

Spire Dunedin Hospital

Quality Report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Dunedin Hospital, located in Reading, is one of 38 private Spire hospitals in the UK.

The hospital provides a range of medical, surgical and diagnostic services. The onsite facilities include two laminar flow theatres, a minor procedure room, a pain management suite, an oncology unit, an endoscopy room, 15 consulting rooms, 24 inpatient beds and 15 day case beds. The hospital offers physiotherapy treatment as an inpatient and outpatient service and has four treatment areas and a small gym for this service. Radiology services including CT and MRI scanning, digital mammography and ultrasound are provided onsite.

Services offered include general surgery, orthopaedics, cosmetic surgery, ophthalmology, general medicine, oncology, endoscopy and diagnostic imaging. Most patients are self-funded or use private medical insurance. Some services are available to NHS patients through the NHS choose and book service.

There were no surgical procedures carried out on children under the age of 16 years old at this hospital in 2015.

We inspected the hospital as part of our planned inspection programme, visiting 13-14 April 2016 followed by an unannounced visit 22 April 2016. This was a comprehensive inspection and we looked at the three core services provided by the hospital: medicine, surgery, and outpatients and diagnostic imaging.

Spire Dunedin Hospital was selected for a comprehensive inspection as part of our routine inspection programme. The inspection was conducted using the Care Quality Commission's new inspection methodology.

The hospital was rated as good overall and good for safe, effective, caring, responsive and well led services.

Our key findings were as follows:

Are services safe at this hospital?

By safe, we mean people are protected from abuse and avoidable harm.

- Patients were protected from the risk of abuse and avoidable harm across medical, surgical services and outpatient and diagnostic imaging services.
- Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed. We saw examples of changes in practice that occurred as a result of learning from incidents. Staff we spoke with understood Duty of Candour legislation however, following a serious incident of avoidable patient harm legislation was not fully followed.
- Staffing (nursing and medical) was sufficient to provide good care and treatment across all areas. All areas inspected were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staff routinely assessed and monitored risks to patients. There were appropriate transfer arrangements to transfer patients to a local NHS hospital if required.
- Staff followed comprehensive risk assessments from the initial pre-assessment clinic through to discharge, however the preoperative assessment service was currently stretched due to lack of staff. Major cases were being prioritised but this meant that some patients may not be preoperatively risk assessed prior to admission.
- Medication management across the hospital was variable. There were good systems for storage and checking. However we found medication omission codes were inconsistent on the charts.

Are services effective at this hospital?

Summary of findings

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence..

- Care and treatment took account of best practice and evidence base guidelines across the services. However the medicine reconciliation process, (the checking of patients' pre-admission medication against a GP's or other record) which was considered best practice, was not completed consistently.
- The service was taking action to be able to meet current evidence based guidance. A business plan has been produced to drive towards achieving Joint Advisory guidance (JAG) accreditation in gastrointestinal endoscopy.
- Oncology patient outcomes were monitored at cancer multi-disciplinary (MDT) meetings and staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.
- The hospital routinely collected and monitored information about patients' surgical outcomes for comparative analysis against the Spire corporate dashboard and national performance audits.
- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. The medical advisory committee (MAC) reviewed patient outcomes and the renewal of practising privileges of individual consultants. It also reviewed policies and guidance and advised on effective care and treatments.
- Staff were supported in their role through appraisals. All staff were appraised or had appraisals booked with their managers. Staff were encouraged to participate in training and development to support them to deliver good quality care.
- Staff were competent and sufficiently skilled to deliver effective care and treatment. This hospital provided core training for staff in Mental Capacity Act, 2005, and Deprivation of Liberty Safeguards.

Are services caring at this hospital?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- Feedback from patients about their care and treatment was consistently positive.
- Staff treated patients with kindness and compassion. Staff treated patients courteously and respectfully, and patients' privacy and dignity were maintained.
- Patients told us they had sufficient information about their treatment and were involved in decisions about their care. Results of the latest patient survey showed a high level of patient satisfaction with the hospital scoring over 95%.
- Staff supported patients emotionally with their care and treatment as needed.

Are services responsive at this hospital?

By responsive, we mean that services are organised so they meet people's needs.

- The hospital met national waiting times for endoscopy patients to wait no longer than 18 weeks for treatment after referral.
- The needs of different people were taken into account when planning and delivering services. The provider planned and delivered services in a way that met the needs of the local population. The service reflected the importance of flexibility and choice.
- Staff took account of individual patient's spiritual, religious and emotional needs when delivering care and treatment. Suitable adjustments were made to meet individual needs. For example adjustments had been made to support a patient living with dementia.
- The hospital dealt promptly with complaints or concerns. There was evidence that the hospital used learning from complaints to improve the quality of care.
- There was patient information on specific procedures, conditions and hospital charges. This was routinely in English, but could be provided in other languages or formats, such as braille if required. There was good access to translation services for patients that required it.

Summary of findings

- The preoperative assessment service was currently stretched due to lack of staff. Recent recruitment had taken place. Whilst the hospital was waiting for the new members of staff to commence employment major cases were being prioritised but this meant that some patients could not be preoperatively assessed prior to admission, this at times resulted in patients operations being cancelled.

Are services well led at this hospital?

By well led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovations and promotes an open and fair culture.

- There was a clear statement of goals and a local strategy with a strong focus on patient care and improvement across the hospital. This aligned with the corporate vision and mission for excellence and highest quality patient care. Most of the staff were clear about the vision and strategy for their services, driven by quality and safety
- There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems to share information and learning. However the hospital was in the process of transferring from one system to another and arrangements for risk management and governance were not always clear with duplicated risk registers held locally and hospital wide. Action plans to mitigate risks did not always have timescales or dates for review.
- All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital. There was an open and supportive learning culture. Most staff across the services described being proud of working for the hospital because they were well supported and respected by visible and accessible managers, with good communication structures.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. During 2015 the hospital reported consistently high levels (over 85%) of patients would recommend the hospital to their friends and families.

We saw areas of outstanding practice including

- The rapid access spinal pain clinic offered patients an appointment within a week of referral which included diagnosis, expert advice and a treatment plan.

However, there were also areas of where the provider should ensure:

- Systems are in place to review, update and monitor actions against known risks recorded on the risk register.
- Audits are undertaken into antibiotic prescribing.
- Risks are assessed, recorded and mitigated against consistently.
- Consistent medicines reconciliation across surgical and medical services.
- Staff are trained and follow guidelines to recognise female genital mutilation (FGM)
- All staff are familiar with the medication chart in use for their area.
- Ensure all staff are aware of the assessment tool in the outpatient's and diagnostic department in order to help identify a patient whose condition might deteriorate.
- Patients have chaperones available to provide support in all clinics as needed.
- Audits are developed in outpatient departments to include did not attend (DNA) and patient group directives (PGD).
- All medication fridges in the outpatient's departments are locked.
- Duty of Candour is applied in line with requirements.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating Summary of each main service

Good



Overall, we found medical care at this hospital was good.

Endoscopy, oncology and the ward and were visibly clean and there were good infection prevention and control practices. Patient risks were assessed, reviewed and appropriately monitored during their stay. Staff were supported in their role and were aware of the hospital's safeguarding process and were clear about their responsibilities. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

However, the hospital did not have audit processes in place to assure safe antibiotic prescribing. Intravenous medications were sometimes prescribed in the wrong place on medication charts which could potentially put patient's safety at risk.

Medical staff obtained informed consent from patients prior to endoscopy procedures and chemotherapy. The service was taking action to be able to meet current evidence based guidance. A business plan has been produced to drive towards achieving Joint Advisory guidance (JAG) accreditation in gastrointestinal endoscopy

During the inspection, we saw that staff were caring, compassionate and sensitive to the needs of patients. Patients commented positively about the care provided from all of the endoscopy, oncology, and ward staff. Patients felt well informed and involved in their procedures and care.

The service met national waiting times for endoscopy which meant patients would wait no longer than 18 weeks for treatment after referral. Care and treatment was coordinated with other providers. The needs of different people were taken into account when planning and delivering services.

There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems to share information and learning. The hospital was in the process of transferring from

Summary of findings

one system to another and there were duplicated risk registers held locally and hospital wide. However the arrangements for risk management and governance were not always clear.

Staff across the service described being proud of working for the hospital because they were well supported and respected by visible and accessible managers, with good communication structures

Surgery

Overall we found surgical services provided good care and treatment to patients.

All areas of the service we visited were visibly clean, systems had been implemented to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures. On the ward, we observed all staff were bare below the elbows. Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance.

Patients had a comprehensive assessment of their needs and access to a variety of methods for pain relief. Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness, compassion and dignity throughout our visit. Patients' privacy and confidentiality was respected at all times. Patients told us they felt informed about their treatment and had been included in decisions about their care.

Staff across the service described a 'family' culture and felt well supported by visible and accessible managers. There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems to share information and learning. The hospital was in the process of transferring from one system to another and there were duplicated risk registers held locally and hospital wide. However the arrangements for risk management and governance were not always clear.

Staff followed comprehensive risk assessments from the initial pre-assessment clinic through to discharge, however the preoperative assessment service was stretched due to lack of staff. Major cases were being prioritised but this meant that some patients may not be preoperatively assessed prior to admission.

Good



Summary of findings

Ward staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times.

Medication management across the hospital was variable with good systems for storage and checking. However we found medication omission codes were inconsistent on the charts, and inconsistent medicine reconciliation. Some medication errors were not escalated appropriately to serious incident level. However, we saw all the incidents had been investigated action plans developed and learning shared to prevent the risk of recurrence.

Outpatients and diagnostic imaging

Overall, this service was rated as good. We found outpatients and diagnostic imaging good for the key questions of safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to enable a rating.

Patients were positive and complimentary about the care they received from staff, access to appointments and the efficiency of the service as a whole. Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) incidents and followed their internal procedures to report to the radiation protection team and the Care Quality Commission as required.

Good



There were appropriate systems in place to keep patients safe. Staff were aware of their responsibilities to raise concerns and report incidents and near misses. There were clearly embedded systems and processes to keep patients and staff safe and safeguarded from abuse. Staff received up-to-date training in all aspects of health and safety.

Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits in diagnostic and imaging service and reviews were undertaken at regular intervals. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Staff were supported to deliver effective care and treatment, through ongoing training and appraisal.

Summary of findings

We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect at all times when providing care and support. Patients and their relatives' feedback were positive. Staff managed, and scheduled, clinics appropriately. Services were planned and delivered in a way which met the needs of the local population. Waiting times, delays, and cancellations were minimal and managed appropriately. There was openness and transparency in how complaints were dealt with. There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and the service's goals.

Summary of findings

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Good 

Spire Dunedin Hospital

Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging;

Summary of this inspection

Background to Spire Dunedin Hospital

Spire Dunedin hospital was opened in 1918, initially as a surgical nursing home and became part of Spire Healthcare in 2008.

The main hospital is located at 16 Bath Road with outpatient clinics across the road at 13 and 22 Bath Road. The hospital has 24 inpatient beds and 15 day care beds.

The following services are outsourced to other providers including:

- Human Tissue Supplies - NHS Blood and Transport
- Pathology Services - Frimley Health NHS Foundation Trust/North Bristol NHS Trust
- Provision of Resident Medical Officers - NES Holdings (UK) Limited

- Specialist Blood Services - NHS Blood and Transport.

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the four core services provided by the hospital: medicine, surgery and outpatient and diagnostic imaging.

The registered manager at the time of inspection was Miss Margaret Da Costa and they were registered with the Care Quality Commission on 26 June 2013.

The nominated individual from Classic Hospitals Limited at the time of the inspection was Jean Jacques De Gorter.

Our inspection team

Our inspection team was led by: Caroline Bishop, Inspection Manager, Care Quality Commission (CQC).

The team of ten included five CQC inspectors, one CQC assistant inspector and a variety of specialists including: a nurse team manager, a consultant surgeon, a senior lecturer in radiography & medical ethics and an outpatient's manager.

Information about Spire Dunedin Hospital

The hospital provides a range of services to patients at any age though most commonly patients are aged 16 years and over. Between January 2015 and December 2015, one per cent of the hospital's overall activity was care and treatment delivered to children between the ages of three and 15 years old and one percent was delivered to young people 16 or 17 years old. The total activity in the same reporting period for children under the age of three years old was less than one percent. 23% of all patients are NHS funded.

