patients who had received treatment as an inpatient at the hospital and were then seen in outpatients would be made available for their appointment. For new patients, consultant's medical secretaries were responsible for ensuring that records were available for their outpatient appointment.
- The hospital did not keep figures on the percentage of missing notes for clinics. All patients who had been an inpatient at the hospital had hospital medical records. There were sometimes delays for follow up patients who waited for the outpatient medical records from consultant secretaries.
- Any new patient arriving at the outpatient department who did not have a GP letter were risk assessed individually. The consultant would decide if their appointment should be rescheduled or if they could have a consultation without their referral letter.

- Information governance training was provided for all staff to ensure compliance with the Data Protection Act. Ninety eight percent of staff had completed this training. Records management was satisfactory any breaches reported were discussed and actions taken to remind staff of the importance of data protection.

Safeguarding

- There was on an on line safeguarding training package for staff which had been completed by 89.2% of staff. The safeguarding policies and procedures were understood and implemented by staff. Chaperones were offered in all departments.
- The hospital matron was a member of the local independent safeguarding group and had attended an update training day in July 2014. There was an awareness that as the hospitals client base had changed there needed to be an increased awareness of the staff's responsibilities to ensure that the patients were safe.
- A ward sister managed the hospital process to ensure that all staff, who required a professional registration, to practice provided current evidence of their registration.
- There was an established recruitment process that included the requirement for two references and a current disclosure and barring scheme check (DBS) prior to a new member of staff commencing employment.
- There had not been any safeguarding alerts or concerns for the outpatients and diagnostic departments in the last 12 months.

Mandatory training

- There were nine mandatory elearning modules for staff to complete these included fire safety, manual handling, information governance, infection prevention and control, safeguarding adults and children and equality and diversity.
- There was a mandatory training policy that detailed which training staff were required to attend this also included resuscitation training. The training records showed that attendance at training was monitored.
- Some staff needed to do complete their life support training. The hospital training figures for the end of year demonstrated what training was outstanding for 2014. In the diagnostic imaging department all staff had completed adult immediate life support training and 87.5% of staff had completed adult and paediatric basic life support training. In the outpatient department 85.7% of staff had completed adult immediate life support training and all staff had

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completed paediatric immediate life support training; 87.5% of staff had completed adult and paediatric basic life support training. Only 72% of physiotherapy staff had completed adult and paediatric basic life support training.

- At the end of 2013, 83% of staff were up to date with their mandatory training modules this had been lower than the hospital target of 95%. For the year to date (1 January to 31 August 2014), 58% of staff had completed the mandatory training modules.
- Staff were clear about mandatory training requirements, and where there was a backlog, such as for manual handling training, action was being taken to address this through an increase in trainers,
- Health and safety reports showed there was on going monitoring to ensure mandatory training compliance and noted that outpatients and diagnostics were satisfactory although some bank staff in physiotherapy needed to improve attendance.
- A new employee had to complete all on-line mandatory training as well as attend an induction session with the risk manager as part of the induction programme.

Assessing and responding to patient risk

- The sister and staff in the outpatients and diagnostic departments confirmed that they had received training in the recognition and management of the deteriorating patient. They were confident of actions to be taken in the event of a collapse. Training records supported this.
- The Perform Centre had an emergency response policy to deal with patients who might collapse in the department. Staff were aware of the actions required, including how to maintain basic life support until emergency services arrived.
- The hospital did simulation exercises to test staff emergency response times to a patient that may have collapsed. The response in the outpatient and radiology departments times from the emergency support teams were reported by staff as good. We saw reports that demonstrated quick and safe emergency response times.

Nursing, physiotherapy and imaging staffing

- Staff were confident that managers ensured the right staffing levels and skill-mix across all clinical and non-clinical functions and disciplines.
- The numbers of NHS patients was up by 56% this year leading to an increase in workload. This therefore had

had an effect on the hospital's workforce. Managers showed us how staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. Additional recruitment had been agreed in outpatients and diagnostics services to support the increase in demand.

- There was evidence of staff stability in physiotherapy, radiology and outpatients as turnover and agency use was low. The current vacancy rate for outpatient departments nurse staff was 5%. However, the vacancy rate was 10% for physiotherapy staff which they were actively recruiting to.
- Staff were willing to be flexible when needed and told us they liked the work and patient safety was a priority. It was reported that radiology had a high reliance on good will and some staff felt more bank support would be helpful at times.