Hospital activity during the year January 2015 and December 2015 included:

- 1,728 overnight inpatients
- 2,497 day-case patients
- 6,543 outpatients (first attendees)

- 25,902 outpatient (follow up appointments)

Of the 4,201 visits to the theatre between January 2015 and December 2015. The most common procedures performed were:

- Cataract (883)
- Hernia repair (186)
- Breast surgery (135)
- Surgical removal of buried teeth (133)
- Cosmetic surgery (88)

The most common medical procedure between January 2015 and December 2015 was ultrasound guided drainage of fluid collection (11).

The accountable officer for controlled drugs was Miss Margaret Da Costa / Joan Palmer.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

We will rate effectiveness where we have sufficient, robust information which answer the KLOE's and reflect the prompts.

Medical care

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

Information about the service

Spire Dunedin Hospital is registered for 50 beds of which 24 are en-suite. During our inspection, we saw 24 overnight beds and 15 day-care beds in use. The hospital conducts both private and NHS work in orthopaedics, ophthalmic and general surgery. A third of all patients seen at the hospital were NHS patients through the choose and book service.

Specialist nurses provide expertise across colo-rectal, gastro-intestinal and breast surgery. For example a specialist nurse co-ordinates and supports the patient through their individual journey from initial consultation for a breast lump to diagnosis and treatment and aftercare.

The physiotherapy department provides outpatient and inpatient treatment to patients, as well as classes such as Pilates, new mums, breast cancer wellbeing.

The cardiology suite has seven consultants and provides a 24 hour response to urgent cases with emergency cases going direct to a local NHS Trust.

The endoscopy manager is commencing work to meet Joint Advisory Group (JAG) accreditation in both theatres and endoscopy.

The hospital did not treat NHS oncology patients. The majority of oncology patients were either insured or were self-paying. Patients that were not eligible for treatment funded by the NHS or patients that chose to pay for medication not available on the NHS self-funded their treatment. Chemotherapy was provided for patients living in West Berkshire and East Berkshire.

We spoke with four patients receiving chemotherapy and one patient attending for an endoscopy. We spoke with

eight members of staff including an endoscopy consultant, an oncology consultant, a ward sister, a senior staff nurse, an oncology nurse consultant and two staff nurses. We reviewed seven patient records within oncology.

We checked the clinical environment and equipment, observed care and we reviewed hospital policies and procedures, staff training records, audits and performance data. Before, during and after our inspection we reviewed the provider's performance and quality information.

Medical care

Summary of findings

Overall, this service was rated as good and specifically good for each of the key questions of safe, effective, caring, responsive and well-led.

Staff reported incidents appropriately. Staff had access and understood how to use the electronic reporting system, appropriate actions were taken, and learning occurred as a result. In addition, the staff all understood the principles and the full requirements of the Duty of Candour.

All areas of the service we visited were visibly clean, systems had been implemented to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures. In clinical areas we observed all staff were bare below the elbows. The unit sister encouraged staff to challenge each other's practice to ensure that the infection prevention and control policy was upheld.

All clinical staff followed comprehensive clinical pathway risk assessments to ensure patient safety and highlight any concerns. Medication management across the hospital was variable however there were good systems for storage and audit checks.

Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance.

Feedback from patients about their care and treatment was consistently positive. We observed patients were treated courteously and respectfully with kindness, compassion and dignity throughout our visit. Patients' privacy and confidentiality was respected at all times. Patients told us they felt informed about their treatment and had been included in decisions about their care. Anxious patients or patients with a learning difficulty were given the opportunity to visit the treatment area before their treatment and care commenced.

Services were planned and delivered in a way which met the needs of patients. Access to appointments was timely and depended on patients' preferences. Patients were offered printed information about their treatment and there was access to interpretation services for

patients who required it. Patients had a comprehensive assessment of their needs. The clinical staff monitored patients' pain levels regularly and responded appropriately with a variety of methods for pain relief.

There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems to share information and learning. Staff across the service described being proud of working for the hospital because they were well supported and respected by visible and accessible managers, with good communication structures.

The arrangements for risk management and governance were not always clear. The hospital was in the process of transferring from one system to another and there were duplicated risk registers held locally and hospital wide. Some of the risks identified on the register had no actions or timescales associated with them.

The arrangements for male and female patients waiting for and recovering from endoscopy and colonoscopy procedures was not compliant with Joint Advisory Group (JAG) on gastro-intestinal endoscopy guidance accreditation standards in relation to maintaining privacy and dignity.

Information was not routinely available in other languages or formats. However staff could access this information on request through Spire's corporate translation service arrangement.

Medical care

Are medical care services safe?

Good 

By safe we mean that people are protected from abuse and avoidable harm

We rated medical care as good for safe because:

- Risks to patients were assessed, monitored and managed daily. Nurses used the modified early warning score to identify patients whose condition might deteriorate and there were appropriate transfer arrangements of patients to a local NHS hospital if required.
- Staff understood their responsibilities to raise concerns. Staff reported incidents, took appropriate actions and learning was shared. Staff were aware of the hospital's safeguarding process and were clear about their responsibilities
- Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who use services. The hospital employed two Resident Medical Officer's to provide medical care to patients 24hours and seven days a week supported by an 'on call' consultant rota.
- All clinical areas in use were equipped to provide safe care and were visibly clean. Regular infection control audits were completed and monitored.
- The NHS Safety Thermometer showed 100% harm free care for March 2015- 2016 for the 27 NHS patients.
- Portable resuscitation trolleys were available in the endoscopy theatre suite and on the ward. They had tamper-proof equipment and medications which had been checked, was in date and were ready for use.

However,

- The use of outdated prescription charts, with intravenous medications being prescribed in the wrong place on the chart could potentially put patient's safety at risk.

Incidents

- All oncology and endoscopy staff were confident about reporting incidents on the electronic incident reporting system, in line with the hospitals adverse event /near miss reporting policy 2015.
- The hospital reported no never events (a serious largely preventable patient safety incident)
- There were 152 incidents reported at this hospital in 2015. Of these, 45 were operations cancelled on the day, 15 medication incidents, 10 treatment or care delays and nine patients who suffered a slip, trip or a fall. The hospital benchmarked the incidents they reported against corporate dashboards to enable identification of any underreporting.
- The oncology nurse consultant, (ONC) who had received incident report training investigated oncology related incidents, unless the incident happened on the ward, in which case the ward sister investigated the incident. The results of an investigation were sent to the clinical governance lead and an action plan was put in place to prevent the risk of the incident reoccurring. There was a senior nurse available for further assistance with investigations if required. We saw evidence that potential risks were assessed and added onto the local risk register if necessary.
- Incidents and the outcome of investigations were discussed at monthly team meetings. The meetings were recorded and any member of staff who was absent was expected to read the folder which contained team meeting minutes.
- If an incident showed more urgent action was required to ensure it did not happen again, the teams were small enough for the senior staff to speak with team members individually, rather than wait until the next meeting.
- Staff told us about learning that had taken place as a result of a specific incident. One chemotherapy patient tried to re-site a needle that had moved position when the patient was at home. As a result, nurses immediately informed patients about the dangers of doing so and a warning was added to patient information leaflets.
- Learning from incidents that occurred at other Spire hospitals was shared with staff via the intranet.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or

Medical care

other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. All members of staff were aware of the principles of duty of candour.

- Root cause analysis and lessons learnt were discussed at clinical governance meetings. For example one oncology patient developed a grade 2 pressure ulcer. A Waterlow score which gives an estimated risk for the development of a pressure ulcer in a given patient was completed but no action plan was documented. Lessons learnt were discussed at the ward meeting which included a reminder to clinical staff to ensure completion of action plans which comprised ensuring patients were on the correct pressure relieving mattress. We observed charts were used to document when patients were turned.
- The hospital reported three incidents relating to medical care. Two patients were admitted with E-Coli bacteraemia in June and November 2015. Infection control and antibiotic protocols were followed and no harm to other patients occurred. The other incident was a non-clinical legionella bacteria incident identified in water pipes during routine maintenance. Clinical staff managed this incident effectively, requested advice and halted oncology services immediately until they received an 'all clear' to re-admit patients. No patients were harmed and an action plan was completed to prevent this incident from occurring again. During our inspection we observed staff followed new policies and procedures to prevent the risk of reoccurrence.
- The hospital reported seven patient deaths in 2015; all patient deaths were expected due to advanced co-morbidities and do not attempt cardio pulmonary resuscitation status recorded. The deaths were discussed at the clinical governance meetings.
- Staff told us patient discharge summaries to the GP included details of any incidents that had occurred whilst the patient was receiving care at the hospital.

Safety thermometer or equivalent

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient 'harm or harm free' care. The hospital is only required to submit data for the NHS patients, which the hospital are caring for on the day of the data input. The submission

included data on patient falls; pressure ulcers, catheter and urinary tract infections, and these showed 100% harm free care for the past year (March 2015 to March 2016) for a total of 27 NHS patients.

- Day cases were excluded from the NHS Safety Thermometer. None of the patients undergoing an endoscopy procedure in the reporting period (April 2014 to March 2015), stayed overnight.
- The ward did not display the results of the safety thermometer for staff, patients or visitors to see how the ward performed. The ward sister discussed the results with staff at ward meetings.
- The hospital monitored patient safety for all patients, including NHS and those that were self-funded or funded by insurance policies via the electronic reporting system. The information gathered through this system was reported in the clinical governance meeting and monitored via the organisations quality dashboard. The dashboard information benchmarked the hospital against other hospitals in the Spire[AA1] group. The dashboard showed that the hospital achieved or exceeded targets for most of the areas on the dashboard. For example they exceeded the target of 85% for appropriate blood transfusions, over 80% for recording of patient temperatures in theatre and over 55% for effective discharge. However, the hospital scored higher in patient falls (5.68) compared to a target of less than 2.0. We saw that action plans were in place which addressed the incidence of patient falls.

Cleanliness, infection control and hygiene

- All areas inspected were visibly clean. We observed all staff throughout our inspection washed their hands properly and wore gloves and aprons. Long gloves and eye shields were worn for endoscopy procedures to prevent the spread of infection. Disposable aprons and gloves were readily available.
- Staff were clear who was responsible for cleaning equipment and clinical areas. 'I am clean' stickers were attached to equipment so that staff knew they were clean for use.
- Staff completed infection control training annually; 100% of staff were up to date with training.
- Compliance with hand hygiene was audited. From September to December 2015, 83% of oncology staff

Medical care

passed the hand hygiene test. Following one-to-one refresher training by the infection control link nurse, compliance improved to 92% in the following quarter and was 100% between January and March 2016.

- The hospital achieved 95.34 % for cleanliness in the patient led assessment of the care environment (PLACE) which was better than the England average.
- We observed there were effective procedures in place which ensured all endoscopy equipment was cleaned and sterilised. This included separate sinks for clean and dirty equipment.
- Two members of staff had attended training and achieved competencies which ensured they were capable of cleaning the equipment to the required standard. The senior manager oversaw the management and decontamination of equipment.
- Endoscopy audits were conducted to ensure cleaning of equipment was in line with national guidance. For example the endoscopy decontamination facilities audit (IHEEM). The results of the audit showed the hospital complied with guidelines and the results could be used towards their JAG accreditation.
- Nursing staff tested the endoscopy sterilisation machines every morning, to ensure they reached the correct temperature for the required amount of time to sterilise the used scopes. An engineer serviced the endoscopy sterilising machines weekly.
- There was a system that tracked the use of endoscopy equipment on patients to ensure infection control standards were met. The endoscopy sister audited the system in March 2016, which showed there was 100% compliance.
- There were no cases of MRSA between January 2015 and March 2016. One chemotherapy patient was diagnosed with *C. difficile*, a bacterium that can infect the bowel and cause diarrhoea but the patient had symptoms prior to being treated at the hospital. The patient was tested for the bacterium and before the result was known, the patient's room was deep cleaned to prevent the spread of infection.
- Staff were trained in 'source isolation' to minimise the risk of spread of disease to other patients. The room nearest the toilet in the chemotherapy unit was used for isolation and toilets were not shared to reduce the risk of spread of infection.

- The provider had a legionella risk assessment. Following an incidence of legionella found in the water supply during routine maintenance in June 2015, quarterly water sampling was introduced as an additional safeguard as well as the regular flushing schedule.

Environment and equipment

- There was oxygen, suction and a bag and mask by each endoscopy patient's bed, which ensured the necessary equipment was available in case of a respiratory arrest. A defibrillator was available in case of a cardiac arrest.
- Emergency mobile resuscitation trolleys were available on the cardiology and recovery areas. They were secured with tamper-evident tags and were tested daily.
- Staff nurses told us that equipment was always available and in good working order. We observed equipment was readily available and service level agreements were in place which ensured equipment was checked and suitable for use.
- Equipment was planned for in advance. For example, if a consultant thought a patient might need a smaller or larger scope than standard, a different size could be acquired on loan for their procedure.
- The hospital achieved scores higher than the England average for its condition, appearance, and maintenance (93.49%) in the patient led assessment of the care environment (PLACE) audits. This showed the environment was maintained to a satisfactory standard and met the needs of patients.

Medicines

- The pharmacist attended the medical ward rounds and advised the clinical team on patient medication choices.
- Nurses did not administer chemotherapy to patients unless blood test results from within the previous 48 hours showed it was safe to do so.
- Chemotherapy drugs were manufactured off site. Every morning a nurse and a pharmacist checked that the drugs received matched the consultant's prescription and the protocol recorded.
- Two nurses checked chemotherapy drugs were correctly drawn up to be administered. The nurse who was administering them checked the patient's details at their bedside in order to be sure the right dose was given to the right person, at the right time and by the right route.

Medical care

- Nurses were trained in safely dealing with a chemotherapy spillage, which ensured patients and staff were not exposed to unsafe levels of potentially harmful chemicals
- Medicines were stored in locked cupboards. The clinical staff locked and secured the medicine trolley within the locked treatment room when not in use. The ward's medicine fridges were locked and clean with suitable minimal stock at the time of inspection.
- Maximum and minimum temperatures were recorded daily and when checked were within safe parameters. There was evidence that pharmacy staff audited fridge temperatures monthly to ensure that the fridge was at the correct temperature for medication storage.
- The stock lists were checked on a weekly basis by the hospital pharmacist. Nurses in each clinical area checked for expired medication and we saw documentation which supported regular checks had been conducted.
- Controlled Drugs (CDs) were stored in appropriate double locked cupboards and managed appropriately. Pharmacy staff completed a quarterly CD audit and any deficiencies identified had action plans.
- Access to the blood fridge was secure. Only registered nurses had access via the use of a swipe card.
- Anaphylaxis kits were available in all departments; these were sealed securely with tags and were readily available for use.
- The hospital used only one model of syringe driver to prevent potential errors in using multiple types.
- Nursing staff had arranged for pharmaceutical representatives to attend twice yearly at the nurses meetings. This was to ensure they were up to date with any potential risks and side effects of the medication they administered.
- New Spire corporate medication charts were being trialled in one part of the hospital. The old style chart was in use in other parts of the hospital. The continuation sheet of each medication chart had a different coded sheet. This was a potential risk for medication errors. The hospital had a plan for all clinical departments to change to one corporate medication chart but no date had been set.
- We reviewed seven medication charts. The hospital policy required each signature on a prescription chart to

be accompanied by the printed name of the prescriber. This was to ensure they could be identified should the need occur. We observed none of the medication charts contained the additional identifiers.

- Antibiotic prescriptions had no end or review dates attached. Regular intravenous antibiotics were prescribed on a section of the chart for 'intermittent use'. This could cause confusion and potential risk as administration times were subjective. One incident illustrated an extra dose of intravenous antibiotic had been given, yet in the incident analysis the chart design was not considered as a cause.
- Consultants had access to a Spire antibiotic prescribing policy. Staff told us that consultants also followed their local NHS hospital policies, but there were no copies of the formularies to check if the prescribing was evidence based and completed correctly. We saw from the minutes of the clinical governance meeting in November 2015 that the antibiotic guidelines were due for review and medical staff followed prescription guidelines from the local trust.
- The hospital had 15 medication adverse incidents during 2015. These included processes for ordering medication and medication not available in theatres. We saw action plans had been developed following investigation into the incidents and learning was cascaded to staff in team meetings.

Blood transfusion

- The transfusion service was provided by the local NHS trust.
- The blood transfusion facilities at the hospital complied with the blood safety and quality regulations for the blood bank service in partnership with the local NHS trust.

Records

- Records were stored securely. Staff used a unique identifier to gain access to computerised records. For example we observed the oncology receptionist 'locked' their computer when they left their desk, this prevented unauthorised access to patient information.
- Nursing notes were kept in the hospital locked notes cupboard. A tracker was completed when notes were removed from the cupboard, which ensured records were located in a timely manner.
- Information governance training had been completed by 100% of staff.

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- Staff stored risk assessments in the main patient record to ensure that risks were understood by other staff accessing the clinical notes. Patients were given a paper copy of their summary record on discharge from the hospital.
- The patient's oncology service records and consultant records were in locked cupboards.
- We reviewed seven sets of patient records. We saw that all relevant assessments had been completed in a timely way, and were signed dated and legible entries.
- The care records contained patient assessments, observations, medical and nursing notes plus ongoing risk assessments and discharge planning documents.

Safeguarding

- The head of clinical services was also the safeguarding lead and had completed level 3 adult and children safeguarding training. The registered medical officers and all the consultants at the hospital had completed level 3 adult and children safeguarding training. The safeguarding lead demonstrated a clear understanding of their responsibilities with regards to both adult and children safeguarding concerns.
- One member of oncology staff had been trained in 'Prevent', a Government strategy, which helped to recognise and support individuals at risk of radicalisation.
- All staff were required to complete level 1 and level 2 safeguarding adults and children e-learning training. Staff were required to update their safeguarding training on an annual basis. We saw that 98% of all staff had completed safeguarding adult and children training to March 2016. Staff knew who the safeguarding lead was and told us they contacted a member of the on call senior management team if the lead was not available.
- There were no reported safeguarding alerts in 2015.

Mandatory training

- All staff were required to attend yearly mandatory training to ensure they were trained to care for the patients safely. Training included prevention and management of fire risks and health and safety.
- The hospital had declared 81% compliance of mandatory training against an organisational target of 95% in December 2015. The annual clinical governance report stated that individual compliance would be necessary before any financial bonus would be considered. The ward sister planned one day a month

within the rota to ensure that each of the staff members completed their mandatory training. The figures for mandatory training improved to 87% by March 2016. Basic life support resuscitation training had been completed by 100% of staff as of March 2016. Ten clinical staff members, including two resident medical officers, had completed advanced life support training as of March 2016.

Assessing and responding to patient risk

- The 95% target for venous thromboembolism screening rate was achieved in each quarter of the reporting period (January to December 2015).
- Chemotherapy patients carried a wallet-sized medical alert card, which advised them about risks of developing an infection and told them what symptoms to act on and the hospital's contact numbers.
- Nurses worked within the hospital policies. For example they told us that if a chemotherapy patient's symptoms were cause for concern they would not risk the patient developing febrile neutropenia; a blood infection. Nurses recommended the patient attended for a blood test. If they felt the patient had an infection, they commenced them on intravenous antibiotics immediately.
- Complex chemotherapy regimens were scheduled so that patient treatment times did not overlap, this enabled staff to spend the required time responding to increased risks if presented.
- Staff were trained and competent and equipment was available to treat any patients who experienced anaphylaxis. After patients were stabilised they were transferred to the local NHS trust for further treatment. This enabled access to an intensive care unit for their next chemotherapy treatment.
- In the event that a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. All staff we spoke with were aware of the processes to follow.
- The oncology unit only treated 'level one' haematology patients; any patient who required high dependency care was not accepted for treatment at this hospital.

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- Patients booked for endoscopy procedures were sent a medical questionnaire, which was reviewed by nurses on arrival at the hospital. These ensured risks were identified prior to the procedure.
- The hospital used the Five Steps to Safer Surgery WHO Checklist (a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. We observed one procedure and the process was done correctly and was well embedded. A member of theatre staff acted as a champion for the WHO checklist to ensure the process was done and recorded correctly.
- Patients who had undergone an endoscopy were accompanied back to the ward by a qualified nurse for further assessment and supervision. If patients felt unwell after their procedure, they were taken to the theatre recovery area until they became stable.
- Patients were discharged with post procedure advice and an out of hour's telephone number in case they became unwell after their endoscopy.
- We reviewed seven sets of patients' records and saw that the National Early Warning Scores (NEWS) were appropriately assessed. Staff we spoke with demonstrated confidence and competence to request urgent medical assistance if a patient showed signs of deterioration.
- Resident Medical Officers (RMO) reviewed all patients who may be at risk of deterioration. Further advice was sought, if required from consultants and oncologists who provided an on call service by telephone or in person. Staff told us they could always access further advice and support from senior on call medical staff if required.
- Patients assessed as high risk of falls had a red wrist label which enabled staff to easily identify them. Sensor pads were in place which enabled staff to detect if a patient who may be at risk of falls was moving.

Nursing staffing

- Endoscopy nursing staff told us they were flexible to meet any extra demands of the service, or if there were any delays. If the permanent staff were unable to cover any extra work, bank staff were arranged to cover any shortfall.
- Senior staff reviewed the planned staffing levels for the ward and oncology area twice a week. Staffing

requirements were also adjusted daily if required due to patient acuity or the potential demand for beds. On the days of our inspection, the staffing was according to planned safe levels. There was one registered nurse to every four patients. Senior ward staff always planned for a minimum of two registered nurses plus one health care assistant for the ward that had capacity of 16 beds. However staff told us the ward rarely contained 16 patients. The ward occupancy for the past year was only 59%. A months staffing rota for the oncology ward and endoscopy suite demonstrated the planned nursing establishment had been met.

- Staffing numbers allowed for a safe handover of patient's care and treatment from one shift to the next. For example we saw patient handovers and staff briefings which included sufficient information and included adequate time to allow all areas of patients care to be discussed.
- There was a low staff vacancy level with no vacant posts for allied health professionals and care assistants.
- There was less than 20% use of bank or agency staff in all clinical areas of the hospital. Any gaps in numbers were usually covered by permanent staff who worked extra hours. There was always a qualified permanent member of the team in each clinical area and the bank or agency staff were not left in charge. This was to reduce the risks of this staff member not being familiar with safe ward practices and processes.
- The hospital was recruiting to increase staff numbers within their own bank. A local induction checklist was used to make sure that agency staff had a local induction and cared for patients safely.

Medical staffing

- The hospital employed two Resident Medical Officers (RMO) who were on site 24 hours a day, seven days a week. The RMOs worked opposite each other in weekly blocks. They reviewed patient's daily, prescribed additional medication and liaised with the consultants responsible for individual patients care. The RMO had appropriate advanced life support training and skills, and was supported by a 24 hour on call contracted consultant cover rota.
- The RMO reported that the on-call consultant was available at any time of the day or night and responded quickly to any clinical concerns in the hospital.
- The hospital employed medical staff who worked under practising privileges. Senior staff completed relevant

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checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. We observed regular checks were completed twice yearly and monitored by the registered manager.

- Handovers were observed between the RMOs, there was detailed and respectful discussion about the patients within the hospital, with appropriate signposting to patients who required clinical reviews.

Major incident awareness and training

- Training in major incident awareness was available to all new staff during their induction and refreshed annually.
- There was a business continuity plan in place which managers said they referred to if a major incident was declared. Arrangements included a back-up generator in case of power failure and a list of staff and volunteers with fully insured 4x4 vehicles to take essential staff to and from the hospital in adverse weather conditions.

Are medical care services effective?

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Care and treatment mostly took account of current legislation, nationally recognised evidence-based guidance and best practice.
- People had a comprehensive assessment of their needs, which included consideration of clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs.
- The unplanned readmission rate for 2015 per 100 discharges within the Spire group showed that readmission rates were lower for Spire Dunedin compared to other hospitals within the Spire Hospitals Group.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs

- The resident medical officer provided medical cover for the site 24 hours a day, seven days a week. There were robust processes in place which ensured timely discharge of unwell patients to the local NHS hospital.
- When people received care from a range of different staff, teams or services, this was coordinated. 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 people's needs.

However,

- The medicine reconciliation process, (the checking of patients' pre-admission medication against a GP's or other record) which was considered best practice, was not completed consistently.

Evidence-based care and treatment

- The oncology unit had been awarded the Macmillan Quality Environment Mark (MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.
- Endoscopy staff booked procedures in line with British Society of Gastroenterology (BSG) guidance. This meant that sufficient time was given for procedures not to be rushed that could cause endoscopy staff to fail to detect abnormalities.
- The endoscopy service was in the early stages of working towards Joint Advisory Group (JAG) accreditation. This was a formal recognition that an endoscopy service demonstrated they had the competence to deliver against the measures in the global rating scale standards. The endoscopy manager had completed the baseline JAG accreditation audit and a senior nurse had attended a relevant course and was aware of the BSG guidance.
- Other local audits included a quarterly audit which checked that all patients were discussed at local cancer multidisciplinary team meetings. These included an audit of whether all patients were fully consented prior to chemotherapy and that the whole United Kingdom Oncology Nursing Society (UKON) recommendation format was used when triaging oncology patients. The results were discussed at the team meeting and action plans developed. One audit showed that patients visited the intranet and got varying information about their

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clinical condition. As a result one set of leaflets was being devised which addressed patients concerns and provided up to date information about a variety of clinical conditions.