Medical staffing

- Over 345 consultants worked at Spire Southampton Hospital and most were based at the University Hospital Southampton NHS Foundation Trust. Staff told us they were easy to contact and were close when their patients were in the hospital and should they be needed in an emergency. Staff in outpatients and diagnostics confirmed a quick response from the consultants when needed.
- There were 30 radiologists with practising privileges who worked at the hospital.
- There was a resident medical officer (RMO) present in the hospital at all times. There were five RMO doctors at specialist registrar level and all were trained in advance life support. They worked a roster of 24 hours on a week day and 48 hours on a weekend. When on duty they were resident on site for the duration of their shift.
- Staff told us that medical support was available throughout the day and evening and advice could be sought where needed.

Major incident awareness and training

- Staff were aware of the hospital's major incident plan and understood what action to take for example in case of fire and evacuation procedures.
- Staff were informed about the hospital's bomb policy and there was an emergency evacuation plan for the hydrotherapy pool at the perform centre.

Outpatients and diagnostic imaging

- Consideration had been given to situations that may occur, for example, extreme weather conditions such as snow and how this could be managed

Are outpatients and diagnostic imaging services effective?

The outpatients and diagnostic departments could demonstrate that there was a collaborative approach to care and treatment. National guidelines were used and there was evidence that these were monitored although there needed to be more information on patient outcomes. Imaging regulations were followed appropriately. Standard operating procedures reflected national and professional guidance. Outpatient care and treatment plans were recorded and communicated with all relevant parties to ensure continuity of care.

All permanent staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. The number of staff receiving continual professional development and supervision was satisfactory, the appraisal rates were good and staff told us they felt valued and supported by the organisation.

There were timely multi-disciplinary team discussions to ensure patients' care and treatment was coordinated and the expected outcomes were achieved. Staff were supported to participate in training and development to enable them to deliver good effective quality care. Staff needed to have a better understanding of the Mental Capacity Act.

Evidence-based care and treatment

- Staff were understood and used corporate policies such which made reference to current national guidance. For example, Cardiopulmonary Resuscitation: Standards for Clinical Practice and Training (revised November 2013) and resuscitation council guidance to support evidence based care and treatment.
- Specialist areas such as radiation protection and bariatric (weight loss) treatments were supported by evidence based guidelines and monitoring practices in line with national requirements. The annual Radiation Committee Meeting March 2014 showed that in general

the status of the Radiation Protection at the hospital was satisfactory and in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) regulation requirements.

- Local audits were undertaken to monitor care, and action was taken in areas identified for improvement. There had been improvements in consent practices for cosmetic patients, records management in physiotherapy and quality assurance checks in radiology including exposure levels to safeguard patients.

Pain relief

- Pain was assessed and pain relief administered if required for patients undergoing minor surgical procedures.

Patient outcomes

- The imaging department had routine quality assurance and performance checks by the NHS Regional Radiation Protection Service. Reports had only 'points to note' or were 'satisfactory' overall, there were only a few areas to be addressed, for example, to update local rules for the use of the CT Scan.
- The corporate MRI quality assurance audit report for 2013 identified that the hospital had no required actions.
- Patient outcomes were not recorded for outpatient services.

Competent staff

- The learning needs of staff were identified through performance reviews and training was provided to meet their needs. Staff told us they were supported to maintain and further develop their professional skills and experience. All radiographers had validated up-to-date competencies using the Spire competency framework, and had completed 25 hours continuing professional development (CPD) in the past year.
- Training that related to the safe use of the laser was managed by the manager and laser protection supervisor. The manager told us all operatives were up to date. Training records and certificates were saw were up to date. Staff told us there was a central development day provided every two years for radiation protection supervisor and other imaging staff as identified to meet role requirements. The manager attends this training annually. A date had been arranged in 2014.

Outpatients and diagnostic imaging

- Staff supervision was provided through group meetings and appraisal, and revalidation of doctors. The appraisal rate across the outpatients and diagnostic services was 96%.
- The corporate 'Spire Behaviours' supported the appraisal system and staff were familiar with them. Outpatient consultants noted that staff provided good customer service to their colleagues and patients and staff said they felt valued and supported by the organisation.
- Patients felt that all the staff were well trained and that they were able to ask questions and be confident that they were safe in their hands.
- There was a lack of training in dementia awareness, meeting the needs of patients with a learning disability and Mental Capacity Act requirements to support people with individual needs. Staff did acknowledge seeing increased numbers of people living with dementia.