- The service followed Thames Valley cancer network chemotherapy protocols, based on National Institute of Health and Care Excellence Guidelines (NICE) 2014.
- The medicine reconciliation process, (the checking of patients' pre-admission medication against a GP's or other record) was not consistently completed. National Institute of Health and Care Excellence guideline NG5 and the hospital medicine policy states that this should be completed within 24 hours of admission. The hospital did not audit this standard.
- The 2015 audit plan stated that an antibiotic audit had been completed between March and May 2015, however the hospital could not provide evidence that this audit had taken place. We saw from minutes of the clinical effectiveness committee in July 2015 that an audit had been undertaken but was unavailable on the hospital intranet.

Pain relief

- Patients assessed their pain between zero and four; scores were documented on their National Early Warning Score chart. The completion of pain scores was audited by senior staff. The target for completion was 95% the audit showed that 98% of assessments had been completed.
- Patients reported nursing staff acted promptly and appropriately if they complained of pain. One patient said they were given their choice of medication after discussion with their consultant.
- Oncology nurses referred patients to the NHS palliative care team for pain management advice if necessary.
- There was access to the on-site pain team which comprised a consultant, specialist nurse and psychologist for advice on patient's pain control if needed.
- Oncology patients based on the ward had hourly assessments of their pain to ensure they were comfortable.
- Pictorial assessments were used to assess pain for patients who were unable to speak.

Nutrition and hydration

- The hospital scored 97% for the quality of food, compared to the England average of 94%, in the

patient-led assessment of the care environment (PLACE) audit in 2015. Patients were offered a wide range of food and drinks to meet their nutrition and hydration needs.

All of the patients we spoke with were positive about the food they received. One patient told us there was always a choice of good quality food. Another patient had a sore mouth due to treatment, they were offered soup, jelly and supplement drinks from the pharmacy.

- We saw that special dietary requirements were catered for on request. For example, catering staff specially sourced food which met patients religious requirements when they attended for chemotherapy.
- Patients had nutritional screening undertaken at on admission. We saw Malnutrition Universal Screening Tool (MUST) assessments to assess nutritional risk were recorded in patient notes. If found to be necessary, a referral to a dietitian was made for help and advice
- Patients told us the chef offered tasty alternative options should the normal menu not appeal to them to ensure that their nutritional needs were met.
- Oncology patients were offered a range of alternative food choices if the menu choices did not appeal to them due to side-effects of chemotherapy.
- Patients in the oncology unit had access to fresh water, fresh juice and hot drinks.
- Patients were offered sips of water then food after an endoscopy.

Patient outcomes

- The unplanned readmission rate for 2015 per 100 discharges within the Spire group showed that readmission rates were lower for Spire Dunedin compared to other hospitals within the Spire Hospitals Group. From January 2015 to Dec 2015 the hospital reported ten patients who had unplanned readmissions within 31 days of being discharged. There was a spread of clinical specialties within the readmissions so no trends could be identified
- There had been five patients who had unplanned transfers to another hospital during 2015 for further assessment or expertise and not for critical care services. This was 0.05 per 100 discharges which was lower than other Spire hospitals which had an average of 0.15 per 100 discharges.
- The endoscopy self-assessed their service using the global rating scale (GRS). The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to

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achieve and maintain accreditation. Endoscopy services were required to score levels B and C before accreditation was awarded. Scoring had improved from the initial C/D and further improvements had been identified to enable the provider to achieve the required standard.

- Senior managers informed us that the provider was working with the private healthcare information network (PHIN) in relation to the collection and publication of clinical outcomes.

Competent staff

- A Spire organisational competency framework was used by nursing staff which ensured they were adequately trained for their roles and signed off as competent and safe to practice.
- All staff were required to successfully complete competency checks, prior to undertaking specific procedures. Assessment included a wide variety of skills, such as cannulation and use of the hospital's medical devices.
- There was an Oncology Nurse Consultant (ONC) and two Clinical Nurse Specialists, one for breast cancer and one for other cancers. All staff nurses who worked in oncology were trained oncology nurses and attended a two day chemotherapy course every two years.
- All chemotherapy and ward nurses were also trained in 'Care of the Dying' and 'Care of the Patient Undergoing Chemotherapy' internally facilitated by the oncology nurse consultant.
- An oncology nurse had given ward staff one-to-one training on the assessment of patients using the United Kingdom Oncology Nursing Society's (UKONS) 'Oncology/Haematology 24 Hour Triage Rapid Assessment and Access Tool Kit'. This was to ensure any patients that called the hospital staff out of hours were assessed and appropriately treated as quickly as possible
- One consultant said the chemotherapy nurses were very experienced and said they would "happily be treated" at the hospital.
- All staff who worked in the service were offered mid-year and yearly appraisals. There was 92% compliance of appraisal rates for December 2015. Staff told us the appraisal system was worthwhile and engaged them in improving themselves and the service to patients. Managers' highlighted and encouraged opportunities for further training and development in appraisals. Staff told us that there was funding available for further training and staff were supported to access further training and develop.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. Spire Dunedin Hospital followed processes via the medical advisory committee to ensure all medical staff who worked at the centre had the appropriate skills and competencies that included regular supervision and appraisals.
- An oncology nurse specialist and another nurse were encouraged to attend the United Kingdom oncology nursing society conference annually, so they were able to access information about all the latest developments.
- All members of staff had attended annual dementia awareness training to ensure they were suitably skilled to meet the needs of patients with a cognitive impairment.

Multidisciplinary working (in relation to this core service)

- Throughout the inspection, we observed good multidisciplinary working between the different teams involved in a patient's care and treatment. We observed medical, nursing and therapy staff attended a daily ward round which ensured clear communication between all members of staff involved in the patients care.
- Physiotherapy was readily available to patients. NHS-funded patients received the same therapy service as privately funded patients.
- Patients were discussed and treatment protocols agreed by the cancer multidisciplinary team (MDT). Members of the team included, the consultant, resident medical officer, senior nurses, therapists and the pharmacist this ensured a variety of specialities were included in discussions about a patients care.
- The Oncology Nurse Consultant (ONC) audited whether the hospital's patients had been discussed at an MDT meeting. The most recent audit was conducted from January to March 2016. From a random sample of 20 sets of patient notes, the ONC found that 80% contained evidence of this discussion. However, ONC stated some

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patients could have been discussed at local NHS trusts' MDT meetings. For example most local women with gynaecology cancer which required surgery were operated on in an NHS trust.

- The generic cancer specialist nurse had met with the local trust's cancer multidisciplinary team's (MDT) coordinators to facilitate two-way communication, specifically regarding the care of patients with colo-rectal, lung and breast cancer. The specialist nurse felt communication had improved "immensely".
- Oncology nurses had good working relationships with the resident medical officer and colleagues in pharmacy and x-ray. They told us oncology consultants trusted them and listened to their opinion.
- Staff in the oncology unit had good working relationships with their peers in other local trusts for example; they administered the chemotherapy and prepared patients for stem cell transplant elsewhere.
- Oncology nurses felt able to challenge medical staff if, for example, they noticed a drug protocol was not what they expected.
- Oncology patients were discussed in a multi-disciplinary team meeting at a local NHS trust and this provided opportunity for peer review and benchmarking. Oncology nursing and medical staff at the hospital monitored individual patient outcomes. We saw the service achieved 95% which exceeded the target of 65% of patients with evidence of MDT discussion set by the National Institute of Clinical Excellence cancer standards.

Seven-day services

- There was a laboratory which processed blood tests on site between 8.30am to 4.30pm Monday to Friday. However if an oncology patient was unwell outside of those hours, they attended the hospital for their blood test, and their blood sample was couriered to the local NHS hospital for processing. Other support services such as pharmacy and imaging were available on request at the weekend
- Appointments for medical treatments of cancer could only be accessed Monday to Friday
- Oncology consultants were on call to carry out weekend ward rounds, if a patient was admitted for symptom control.
- The resident medical officer provided medical cover for the site 24 hours a day, seven days a week.

- Other support services were available, such as physiotherapy, on request at the weekend.
- Chemotherapy patients could access advice from the oncology unit between 8am to 4pm Monday to Friday. The telephone was answered by ward nurses at all other times.
- The hospital could admit oncology patients at any time over the whole 24hours and seven days a week period.

Access to information

- Consultants' notes, which included test results, were brought via courier to the hospital when patients were booked for admission. The nurses and patients we spoke with agreed consultant notes were always present for the appointment time. The presence of notes was audited and showed that 98 % of records were available. Staff told us when notes were not available the patients GP was contacted and the referral faxed to the hospital
- Nurses on the ward had access to the local NHS hospital's pathology results. This enabled them to check the blood test results of any chemotherapy patients' that may have been processed out of hours.
- Staff had access to the intranet, folders with policies and procedures in all clinical areas.
- Patients and general practitioners received same day discharge information. This included: plans for future care, discharge medication, follow up advice and support and community care arrangements if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us the advantages and side effects of treatments were clearly communicated to them so they were able to give informed consent. Consent was taken by consultants during the patient's first appointment. During our inspection we observed consent was also gained prior to any procedures or further tests throughout the patient's hospital stay.
- The Oncology Nurse Consultant audited chemotherapy consent forms and found that between September and December 2015, only 50% of forms had been fully completed. However, after an action plan had been implemented, 80% of forms had been fully completed between January and March 2016. Another audit was planned for the next quarter.
- All staff was clear about their roles and responsibilities with regards to the Mental Capacity Act 2005 and

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Deprivation of Liberty safeguard. All staff was up to date with their mandatory annual Mental Capacity Act 2005 training. Deprivation of Liberty Safeguards training was included in safeguarding training. We saw from records that 100% of staff had attended the training within the last 12 months.

Are medical care services caring?

Good 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- We observed throughout our visit that patients were treated with dignity, respect and kindness during all interactions with staff and relationships with staff are positive. People felt supported and say staff cared about them.
- Staff maintained patient privacy at all times. Staff responded compassionately when people needed help and support when required. Patients and their families had access to private rooms if they received bad news.
- Staff took time to involve patients in their care. Patients told us they were informed about their treatment and staff involved them in all decisions about their care.
- Flexible visiting hours allowed patients to maintain supportive relationships with those close to them. Staff supported patients to keep their independence and connections with family and friends.

Compassionate care

- All of the patients we spoke with said they found the care to be compassionate. One patient who had attended the oncology unit many times described staff as “friendly, approachable and without judgement”. Another patient wrote a ‘thank you’ card describing a, “kind, special and caring oncology team” who were “compassionate and understanding”. Another patient thanked the staff for being “gentle and kind”. One relative told us the situation was much more pleasant than it would have been without the staff’s “warmth”.
- Staff were aware of the hospital’s privacy and dignity policy 2015. We saw rooms were available so that bad news could be delivered in private.

- Patients said they would recommend the hospital to their family and friends. Between July 2015 and December 2015, the scores for the Friends and Family Test (FFT) were above 95%. Endoscopy staff told us they were proud of the results of their patient satisfaction surveys. One patient commented ‘the nurses are so lovely, nice and chatty, they help to relax you.’

Understanding and involvement of patients and those close to them

- Chemotherapy patients did not have a ‘named nurse’. Staff told us this was because they did not want patients becoming attached to a nurse and possibly becoming upset if they could not be treated by the ‘named nurse’ one day. Instead, patients were shown around the unit and introduced to all nurses as a team before they attended for treatment.
- All the patients we spoke with felt involved in their care and the relatives of chemotherapy patients appreciated that they could stay for as long as they liked.
- One patient described receiving “constant reassurance” from the staff and said that when they asked questions “you never feel you are a pain”. Another patient told us, “I look forward to seeing the staff, and they make it possible to have a positive attitude.” They added that the receptionist and the nurses were, “lovely and are the right people for the job.”
- Patients chose their treatment room on arrival in the oncology unit.
- Patients were told about the positives and negatives of wearing a scalp-cooling hat during chemotherapy. This meant patients understood what treatment involved and enabled them to make informed choices about their care.
- Family members were involved where possible in discussions about care and treatment. Staff acknowledged chemotherapy affected all family members and included relatives, with the patient’s permission, in care planning. Staff considered the needs of the patients’ loved ones when they planned cancer treatment.
- Consultant gastroenterologists were accompanied by specialist cancer nurses when the results of their endoscopy indicated the patient may have cancer. This ensured patients and relatives had immediate access to support and information about the next steps of their treatment.

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- Consultants visited endoscopy patients once their sedation had worn off, to ensure they understood the results of the procedure.

Emotional support

- Both cancer nurse specialists had specific communication training which ensured they were highly skilled in breaking bad news to patients.
- One consultant told us how they adapted treatments for patients with incurable cancer. This was to ensure, symptoms were minimised which enabled the patients to attend social events or go on holiday. They said, “My aim is to work in partnership with the patient”.
- Specialist nurses were able to spend time with their patients in their care to give them any support they needed. Patients told us the cancer nurses rang them to ask how they were after their treatments.
- One chemotherapy patient told us, “Staff are very supportive, especially to my husband.”
- Patients had access to clinical psychologist assigned from the NHS Trust if clinical staff assessed this was required.
- Patients had access to visiting chaplain from a local NHS Trust if required. The ward areas displayed lists of on call numbers for spiritual advisors for other faiths if needed.
- Counselling services were available upon request from the NHS Trust via the oncology service

Are medical care services responsive?

Good 

By responsive, we mean that services are organised so that they meet people’s needs.

We rated responsive as good.

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service. The service met national indicators of 92% of incomplete admitted patients beginning treatment within 18 weeks of referral for most months in the reporting period of January to December 2015.
- The needs of different people were taken into account when services were planned and delivered. There were

good examples where staff adapted procedures and worked flexibly to meet individual requirements. Care and treatment was coordinated with other services and providers.

- Complaints and concerns were taken seriously, and responded to in a timely way. Learning from complaints was distributed in mandatory training sessions and used to improve the quality of care.

However,

- There were no single sex arrangements for patients in the endoscopy area. Staff told us they drew the curtains around fully dressed patients waiting for and recovering from endoscopy as there were male and female patients in the eight-bedded area. There was a morning and afternoon list to segregate male and female patients undergoing colonoscopy procedures.

Service planning and delivery to meet the needs of local people

- Senior clinical staff met periodically with the clinical commissioning groups to plan service provision.
- The endoscopy manager had completed the baseline JAG accreditation audit. Clinical governance minutes confirmed a proposal for changes to the fabric of the endoscopy suite with detailed plans and costs was awaiting approval.
- The hospital did not offer medical services to children.
- Arrangements were in place with a local NHS hospital to ensure patients who required enhanced support were transferred within a service level agreement.
- The providers had regular meetings with local GPs to identify future service provision.

Access and flow

- In 2015, the hospitals activity against the indicator of 92% of NHS patients waiting times of incomplete admitted patients beginning treatment within 18 weeks of referral was met for all months except January 86% October 88% and December 89%
- Patients told us they received timely treatment. All of the patients we spoke with told us they had short waits for their treatment. For example, one patient told us, “I started my first treatment three days after my appointment with the oncologist.” We saw from patient notes that endoscopy procedures could be carried out within a week from initial consultation.

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- Patients who were suspected of having cancer were able to access needle biopsies and mammograms on the same day as their initial consultant appointment.
- Staff told us surgical biopsy was performed within a week of initial consultation and if a tumour was found, surgery to remove it was performed within the following week. One patient we spoke with confirmed what staff had told us.
- Patients told us the appointments at the hospital ran on time. Chemotherapy patients were given a choice of appointment times, taking into account individual patient's needs, such as fitting in treatment around working hours. For example, to accommodate people who worked office hours, appointments were available between 5pm and 8.30pm on a Thursday.
- A garden was provided so that patients and relatives had space to think, away from the ward environment
- Patients with individual specific needs were able to visit the clinical environment prior to any treatment interventions to see the clinical area, meet staff and reduce any fears.
- The hospital hosted 'Bosom Buddies', the breast cancer support group for patients who received treatment at the local NHS hospital and Spire Dunedin. In addition, breast cancer patients were given a card about a 'Bosom Buddies' support group at their diagnosis appointment by clinical staff.
- There was also a poster advertising the 'Latissimus Ladies Luncheon Club' which was set up and run by the hospital's former breast cancer patients. The Latissimus Ladies former patients offered to sit with current patients during chemotherapy or before and after surgery.

Meeting people's individual needs

- Patients were treated as individuals. Endoscopy staff gave an example of how they made reasonable adjustments for a patient living with dementia. The patient's relative was allowed into the anaesthetic room which helped relieve any distress and anxiety for the patient.
- Patients living with advanced dementia were risk assessed for their safety within the environment which was constrained by the existing layout.
- Staff worked hard to ensure that individual needs were met. We saw a former patient had sent a card to thank staff for helping them set up a "mobile office" so they could continue to work whilst they received their chemotherapy.
- Easy read books were readily available for patients with a learning disability who were diagnosed with cancer. The books were produced by Macmillan Cancer Support and covered all aspects of care, from tests to treatments.
- Endoscopy patients were given patient information leaflets when they were booked for medical procedures, this was to enable them to know what to expect during their procedure. These leaflets were routinely available in English. Staff told us they could access information in other languages through the Spire corporate website if required. Staff also reported that the Macmillan website was used to produce leaflets for oncology patients in whatever language was required for the patient.
- Staff we spoke with said they could access translation services for patients whose first language was not English.
- Nurses arranged for chemotherapy patients to stay overnight in the hospital if they were nauseous and had no support at home.
- Relatives of chemotherapy patients were able to purchase lunch from the room menu at a small charge, which enabled them to eat together.
- In the Patient-Led Assessments of the Care Environment (PLACE), privacy, dignity and well-being scored 84%, slightly lower than the England average of 87% for the period between February 2015 and June 2015. We were told this related to the lack of solid walls between the cubicles in the chemotherapy pods and an action plan to remedy was being discussed at the clinical governance meeting.
- All rooms in the oncology unit had televisions and free Wi-Fi was available
- Staff told us they drew the curtains around fully dressed patients waiting for and recovering from endoscopy as there were male and female patients in the eight-bedded area. Staff informed us that they had a morning and afternoon list to segregate male and female patients undergoing colonoscopy procedures. Staffs were aware that this arrangement was not compliant with JAG standards in relation to maintaining privacy and dignity the endoscopy manager had completed the baseline JAG accreditation audit. Clinical governance minutes confirmed a proposal for changes to the fabric of the endoscopy suite with detailed plans and costs to improve and the manager was awaiting approval.

Medical care

Learning from complaints and concerns

- Comments and complaints from patients were shared with the nursing team on the ward. During 2015, 26 complaints were received, most of which related to poor staff communication. Senior managers asked to see any patient that was unhappy in an effort to resolve the patients concerns. We saw from documentation the matron had discussed poor communication at all staff meetings and highlighted the need to listen to all patient and families concerns. If the concern could not be dealt with by that staff member staff was to seek senior nurse support as a priority.
- 98% of all complaints were responded to within the hospital policy of 10 working days. There was one medical complaint regarding the oncology unit. The complaint was due a delay in the receipt of medication delivered by an external courier. As a result of the complaint we saw discussions had been held with the courier company to ensure medication was delivered in a timely manner.
- We saw that the annual clinical governance report illustrated and discussed the complaints from 2015; learning was also identified with one example of a patient having an incorrect bill. Actions were taken to ensure the issue did not occur again.
- We saw where service improvement occurred as a result of learning from complaints. In response to complaints from oncology patients, two further patient information leaflets were produced. One explained the role of the clinical nurse specialist and the other described what happened at cancer multidisciplinary team meetings.
- The generic cancer nurse specialist was in the process of producing leaflets for each tumour type, as a result of patient concerns after accessing information on the internet.
- All staff was trained in the use of the complaints policy and gave examples of listening to concerns and acting to improve the situation as soon as the concern was identified.

Are medical care services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- Most of the staff were aware of the values of the organisation and were passionate about good patient care. There was a clear statement of vision and values driven by quality and safety. Staff had strategy 'built into' their appraisal process.
- Staff spoke positively about the 'no blame' culture of the team and of the visibility and support of managers.
- There was a comprehensive process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant committees through clear structures and processes. Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

However,

- The current system of managing and mitigating risks did not consistently have detailed actions and timescales. Only 19% of risks on the hospital risk register had key actions and dates identified.

Vision and strategy for this this core service

- Clinical staff in the oncology service was aware of the Spire vision and strategy and were able to discuss the action plans and their part to improve patients services. Part of the vision and strategy was to address patient and families concerns as a priority before a complaint was raised.
- The oncology service leads had developed a clear strategy for cancer care at the hospital. The strategy was on display for staff to see. Staff told us they had been

Medical care

involved in the development of the strategy. The oncology strategy linked to the hospital's overall strategy and staffs was given objectives to help the service meet its aims.

- The oncology strategy included the provision of a high level of service and updated GP clinics on the services provided in order to be the market lead. For 2016, the unit was working towards renewal of the Macmillan Quality Environmental Mark (MQEM).
- The oncology nurse consultant was clear about the vision in the oncology unit, which was to give patients the best experience at a difficult time, be the market leader and offer the best clinical care in the area.
- Endoscopy staff were not aware of the Spire vision or strategy. However they were clear about the strategy for their department and could demonstrate their role to improve patient's services for the future.

Governance, risk management and quality measurement for this core service

- Risks to patient safety were identified at local, hospital and organisational wide levels. The hospital was in the process of transferring from one system to another. Risks were documented on a risk register and within local 'risk libraries'. Heads of departments managed risks locally, but there was inconsistent management with hospital wide risk registers regarding timelines and actions to mitigate the risks. Only 19% of risks on the hospital wide risk register had any key actions with dates identified. The current process did not fully engage staff in a clear process for managing and mitigating risks and staff did not have a clear understanding of how to use the hospital wide risk register. However, all staff were aware of their local risks which were recorded in the departmental risk library.
- The hospital risk register listed 13 medicine management risks, but mitigations and actions to keep patients safe were not clear. The pharmacist did not have a clear understanding of how the hospital wide risk register should be used. The pharmacy department held separate, more detailed, risk assessments (for example, handling chemotherapy, lone working, resident medical officer dispensing)..
- The hospital governance structure was well established and included the Medical Advisory Committee (MAC), the Clinical Governance (CGM) and the Clinical Effectiveness Committees (CEC) which covered both clinical and non-clinical compliance to statutory and

organisation policy. MAC meetings were attended by a variety of specialities. We saw from meeting minutes that over five consultants and senior members of staff had attended the meetings which met the meeting guidelines.

- The department lead reported to the senior team through the monthly governance meetings. The senior team reported to the corporate Spire leadership team through the clinical governance committee and the medical advisory committee.
- Quality measurement and performance dashboards were maintained by senior clinical staff of each service. Outcomes were discussed at the clinical governance meetings and comparisons made with other Spire hospitals. All clinical staff had access to the performance dashboards to which enable them to assess the hospitals performance.
- Oncology staff attended monthly team meetings led by the oncology nurse consultant. Areas for further development and training were discussed with action plans and timelines for completion and learning from incidents and complaints was discussed at these meetings.
- There was a rolling programme of audits. Action plans and re-audits showed improvements in the services. For example, the oncology nurse consultant audited the United Kingdom oncology nursing society rapid assessment and access triage tool and found that whilst 90% of oncology staff had fully completed the form, only 20% of the ward staff had completed the form between January and March 2016. Actions included publishing the results, a discussion with ward staff and one-to-one training for the ward nurses. A date for re-audit was set for the following quarter.
- The monthly management strategy meetings were well attended with named leads and key action points monitored.

Leadership and culture of service

- We observed a positive staff culture across the hospital. The oncology nurse consultant told us they worked positively in "open and frank dialogue" with the nurses in their team. They described a "no blame culture". Nurses and administrative staff confirmed there was a supportive culture and most nurses had worked in the hospital many years.
- The clinical staff said they "loved" working at the hospital and that they felt valued and respected.