Multidisciplinary working

- We observed clinical areas and saw that doctors, nurses, support staff and administration staff had multi-disciplinary team discussions to ensure patients' care and treatment was coordinated and the expected outcomes achieved. Outpatient care and treatment plans were recorded and communicated with relevant parties to ensure continuity of care.
- Staff felt there was good team work with allied health professionals (AHP) that supported an integrated care pathway for patients. They said medical input was good and liaison with GPs was satisfactory.
- Patients received care from a range of different staff, teams or services, which were coordinated. For example, cosmetic surgery and the tier 3 programme for overweight patients required input from dieticians, counsellors, psychologists, cosmetic nurses and physiotherapists to ensure patients received appropriate support. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment. Staff worked collaboratively to understand and meet the range and complexity of patient's needs.

Seven-day services

- The outpatient department provided services Monday to Saturday.

- The pharmacy was open 8.30am to 5.30pm Mondays to Friday and 9am to 1pm on Saturday mornings. Out of hours there was an on call service that was shared with Portsmouth Spire Hospitals.
- The radiology department operated from 8am to 9pm Monday-Friday and 8.30 to 1pm Saturday; there was a 24/7 on-call service. MRI scans were also available between 8am and 3pm on Saturdays.

Access to information

- Staff had identified the things in their area that were important to safe and effective care and had established standard operating procedures that reflected national and professional guidance.
- The IR(ME)R regulations and local rules noted in all relevant treatment rooms and staff were familiar with current legislative requirements.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient consent was appropriately obtained. Pre assessment clinics supported informed consent and patient information outlined procedures and risks. Staff were aware of, and undertook, written and verbal consent practices.
- An e-learning training course was available for staff based on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). At the end of June 2014, 48% of all staff had completed this training. Staff had a limited understanding of their responsibility under the Act and it was acknowledged that this was an area for improvement.

Are outpatients and diagnostic imaging services caring?

Staff were caring and compassionate and treated patients with dignity and respect. Patients felt well-cared for as a result. Patients we spoke with and those close to them were encouraged to be involved in their care. They were treated as equal partners, listened to, and were involved in decision making at all levels.

Care was patient centred. There were positive views from a breadth of patients and those close to them about the care provided, which were supported by the views of the staff. Staff were encouraged to develop services to provide patients with emotional support where needed.

Outpatients and diagnostic imaging

Compassionate care

- Patients told us they were treated with privacy, dignity and respect and they felt staff cared about them.
- A recent PLACE assessment March 2014 noted good use of clinic rooms in outpatients with no conversations overheard. All staff were courteous to both patients and visitors.
- We observed good interactions between staff and patients in the outpatient and diagnostic departments. Staff spoke with us about the caring and supportive service they wanted to provide.
- We received 3 comment cards from patients using the Perform physiotherapy service. Patients were positive about the service and told us about excellent, professional and caring staff.

Understanding and involvement of patients and those close to them

- We spoke with 20 patients who were all very positive about the information and care provided in the outpatients and diagnostic departments. Patients told us they were involved in decision making and understood the care and treatment they received. They were positive regarding the professionalism and support provided by the clinical and non-clinical staff.
- One patient said “I was treated very quickly and efficiently, the whole experience was good” another stated “staff are very helpful and do everything with a smile.”
- We received 3 comment cards from patients using the Perform physiotherapy service. Patients told us they were given clear explanations of their care and treatment and this had helped them to follow the advice and make progress.

Emotional support

- We saw good interactions between staff and patients in the outpatient and diagnostic departments and the interviews and forums with staff indicated a caring supportive service.
- There were clinical nurse specialists such as the cosmetic lead nurse to support patient's individual needs. Counselling services were available and provided to cosmetic patients prior to surgery being actioned to ensure they were fully prepared and well informed.

- Bariatric patients on the Tier 3 programme were provided with counselling and psychological support to help them maintain their healthy living programme and lose weight.

Are outpatients and diagnostic imaging services responsive?

The Outpatient and Physiotherapy Departments were undergoing development and refurbishment to improve and expand the areas to meet increasing demands for clinical services and to provide more car parking facilities on the hospital site to meet the needs of local people. Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided both for insured and NHS patients.