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- Oncology nurses told us the ONC kept them informed about what was happening in the hospital.
- Oncology staff were encouraged and supported to develop and potential was recognised. One oncology nurse told us their manager had worked with them to make their “work/life balance work”.
- The culture of the endoscopy team was nurturing and professionally supportive of each other.
- Both oncology and endoscopy staff discussed senior staff were approachable and visible and had an “open door” to discuss concerns.
- Oncology services were delivered to meet the needs of patients. The service aimed to be flexible to ensure that patient’s needs were met. One member of staff told us, “The department’s ethos is everything is negotiable.”
- Endoscopy staff had recently set up an ‘Endoscopy Users Group’ which formed part of the Joint Advisory Group (JAG) on gastro-intestinal endoscopy guidance accreditation. The minutes highlighted the groups purpose of ensuring safety standards were met and to oversee audit and clinical outcomes. This meant that people who had used endoscopy services at this hospital were given the opportunity to engage in future service planning.
- Staff received both electronic and paper copies of the hospital newsletter which highlighted good practice, new ideas and praised staff. Staff discussed an “open door” approach of senior managers to discuss ideas or concerns and were valued and respected.
- The 2015 GP satisfaction survey showed that 88% of GPs rated the hospital as excellent/very good. 96% of GPs said they would definitely/likely or quite likely recommend the hospital to colleagues.

Public and staff engagement

- All patients were asked to complete a patient survey questionnaire. Senior managers sent copies of any patient satisfaction surveys to staff that were specifically mentioned.
- The oncology nurse consultant (ONC) ensured oncology specific patient satisfaction surveys were sent to all patients that had been treated in the previous quarter. The surveys could be completed anonymously. We saw the results from 2015’s survey which showed high levels of patient satisfaction. The ONC showed us action plans that they had written to address any concerns patients raised. All actions had been completed to date.

Innovation, improvement and sustainability

- Senior managers discussed proposal plans to invest in the endoscopy service to enable Joint Advisory Group (JAG) accreditation.
- The oncology services benchmarked their performance against other services to measure and identify further areas for improvement.

Surgery

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

Information about the service

Spire Dunedin Hospital provides elective surgery to patients who pay for themselves, are insured, or are NHS funded patients.

The hospital carried out 4,225 in-patient and day case surgical procedures in 2015. Of these, the NHS funded 1,728.

Surgical specialities offered on this site include orthopaedics, ophthalmology, general surgery, gynaecology, breast surgery and cosmetic surgery.

The hospital performed five surgical procedures on young people aged 16 to 17 years old in 2015. There were no surgical procedures carried out on children under the age of 16 years old at this hospital in 2015.

The hospital has two theatres, which have laminar flow (a system of circulating filtered air to reduce the risk of airborne contamination) and one minor procedure room. In addition there is a pain management suite for procedures. The hospital has 24 beds suitable for inpatients and 15 for day case care. Of the inpatient beds, only 16 are used routinely in Ward Level 4, with a further 8 available in Ward Level 3 as overflow capacity which are only used about once a month.

During our inspection, we visited theatres, the ward and the day case area. We spoke with 19 patients, three carers/relatives /significant others and 24 members of staff. Staff we spoke with included managers, health care assistants, registered nurses, medical staff, theatre personnel, operating department assistants and administrative staff. We looked at the patient environment and observed

patient care in all areas. We reviewed 16 sets of patients' records. Before, during and after our inspection we reviewed the provider's performance and quality information.

Surgery

Summary of findings

Overall, this service was rated as good and specifically good for each of the key questions of safe, effective, caring, responsive and well-led.

Staff at the hospital reported incidents appropriately. All staff had access and understood how to use the incident reporting system, appropriate actions were taken, and learning occurred as a result. Within the management of serious incidents (SIs) investigation techniques and documentation were not always consistent. Staff we spoke with understood the principles and full requirements of Duty of Candour legislation. However, following a serious incident of avoidable patient harm for one patient, the duty of candour principles had not been fully completed.

All areas of the service we visited were visibly clean, systems had been implemented to ensure nurses, medical, and domestic staff adhered to infection control policies and procedures. On the ward, we observed all staff was bare below the elbows. Senior staff encouraged staff to challenge each other's practice to ensure that the infection prevention and control policy was upheld.

Staff followed comprehensive risk assessments from the initial pre-assessment clinic through to discharge, however the preoperative assessment service was currently stretched due to lack of staff. Major cases were being prioritised but this meant that some cases could not be preoperatively assessed prior to admission. Ward staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. At the time of the inspection, inpatient occupancy was low with only 11 of the 16 beds occupied on ward level 4.

Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed organisationally and locally to reflect national guidance.

Patients had a comprehensive assessment of their needs and access to a variety of methods for pain relief. The ward nurses monitored patients' pain levels regularly and responded appropriately; patients told us they had adequate and timely pain relief.

Feedback from patients about their care and treatment was consistently positive. We observed that patients were treated with kindness, compassion and dignity throughout our visit. Patients' privacy and confidentiality was respected at all times. Patients told us they felt informed about their treatment and had been included in decisions about their care. Printed information was not available in other languages or formats, which meant some patients, did not consistently have access to written information about their care and treatment.

Staff across the service described a 'family' culture and felt well supported by visible and accessible managers.

There were risk, quality and governance structures, managed at departmental, hospital and corporate levels, and systems to share information and learning. However the arrangements for risk management and governance, were not always clear. The hospital was in the process of transferring from one system to another and there were duplicated risk registers held locally and hospital wide, 81% of hospital wide risks had no actions or timescales associated with them.

Medication management across the hospital was variable with good systems for storage and checking. However we found medication omission codes were inconsistent on medication charts and continuation sheets and there was inconsistent medicine reconciliation. A broad spectrum of medication errors included some poor practice. Some incidents were not escalated appropriately to Serious Incident level. However, we saw all the incidents had been investigated, action plans developed and learning shared to prevent the risk of recurrence.

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Are surgery services safe?

Good 

By safe we mean that people are protected from abuse and avoidable harm

We rated safe overall as good because:

- Staff understood their responsibilities to raise concerns and report incidents. Staff reported incidents when they arose, took actions to prevent similar incidents and learning from incidents was shared across the hospital.
- Staff we spoke with were aware of the hospital's safeguarding process and were clear about their responsibilities.
- Staffing levels and skill mix were planned, implemented and reviewed on the ward to keep people safe at all times. Any staff shortages were responded to quickly and adequately. There were effective handovers and shift changes, to ensure staff managed risks to people who used the services.
- There was a 24 hours and seven days a week site cover by a Resident Medical Officer, supported by an 'on call' consultant rota. There were robust processes in place which ensured timely discharge of unwell patients to the local NHS hospital.
- Risks to patients were assessed, monitored and managed on a continual basis. Nurses used the modified early warning score to identify patients whose condition might deteriorate and there were appropriate transfer arrangements of patients to a local NHS hospital if required.
- All clinical areas in use were equipped to provide safe care and were visibly clean. Regular infection control audits were completed and monitored.
- The NHS Safety Thermometer showed 100% harm free care for the past year (March 2015- 2016) for the 27 NHS patients.
- Portable resuscitation trolleys were available in theatres and on the ward. They had tamper-proof equipment and medications which had been checked, was in date and were ready for use.

However,

- While all grades of staff understood the principles of Duty of Candour; following one recent serious incident the full requirements of the duty were not met as a written apology was not sent to the patient concerned, this was rectified immediately during our inspection.
- While the preoperative assessment service was short staffed, major cases were being prioritised but this meant that some cases were assessed close to their admission dates or on the day of their admission.
- Two medication adverse incidents had not been identified as a serious incident. However we saw investigations had taken place and action plans devised to prevent recurrence. Because some errors had not been identified as a serious incident it was not clear if the full requirements of the Duty of Candour were followed in these cases.
- The use of outdated prescription charts, with intravenous medications being prescribed in the wrong place on the chart could potentially put patient's safety at risk.

Incidents

- Staff at all grades was aware of, and had access to, the electronic reporting system to report incidents. Staff described the system as easy to use and they received local feedback on incidents from managers or at team meetings.
- There were 152 incidents reported at this hospital in 2015. Of these, 45 were operations cancelled on the day, 15 medication incidents, 10 treatment or care delays and nine patients who suffered a slip, trip or a fall.
- Senior staff investigated each incident and provided feedback to staff. We saw evidence that learning from incidents took place promptly following a specimen-mislabelling incident in theatre in January 2016. Following this incident, theatre practice was changed to reduce the risk of further mislabelling incidents.
- The hospital reported no never events (a serious largely preventable patient safety incident).
- The hospital reported and investigated four serious incidents (SIs) over the past year: a retained needle following an operation, high levels of legionella bacteria within the water supply, a patient admitted from overseas with a serious blood infection, and the late reporting of another patient with a serious blood

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infection. The hospital highlighted all of the investigations in the annual clinical governance report issued February 2016 including actions planned to prevent recurrence of the incidents.

- Patient discharge summaries to the GP included details of any incidents that had occurred whilst the patient was receiving hospital care.
- The majority of staff we spoke with had an awareness of the principles of the Duty of Candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. However, following a recent serious incident, which had been investigated, the duty had not been fully met. A verbal apology had been given to the patient but this was not supported by a formal written apology, this was written and sent following our prompt on inspection.
- The hospital had 15 medication adverse incidents during 2015, which were examined in detail by the inspection team for trends. Apart from three that were attributable to a new member of the pharmacy team last May/June, there were no identified trends. Some of the medicine incidents reported had been incorrectly classified as low risk incidents. This was discussed during our inspection with the pharmacy team. We saw the incidents had been investigated and action plans developed to prevent the risk of recurrence. However it was unclear whether the full requirements of the Duty of Candour were carried out for incidents not classified as a serious incident.

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

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient 'harm or harm free' care. Hospitals are required to submit data for the NHS patients, which the hospital are caring for on the day of the data input. The submission includes data on patient falls, pressure ulcers, catheter and urinary tract infections, and these showed 100% harm free care for the past year (March 2015- 2016) for 27 NHS patients.
- The ward did not display the results of the NHS safety thermometer on the ward. This meant that patients, their visitors and staff could not access this information about how the ward had performed in key areas of patient safety.
- The hospital monitored patient safety for all patients, including NHS and those that were self-funded or funded by insurance policies via the electronic reporting system. The information gathered through this system was reported in the clinical governance meeting and monitored via the organisations quality dashboard. Areas monitored included pressure ulcers, falls, returns to theatre and infection control. The dashboard showed the hospital was similar in performance to other hospitals within the group. However, the hospital had a higher incidence of falls 5.68 per 1000 bed days compared with the target of 2.34. The hospital had identified areas for improvement and an action plan produced to address these areas.

Cleanliness, infection control and hygiene

- All clinical areas and departments visited were visibly clean. Staff cleaned equipment and applied green stickers to show other staff that equipment was cleaned and ready for use. However, on the day of the inspection, the resuscitation trolley on the ward had grey dust on its surfaces and one of the mobile trolley bases was rusty which meant cleaning would not be effective.
- Senior managers encouraged staff to challenge each other regarding infection control compliance. Infection control link nurses on the ward and in theatres monitored 'bare below the elbow' compliance and reported to the infection prevention and control lead. Infection control compliance was audited monthly and the figures showed the hospital scored better than other hospitals within the group.
- Staff used cleaning schedules and the infection control team monitored the schedule completion. For example weekly floor cleaning audits were completed and signed by the infection control team when the cleaning was satisfactorily completed.
- The ward notice board displayed infection prevention and control information, which included hand hygiene. The infection control lead carried out audits of practice, observation and spot checks plus the required organisational audits, non-compliance with the audits led to monitored action plans.

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- The infection prevention and control team had taken over the management of housekeepers to improve their knowledge and understanding of cleanliness. This was in response to the lower than England average results within the Patient-Led Assessments of the Care Environment (PLACE) for February to June 2015 (95% against England average 98%) for cleanliness. This had ensured improvements in the cleanliness overall.
 - There were no healthcare-associated infections of C.Difficile, MRSA or MSSA reported last year. Senior ward staff informed us that where a patient's infection status was not yet confirmed, the patient was segregated and screened until the infection status was known.
 - Hand hygiene gel was available and visible for the use of staff and visitors; we observed staff used hand gel and washed their hands appropriately. Personal protective equipment was available and used appropriately in the ward and in theatres.
 - Theatre staff had a cleaning schedule that included a monthly trolley clean. The theatre manager organised theatre lists to minimise cross infection and to support patients with other allergens.
 - There was an organisation wide policy for the management of waste, which included the disposal of human tissue.
 - Following an incidence of Legionella in the water supply in June 2015 the hospital had introduced quarterly sampling of water quality as a further safeguard to support the regular flushing schedule.
- checked 10 pieces of equipment and found two nebulisers and two calf pumps were overdue for servicing. We informed ward staff of our findings to ensure the equipment was serviced prior to use. The remainder of equipment was stored, accessible and in date for maintenance and safety testing.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required; clear patient advice signs on the patient's room wall asked the patient to call for help before trying to get up to avoid falls. Storage space in theatres was limited due to the constraints of the building which was not purpose built. Theatres were small for the work undertaken but we were given assurance that there was enough space providing equipment storage was managed.
 - Theatre staff received patient booking forms a week in advance of surgery; this was to ensure the theatres had the correct equipment available for the procedure. The consignment or specialist stock equipment was checked every three months
 - The engineering services manager carried out routine preventative and day-to-day reactive maintenance. For added security, the hospital site was 'locked down' at night with CCTV cover in key areas. An external company monitored intruder alarms to all hospital buildings.
 - All areas had first aid kits for staff to administer immediate first aid if needed.