Facilities in the outpatients department were being improved to ensure that people could access the right care at the right time. Patients did not have lengthy waiting times while in clinic and cancelled appointments were minimal. However, the majority of MRI and CT scans were not being reported within 48 hours. The staff recognised the need for supporting people with complex needs, however, there was little support for people with a learning disability or for people who lacked capacity. There was information on specific procedures but this was only available in English and not in other languages or formats such as braille. Posters regarding risk to pregnant women in the radiology department were only in English, which could put a non-English speaking patient at risk.

Complaints were reviewed hospital wide to encourage learning to improve practice. However, we could not see any posters or clear evidence of complaints information being displayed in outpatients or diagnostic departments to inform and encourage people to raise concerns where necessary.

Service planning and delivery to meet the needs of local people

- The Outpatient and Physiotherapy Departments were undergoing development and refurbishment to improve and expand the areas to meet increasing demands for clinical services and to free up more car parking spaces on the hospital site to meet the needs of local people.
- Changes were being made to ensure that people could access the right care at the right time, as well as make

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better use of the limited amount of space.

Developments included upgrading and redesigning clinical areas in outpatients and the following changes were being made:

- pre-admission clinics were now relocated off-site at the Perform centre.
- There would be a dedicated minor operation treatment room with recovery bay and this doubled up as phlebotomy rooms
- The colposcopy service would be relocated to the new 'minor operations' room
- There would be dedicated plaster room and a dedicated ENT clinics and walk in service
- There was now an Electronic call system;
- Administration staff would be relocated from the reception area to improve the meet and greet service
- The recent development and opening of the external Southampton Perform Centre for physiotherapy and pre assessment clinics would allow for the growth of new business from emerging markets within sports medicine, cardiology and respiratory as well as specialist physiotherapy, podiatry and health and wellbeing services. Hydrotherapy and Pilates classes were two additional services now being provided.
- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services provided both for insured and NHS patients through the booking procedures which included choose and book for NHS patients.

Access and flow

- Patients said that the booking process was communicated well through correspondence. Referral times and waiting times were deemed to be appropriate by patients we spoke with.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- The turn around times for MRI and CT imaging did not meet targets. In March 2014, the only 43% of MRI scans were reported within 48 hours. In September, only 21% of CT scans were reported within 48 hours.
- Services and clinics ran on time. If there were any delays, the receptionist's ensured people were kept informed of any disruption to their appointments or treatment.

Meeting people's individual needs

- Staff recognised the need for supporting people with complex needs, but there was minimal evidence that the needs and wishes of people with a learning disability or of people who lacked capacity were understood and taken into account.
- Translation services could be accessed through language line for people whose first language was not English. However, there were no posters or written information available to inform people of the help available.
- Information on specific procedures was provided by consultants and the hospital. General information on coming into the hospital was also sent out to patients prior to admission.
- All posters and written information was in English. Posters regarding risk to pregnant women in the radiology department were only in English, which could put a non-English speaking patient at risk.
- Easy read information leaflets were not available. Information in different formats, such as large font or braille, to help people understand, was available if requested. There was no information to advise patients about this, but staff were aware and told us they could provide this where necessary.

Learning from complaints and concerns

- Staff were aware of the complaints procedure and who to report concerns to.
- Information about how to make a complaint was not displayed in outpatients or diagnostic departments.
- Complaints were reviewed hospital wide to encourage learning to improve practice. The managers were aware and action plans were in place to encourage improvement where necessary. There were no themes for outpatients and diagnostics apart from car parking- which the provider was addressing.

Are outpatients and diagnostic imaging services well-led?

The majority of outpatient and diagnostic staff understood the corporate vision and strategy for developing the services at Spire Southampton hospital. Risks at team and management level were identified and captured and staff recognised their role within the risk management system. There needed to be better monitoring of clinical risks and

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patient outcomes. The culture was open and transparent; staff were clear where they were performing well and confident to challenge poor performance to improve quality of care.

We found the leadership model encouraged cooperative, supportive relationships among staff and a caring approach towards people who use the service.

There were good examples of staff involvement in design and future developments for the outpatient and diagnostic departments. Staff reported that the managers ensured they feel respected, valued, and engaged. Staff contributions and performance were recognised, and celebrated which is good practice.

Vision and strategy for this service

- The hospital's strategic objectives for 2014 were to improve on clinical performance quality indicators and there were also some specific service improvements. For outpatient and diagnostic services, for example, these included developing specialist physiotherapy services, increasing the range of outpatient clinic services and increasing MRI/CT provision and assessing the potential for ultrasound screening services for abdominal aortic aneurysm screening.
- All staff were clear about the hospital's vision and values that encompassed key elements of care such as compassion, dignity, respect, and equality with quality a key priority.
- The majority of staff told us they had attended hospital wide meetings which helped them understand the vision and strategy and also the plans for developing the service.