Environment and equipment

- Portable resuscitation trolleys were available in theatres and on the ward. We saw a daily check sheet which documented all trolleys had been checked to ensure equipment was available and in date. The resuscitation trolley contained on the ward had a tamper evident tag which alerted staff to any potential removal of equipment. A monthly check on the expiry dates on individual equipment items within the trolleys was carried out.
 - Patient rooms had piped gases available, but when portable oxygen was required, it was correctly stored in holders.
 - Equipment, including pressure-relieving mattresses to avoid the development of pressure ulcers, patient hoists for moving and handling and calf pumps to avoid deep vein thrombosis was readily available. Equipment was labelled with the last service or maintenance check. We
- ## Medicines
- Medicines were stored in locked cupboards. Intravenous fluids on the ward were kept in an unlocked cupboard within the locked treatment room. A registered nurse always held the keys to the locked cupboards.
 - Nursing staff on the ward locked and secured the medicine trolley within the locked treatment room when not in use. The ward's medicine fridge was locked with minimal stock at the time of inspection. Maximum and minimum temperatures were recorded daily and when checked were within safe parameters. There was evidence of pharmacy auditing fridge temperatures monthly to ensure that the fridge was at the correct temperature for medication storage.
 - The treatment room medicine storage was checked and found to be well organised. The pharmacy department managed the ward stock replenishment. Anaesthetic technicians managed the topping -up of the medicines required in theatres. There was a system in place to check for expired dates in medicines.

Surgery

- Controlled Drugs (CDs) were stored in appropriate double locked cupboards and managed appropriately. Pharmacy staff completed a quarterly CD audit and any deficiencies identified had action plans.
- Access to the fridge where blood was stored for use in the wards and theatres was secure. Only registered nurses had access via the use of a swipe card.
- Anaphylaxis kits were available in all departments; these were sealed securely with tags and were readily available if there were a patient emergency for a severe allergic reaction to a medication.
- There was a routine process to check emergency medications expiry dates regularly.
- The hospital used only one make of syringe driver to prevent potential errors in using multiple types.
- The medication charts in use used a differently coded continuation sheet from the main chart, which was a potential risk for medication errors. The hospital had a plan to move to the corporate charts but no dates had been shared. We noted allergies were documented but not always consistently signed and dated which was against hospital policy. Prescribers had signed the prescriptions but there were no other identifiers of who the signatory was which may be needed for a query or confirmation of the dosage, although due to the logistics of the hospital size, this could be potentially be worked out by staff.
- Antibiotic prescriptions had no stop or review dates on the prescriptions. These meant nurses could potentially give antibiotics after the course should have finished. Regular intravenous antibiotics were prescribed on a section of the chart for 'intermittent use', which could cause confusion, as nurses had to decide on times of administration. One incident illustrated an extra dose of intravenous antibiotic had been given, yet within in the investigation the chart design/ use was not considered as a 'root cause'.
- Consultants had access to a Spire antibiotic prescribing policy. Staff told us that consultants also followed their local NHS hospital policies, but there were no copies of the formularies to check if the prescribing was evidence based and completed

Records

- Medical records were stored securely within the ward office. A locked key pad secured the office.

- Records included assessment of patients' risks which included falls, pressure ulcers, and blood clots. Risk assessments were recorded at pre-assessment, admission and post-surgery.
- We reviewed 16 sets of patient's records and saw that all relevant assessments had been completed in a timely way, and were legible. The members of staff who had completed the assessments had signed and dated the entries.
- The care records contained preoperative assessments, records from the surgical procedure, recovery observations, medical and nursing notes plus ongoing risk assessments and discharge planning documents. Patients who had joint replacement surgery had care pathway related documentation packs, which detailed the pre and postoperative multidisciplinary care for that patient. Care completed was signed, or the reason for non-completion (variance) was documented. This meant that the records clearly set out the requirement of the patient pathway that acted as a visual reminder to all staff of interventions required.

Safeguarding

- All of the staff we spoke with was clear about their roles and responsibilities and the processes and practices that were in place to keep patients safe and safeguarded from abuse.
- 98% of the clinical teams had undertaken adult safeguarding training, and 96% undertaken child safeguarding training. The matron was identified as the safeguarding lead for the hospital, and whilst safeguarding was not felt to be a frequent issue within the patients using the hospital, the staff were able to describe their actions and responsibilities in response to a safeguarding concern.

Mandatory training

- All staff was required to attend yearly mandatory training to ensure that they were trained to care for the patients safely. This training included caring for people living with dementia and the principles of the Duty of Candour.
- The hospital had declared 81% compliance of mandatory training against an organisational target of 95% in December 2015.

Surgery

- Senior ward staff planned one day a month within the off duty to ensure that each of the ward staff members completed their mandatory training. The hospitals' 81% compliance was across all departments both clinical and non-clinical.

Assessing and responding to patient risk

- Nursing staff completed risk assessments at pre-operative assessment or on a patient's admission to ensure patients were suitable to receive care and treatment. These assessments included pressure ulcer risk, falls risk and assessments for venous thromboembolism (VTE). Rates for screening all patients for the risk of VTE were between 99% and 100% for January 2015 to December 2015, which was above the target of 95%.
- Senior staff told us the pre-operative process was not running efficiently due to gaps in staff that were qualified and competent to do the role. Therefore, senior ward staff was covering the pre-operative assessment clinic on a Monday, Wednesday and Friday. Due to the staffing pressures, some minor surgery patients were admitted on the day without pre-op assessment; but all patients who required major operations or had co-morbidities were pre operatively assessed as a priority. Recruitment of new staff was underway to ensure the service ran smoothly.
- The normal patient admission process included a medical consultation followed by a comprehensive medical questionnaire sent by post. Further assessments were conducted face to face if required. Further investigations such as blood tests, ECGs, anaesthetic reviews or cardiac reviews were available on site if necessary.
- The pre-operative assessment nurse checked the health questionnaires with patients face to face in the pre-admission clinics or by telephone. The nurse, had access to anaesthetic or cardiology staff to check a patients' suitability for anaesthetic or admission to the hospital if required. Patients we spoke with confirmed this process took place and that they were briefed about possible surgical risks and advised on how to minimise risks.
- The American Society of Anaesthesiologists (ASA) grading system for preoperative health of surgical patient guides the admission of patients for surgery, only ASA level one or level two patients can be safely cared for on this site, theatre staff confirmed that there was no pressure to take higher-risk patients.
- The hospital used the Five Steps to Safer Surgery WHO Checklist (a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications). This is a nationally recognised system of checks designed to prevent avoidable harm and mistakes during surgical procedures. Different members of the inspection team observed the procedure six times and each time the process was done correctly and was well embedded. A member of theatre staff acted as a champion for the WHO checklist to ensure the process was done and recorded correctly. Theatre staff was also observed using a detailed and comprehensive safety huddle prior to the lists starting to ensure all patients were discussed and equipment planned for. Staff regularly audited the completion of the WHO checklist. The past two quarterly audits indicated that the WHO checklist was 100% completed in all of the patients notes examined.
- Nurses used a combined document to record patient's vital signs and pain scores, which depending on the results would calculate and provide a modified early warning score (MEWS) to alert the staff of the patients' deterioration and gave specific actions to follow if the score changed. Patients we spoke with described the close observations carried out after their procedure had been completed.
- In the event that a patient's condition deteriorated, service level agreements were in place for transfer of the patient to the local NHS trust by ambulance. There were strict guidelines for staff to follow which described processes for stabilising a critically ill patient prior to transfer to another hospital. All staff we spoke with was aware of the processes to follow.
- In the event of a medical emergency on the operating table, such as a cardiac arrest, theatre staff was trained in advanced life support. The stabilised patient was transferred, accompanied by the anaesthetist to the local NHS emergency department via ambulance.
- The Resident Medical Officer (RMO) was described by the ward staff as always accessible 24 hrs per day seven days per week and was visible on the ward; if there was a case of a patient needing a review because of a raised MEWS, the staff would immediately request an urgent review of the patient.

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- Staff told us approximately once a month the use of overflow beds on Level 3 ward (an additional capacity ward) was needed at the weekend. Risk assessments were conducted by ward staff to ensure only suitable patients was placed on Level 3 and they ensured that there was a permanent registered member of staff caring for them. The area was apart from the main ward and on a different floor so it was important that high-risk post-operative patients were not placed there

Nursing staffing

- Senior managers and ward staff reviewed the planned staffing for the ward areas twice a week and adjusted them if required due to changes in the potential demand for beds. Daily reviews of patient acuity and dependency were required due to the increased diversity in case mix and lower bed capacity to ensure adequate staffing. The ward occupancy for the past year was only 59%.
- There was difficulty in using a recognised tool to plan staffing due to the wide fluctuations in staffing requirements. On the days of the inspection, there was one registered nurse to four patients. The ward sister planned for a minimum of two registered nurses plus one health care assistant for the ward level 4 that had capacity of 16 beds.
- There had been little use of bank or agency staff on the ward with any gaps in numbers covered usually by staff working extra hours. However, the three vacancies for staff in theatres and the lack of a full scrub team had meant that agency staff was employed to fill gaps. Theatre staffing overall consisted of less than 20% cover by agency nurses in 2015.
- Recruitment to fill the three vacant posts in theatres was in progress at the time of inspection.
- The hospital used two accredited nursing agencies contracted by Spire and this allowed for continuity and to ensure regular staff were employed. The hospital was also recruiting to raise numbers within their own bank of staff. A local induction checklist was used to make sure that agency staff have a local induction and cared for patients safely.
- Nursing handovers took place in the ward office. Good verbal information was shared, with the information reinforced by a paper handover sheet, which had been updated by the previous coordinator with changes to patients' care and plans for their discharge.

Surgical staffing

- The hospital employed two Resident Medical Officers (RMO) who worked opposite each other in weekly blocks. The RMO reviewed patients on a daily basis, prescribed additional medication and liaised with the consultants responsible for individual patients care. The hospital RMO was based on site and was available on a rota 24 hours a day, seven days a week (weekends and nights). The RMO had appropriate advanced life support training and skills, and was supported by a 24 hour on call consultant cover rota.
- Handovers were observed between the RMOs, there was detailed and respectful discussion about the patients within the hospital, with appropriate signposting to patients requiring clinical reviews.
- There were 141 consultants who worked under practising privileges at the hospital, 40% had carried out between 10 and 99 procedures, 26% more than 100 procedures and 34% between 1-9. Senior staff completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the GMC and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. We observed regular checks were completed twice yearly and monitored by the registered manager.

Major incident awareness and training

- The theatre manager confirmed that the estates manager dealt with any estate emergencies. Most staff was aware of major incident and business continuity training, with theatres having a plan for lift failure – as the need for evacuation was high due to the environmental issues caused by the layout of the building.
- The hospital held an annual exercise to prepare for emergency breakdowns; the last one involved the lift breaking down. There were also six monthly planned evacuations and resuscitation practice scenarios.
- The hospital told us that if there were a local major incident, although there was no formal agreement, the hospital would offer assistance to the local NHS Hospital.

Are surgery services effective?

Surgery

Good 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective as good because:

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance
- The unplanned readmission rate for 2015 per 100 discharges within the Spire group showed that readmission rates were lower at this hospital than many others within the same comparison group
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs
- When people received care from a range of different staff, teams or services, this was coordinated. 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 people's needs
- Patient's nutritional and hydration needs were met and they had access to appropriate pain relief.

However,

- The medicine reconciliation process, (the checking of patients' pre-admission medication against a GP's or other record) considered best practice, was not completed consistently.
- Surgeons took consent for operations on the day of the procedure. The Royal College of Surgeons considers it is best practice for patients to sign consent forms before the date for surgery, to allow patients a 'cooling off' period and consider further treatment options.

Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for

Health and Care Excellence (NICE) guidelines. For example the modified early warning system (MEWS) was used to assess and respond to any change in a patients' condition. This was in line with NICE guidance CG50.