Governance, risk management and quality measurement

- Team meetings included discussions about complaints, incidents, and risks.
- The hospital's clinical dashboard did not cover measures for the outpatient and diagnostic department whose performance was not monitored in a similar way.
- Records of team meeting and heads of department meetings, risk registers and staff consultation demonstrated that risks at team and management level were identified and captured and staff recognised their role within the risk management system, such as: reporting on-going problems with the CT scanning equipment, to highlight the need for tube replacement in the near future to safe guard patients.

- Risks in outpatient services were reviewed, such as generator checks and the outpatient expansion. The risk register did not include any information on clinical risks.
- The hospital risk registers included contingency plans and risk assessments for managing services during the outpatient development programme and the recent movement of physiotherapy and pre admission services to the external Southampton Perform Centre.
- Staff confirmed that information on risks and lessons learnt was cascaded through the hospitals "hot gossip" newsletter.
- The monitoring of consultants to ensure they all had current medical indemnity insurance, appraisals and professional registration was not robust. Information on appraisal and performance was not appropriately shared and documented with the doctor's responsible officer. Information on medical indemnity insurance was not appropriately acted upon where this was not up to date.

Leadership of service

- The staff were positive about the department managers, there was a sister in charge of the outpatient department and seniors in charge of the radiology and physiotherapy departments, stating that they were approachable.
- The vast majority of staff felt the managers knew their staff, played to their strengths and developed them as individuals. Staff said they were valued which helped during busy times where flexibility and good will was needed to provide a quality service.
- There were consultants from each speciality who represented their speciality at the hospital's medical advisory committee (MAC). There were regular meetings held with the hospital management team and there was an expectation that they would liaise with other consultants.

Culture within the service

- There was an open and transparent culture. Staff were clear about where they were performing well and would be confident to challenge poor performance to improve quality of care.,
- Staff were positive regarding team working practices and that there were good communication processes such as daily handovers and notes to ensure staff were well informed.

Outpatients and diagnostic imaging

- Staff were consistent in what they knew were the key risks and this fitted with the current risk profile for the outpatient and diagnostic departments.
- The vast majority of staff said they felt valued and supported by the organisation.
- Physiotherapy staff had expressed concerns about how the changes with the transition to the Perform Centre had been managed. The Hospital Matron had attended a meeting to discuss and listen to their concerns. This was seen as positive and action was taken to ensure improvements followed.

Staff engagement

- Staff were engaged at all levels. They were consulted on service designs and upgrades to premises through multi-disciplinary meetings, focus groups, team meetings and emails. They told us they were encouraged to be involved in service developments, such as the Perform centre and outpatients developments.
- The Southampton Perform Centre website had been developed to enable patient engagement as it had been built to include a social media campaign via Twitter and Facebook to market the service to the public.

Public engagement

- Staff told us they understood the views of patients on the care they received, through annual patient survey. Any comment and concerns were shared to improve the service and performance.

Innovation, improvement and sustainability

- The new physiotherapy department, the Perform Centre, had considerable input from staff with regard to its design. Patients gave positive comments about the new purpose build for physiotherapy.
- Staff told us they were encouraged to develop new services such as the sports medicine services at the Perform Centre and Ear Nose and Throat (ENT) and dermatology services in the outpatients following expansion.
- There were good examples of forward planning and capacity management developments. Car parking was a real issue for the outpatients and moving clinics off site had improved capacity although it was recognised that more needed to be done.
- A completely new Wi-Fi system was installed during February 2014 to provide a reliable and high speed connection. Also voice recognition reporting was due to be implemented in the radiology department to improve reporting times and reduce the workloads on administrative staff and radiologists.
- Staff were aware of future plans that were hospital wide, such as the potential for a sixth theatre on site and were already considering the impact on radiology facilities and staff resources required to support sustainability of the service going forward.

Outstanding practice and areas for improvement

Outstanding practice

- The Chalybeate Suite for patients receiving chemotherapy and palliative care, was designed by nursing staff and patients. The environment was private, calm and relaxing. The unit had received a Macmillan Quality Environmental Mark which indicates that the unit meets national standards to provide a welcoming private and comfortable environment for people with cancer to support and improve their wellbeing.
- The hospital director and matron/head of clinical services met regularly with the Medical Director of the local NHS trust to share information on consultant's clinical practice, performance and services. The hospital had a joint post with the local NHS trust of associate medical director for governance and patient safety.

Areas for improvement

Action the hospital **MUST** take to improve

The hospital must ensure that:

- Procedures for infection prevention and control are followed (Regulation 12)
- The environment is in line with recommend guidance to reduce the risk of cross infection. Particular attention needs to be placed on the fabric of the building, and keeping dirty and clean equipment for cleaning and sterilisation processes separate (Regulation 12)
- Single use gowns are used appropriately (Regulation 12).
- Access and security arrangements are effective and reduce risks to staff and patients (Regulation 15).
- Medicines are managed appropriately, so that liquid medicines are stored and labelled correctly and there is adequate storage for intravenous infusions, dialysis and irrigation solutions in the critical care unit. Intravenous fluids not recommended for use in children are not stored on the paediatric resuscitation trolley. Patient Group Directions are monitored locally.
- Cleaning fluids covered by the Control of Substances Hazardous to Health (COSHH) regulations, 2002 are stored securely (Regulation 15).
- All equipment in the critical care unit is checked daily where this is required.
- Staffing levels improve in theatre recovery to meet national guidance and improve to ensure appropriate pre-assessment prior to admission. (Regulation 22)
- Nurse on call arrangements for children in the day care unit are in accordance with national guidance (Regulation 22).
- An age appropriate paediatric early warning score system, to identify children whose condition might deteriorate, is introduced in line with current national guidance.
- Staff working in the critical care unit have their competencies reassessed on an annual basis (Regulation 23).
- All staff have appropriate safeguarding training and staff who have regular contact with children should complete safeguarding children training at a level suitable to their role (Regulation 23).
- Staff attend basic and immediate life support training according to hospital targets (Regulation 23).
- Nursing staff have appropriate training to care for medical patients and children (Regulation 23).
- Staff must have an understanding, and follow guidance, to ensure they adhere to the Mental Capacity Act 2005 and deprivation of liberty safeguards (Regulation 23)
- Imaging reporting times meet service standards of within 48 hours.
- Appropriate information for consultant's practising privileges are reviewed and kept up to date, and there is evidence that suspension is timely, where required.

Action the hospital **SHOULD** take to improve

The hospital should ensure that:

Outstanding practice and areas for improvement

- Improve the timeliness of investigation following an incident in areas where this remains outstanding.
- Recruitment continues to alleviate the pressure of long working hours on staff.
- Information is available in a format other than English and that information is available that is specific for children and young people.
- Clinical staff have an understanding of the needs of people living with dementia and those with a learning disability.
- Care plans are appropriately completed for cardiac patients in critical care and there is appropriate documentation for patients on a neurosurgical pathway.
- The capacity within pharmacy is reviewed to ensure more time is spent on providing a clinical pharmacy service.
- A policy on Duty of Candour is implemented with respect to forthcoming legislation.
- There are better systems to audit and monitor compliance with guidelines and patient outcomes
- Quality impact assessments are undertaken for actions taken to meet efficiency targets, and the annual operating plan.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The provider must ensure procedures for infection prevention and control are followed; the environment is in line with recommend guidance to reduce the risk of cross infection. Particular attention needs to be placed on the keeping dirty and clean equipment separate in cleaning and sterilisation processes, and the fabric of the building; and the practice of reusing single use gowns is stopped. Regulation 12 (1) (a) (2) (a) (c) (i) (ii)
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises The provider must ensure access and security arrangements are effective and reduce risks to staff and patients; cleaning fluids covered by the control of substances hazardous to health regulations 2002 are securely stored at all times. Regulation 15 1 (a) (b)
Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The provider must ensure staff working in the critical care unit have their competencies reassessed on an annual basis; all staff have appropriate safeguarding training and staff who have regular contact with children

This section is primarily information for the provider

Compliance actions

should complete safeguarding children training at a level suitable to their role; all staff have training on the Mental Capacity Act, 2005 and dementia care; and where required, all staff complete basic and immediate life support training.

Regulation 23 (1) (a)

Regulated activity

Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations
2010 Staffing

The provider must ensure that there are suitably qualified skilled and experience staff at all times, and according to national guidance, when children are in the hospital and for recovery area in theatres and to ensure pre-admission assessments occur prior to surgery.