- The National Joint Registry was used to record patient outcomes for patients who were having replacement joint surgery. Patient Reported Outcome Measures (PROMS) were collected from patients who had joint replacements or groin hernia repairs. The groin hernia PROM for health improvement was within the expected range of the England average. The Spire group benchmarked the hospital's performance compared to others in the same group by using a scorecard.
- The medicine reconciliation process, (the checking of patients' pre-admission medication against a GP's or other record) was not consistently completed. NICE guideline NG5 and the hospital medicine policy states that this should be completed within 24hrs of admission; however only one chart of five inspected had this completed on the day of inspection. The hospital did not audit this standard.
- The 2015 audit plan stated that an antibiotic audit was done March – May 2015, there was no recollection from staff that this had been done or an audit report available.

Pain relief

- Nurses did regular hourly pain assessment rounds. The patients' pain scores were recorded on the combined observation chart, this ensured patients pain levels were monitored and pain relief provided in a timely manner. This improvement intervention followed complaints relating to pain relief which were highlighted in the annual clinical governance report.
- Patients we spoke with felt that their pain was being assessed and managed appropriately, with prescribed pain relief given when it was needed.
- Patients had access to patient controlled analgesia (PCA) which was checked by nurses hourly.
- There was access to the on-site pain team which comprised a consultant, specialist nurse and psychologist for advice on patient's pain control if needed.

Nutrition and hydration

- Patients had nutritional screening undertaken at pre-operative assessment or on admission. We saw

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Malnutrition Universal Screening Tool (MUST)

assessments to assess nutritional risk were recorded in patient notes. If found to be necessary, a referral to a dietitian was made for help and advice

- Information was given effectively during the pre-operative assessment, which included when to eat and drink prior to an anaesthetic to reduce the risks to them from intraoperative complications.
- Patients received written instructions prior to their admission via pre-operative assessment or in the post that advised them about starving times pre-operatively. Patients were advised to have clear fluids only until two hours before the operation.
- Fluid charts were used following surgery to record the fluids taken orally or via an infusion, and the patients' urine output. This was to ensure patients were sufficiently hydrated after their operation. We saw where charts were in use they were completed and up to date.
- Patients told us that they always had access to water and that there was a good choice of food. Patients told us that the food was well presented and portion sizes were good.
- Patients also had access to additional food and fluids via the local ward pantry, if needed the chef tried to accommodate most requests. Menu options were available for patients who required special diets for religious or cultural reasons. The hospital staff told us the chef offered patients alternate options should the normal menu not appeal to them to ensure that their nutritional needs were met.
- In the Patient-Led Assessments of the Care Environment (PLACE), which took place February-June 2015 the quality of food, scored 97%, which is above the England average of 94%.

Patient outcomes

- The unplanned readmission rate for 2015 per 100 discharges within the Spire group showed that readmission rates were lower for this hospital than many others within the same comparison group. There were eight patients who had unplanned readmissions within 31 days of being discharged. There was a spread of clinical specialties within the readmissions so no trends could be identified.
- There had been five patients who had unplanned transfers to another hospital during 2015 for further

assessment or expertise and not for critical care services. This was 0.05 per 100 discharges which was lower than other Spire hospitals which has an average of 0.15 per 100 discharges.

- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry which monitors infection and revision rates. Whilst patients had consented to participate in the register which ensured their care and joint replacements were monitored at a national level, their details had not been added due to a gap in personnel. The hospital had recruited to this role in April 2016 and planned to input all of the past patients' data.
- Patients were also offered the opportunity to participate in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement, inguinal hernia repair and varicose veins. PROMS measures the quality of care and health gain received from the patients' perspective data. PROMS showed the hospital was within the expected range for knee replacement surgery with regards to the Oxford knee score. (A patient-reported outcome measurement which contains 12 questions on activities of daily living that assess function and pain in patients undergoing total knee replacement). Unfortunately, the operation numbers were low for joint replacements although the response rate was good, Hips 90%, Knees 95% and Groin Hernia 88%. The groin hernia PROM for health improvement was within the expected range of the England average.

Competent staff

- Senior theatre staff told us that surgical first assistants were rarely used as competent scrub staff assisted the surgeon. If a first assistant was used their General Medical Council (GMC) number was taken and Disclosure and Barring Service (DBS) checked before they were allowed to practice.
- A Spire organisational competency framework was used by nursing staff to ensure that they were adequately trained for their roles and signed off as competent and safe to practice.
- Consultants only completed operations they were skilled and competent to perform; systems were in place via the Medical Advisory Committee (MAC) to monitor this. Staff told us the hospital was planning to

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implement a procedure coding system similar to the NHS (specific codes attached to each different procedure). Surgeons requested to operate on additional procedures via the medical advisory committee. Surgeons had to provide evidence that they were competent before carrying out a new procedure and the requests would then be considered by the medical advisory committee before permission was given.

- Staff had mid-year and yearly appraisals. Staff told us managers highlighted and encouraged opportunities for further training and development in appraisals. One nurse we spoke with had received additional training in advanced recovery for colorectal surgical patients. Staff told us that there was funding available for further training and staffs was well supported to undertake further training and development.
- Consultants and anaesthetists worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within the independent sector. Spire Dunedin Hospital followed processes via the medical advisory committee to ensure all medical staff who worked at the centre had the appropriate skills and competencies that included regular supervision and appraisals.
- Clinical outcomes for surgeons were measured which included post-surgical infection rates, complaints and serious incidents.

Multidisciplinary working

- Staff described consultants as accessible and had good working relationships with them.
- There was strong multidisciplinary team working with a daily ward round which included medical, nursing and therapy staff.
- Physiotherapy was readily available to patients. NHS-funded patients received the same therapy service as privately funded patients.
- The replacement joint care pathway was a multidisciplinary care record which included physiotherapy interventions
- Additional physiotherapy and occupational therapy was available on request to all patients NHS or privately funded, patients described receiving physio regularly and being able to continue as an outpatient once discharged.

- Staff described robust transfer arrangements for patients requiring additional services. For example, if a patient required trauma services rather than elective orthopaedic services they could be referred and transferred to a local NHS facility.

Seven-day services

- The RMO provided medical cover for the site over the whole 24 hours and seven days a week.
- Other support services such as pharmacy and imaging were available on request at the weekend.
- Surgical activity took place 6 days per week, Monday to Saturday.

Access to information

- All staff had access to paper patient records and care plans relating to the patient's current episode of care.
- There was a five-day consultant to GP turnaround for patient notes and letters.
- Three copies of the discharge summary were made – one for the patient, one for the GP and one for the consultant; with a copy filed within the patient record.
- Staff told us, and we observed, policies and procedures were stored on the intranet for staff to access if required. There was also a clinic resource folder held within the ward office for staff to access.
- Patients were able to access the ward for advice if they were worried post discharge from the hospital.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The patient consent process was observed to be well embedded and effective. The patients described how they had received lots of verbal and written information before being asked to sign their consent form.
- Surgeons gained consent from patients for surgery. Staff told us written information about the procedure was given to patients at their initial consultation for assessment. However, there was inconsistent recording in the notes we reviewed to detail if the risks and benefits of the operation had been discussed at the patients initial consultation. Once admitted, on the day of the procedure the surgeon conducting the procedure gained and recorded formal consent. We saw that the consent forms had been completed correctly and detailed the risks and benefits to the procedure. The

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Royal College of Surgeons considers it is best practice for patients to sign consent forms before the date for surgery, to allow patients a ‘cooling off’ period and consider further treatment options.

- Interpreters were available if required to assist with informing the patients prior to signing their consent forms, staff were aware of how to request their services.
- Throughout our visit staff we spoke with was clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care. Whilst staff was not aware of having to make a Deprivation of Liberty referral they could describe the principles and how to apply them.

Are surgery services caring?

Good 

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring as good because:

- Feedback from patients about the dignity, respect and kindness the staff treated them with was always positive. Staff maintained patient privacy at all times including while in theatre or transferring between ward and theatre.
- Staff took time to involve patients in their care. Patients told us they had enough information about their treatment and staff involved them in all decisions about their care.
- Flexible visiting hours allowed patients to maintain supportive relationships with those close to them. Staff supported patients to keep their independence and connections with family and friends.
- Staff supported patients to maintain a ‘normal’ daily routine and involved patient in making plans to go home.

Compassionate care

- Patients were consistently positive about the way staff treated them. One patient told us they couldn’t fault the care they received and said “nothing is too much trouble” for staff. Another patient said “the level of care is constant, comprehensive and continual – I feel I can trust the surgeon 100%.”

- Staff maintained patient privacy and dignity at all times by knocking on doors and asking for permission to enter. We observed staff introduced themselves and referred to patients by their preferred name. Theatre staff was mindful of patients’ dignity when they were in a vulnerable condition and protected their modesty with gowns and blankets whilst in theatre or transferring to and from the trolleys.
- Staff took a keen interest in ensuring patients had a pleasant and comfortable experience. The ward clerk collected patients from the waiting room and welcomed them to the ward, escorting them to their room to settle them in. During our inspection we saw staff taking time to interact with patients as individuals.
- The organisation had adopted the ‘6 Cs’ – care, compassion, courage, communication, commitment and competence. These were displayed throughout the hospital. One patient commented, that “the nurses are kind and caring – they are lovely people – cannot praise them enough.”
- We saw that nurses answered call bells promptly and patients told us nurses came in to check on them at regular intervals.
- At the time of inspection, we saw 26 thank-you cards displayed on Level four ward. The ward clerk told us they receive a few cards a week thanking staff for the quality of the care they had received.
- Patients said they would recommend the hospital. Between July 2015 and December 2015, the scores for the Friends and Family Test (FFT) were above 95%. The response rate was mixed, between 10% and 40% of patients across the same period.
- In the Patient-Led Assessments of the Care Environment (PLACE) privacy, dignity and well-being scored 84%, slightly lower than the England average of 87% for the period between February 2015 and June 2015. We were told this related to the lack of solid walls between the cubicles in the day care/ endoscopy ward.

Understanding and involvement of patients and those close to them

- Patients on the surgical ward said they understood their care and treatment and had enough opportunities to discuss their surgery and the risks involved. Patients told us they were given leaflets about how to prepare for their procedure before and after the operation. A patient commented that staff “explains everything.”

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- Staff supported patients to maintain a 'normal' daily routine and involved patient in making plans to go home.
- Staff encouraged patient's family and friends to visit and support them. There were opening visiting times on the ward between 10am and 10pm. We witnessed relatives accessing beverages on the ward and speaking at length to ward nurses about their loved ones care.
- Family members or friends could stay the night with patients, if required. A room was available on the ward with a sofa bed and makeshift beds for relatives to stay. There were facilities to support them and meals were available via the housekeepers.

Emotional support

- Patients commented positively on the calm and supportive atmosphere on the ward.
- Patients had access to private clinical psychologist if they required, and staff could request on their behalf for a chaplain to visit from the neighbouring NHS Trust.
- Private counselling services were available upon request via the oncology service with the hospital.

Are surgery services responsive?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good.

- Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service. The service met national waiting times for patients to wait no longer than 18 weeks for treatment after referral.
- The needs of different people were taken into account when services were planned and delivered. There were good examples where staff adapted procedures and worked flexibly to meet individual requirements.
- Due to the range of clinical specialities covered, patient's' individual requirements were identified during the pre-assessment appointment and their care planned to meet their individual needs

- Complaints and concerns were taken seriously, and responded to in a timely way. Learning from complaints was disseminated in mandatory training sessions and used to improve the quality of care.

However,

- There was a high cancellations rate of surgery on the day. This was largely due to the gaps in pre-operative assessment staff.

Service planning and delivery to meet the needs of local people

- Spire Dunedin provided elective surgery to NHS and private patients for a variety of the specialities which included orthopaedics, ophthalmology, general surgery, gynaecology, urology and cosmetic surgery
- Over the past year the service has had many fluctuations in activity and demand due to the close proximity of two market competitors. There had been a reduction in orthopaedic activity, including elective surgery, in 2014 due to the opening of a new facility close by. The orthopaedic activity was increasing again at the time of our inspection.
- There had been some initial provision of specific urological cases following planning discussions with GPs and the Clinical Commissioning Groups.
- The hospital routinely planned surgical lists between Monday and Friday, with occasional lists running on Saturdays to meet demand. Patients were offered a choice of admission dates to best suit their needs.
- The hospital did not provide in-patient surgical services for children.
- Patients living with advanced dementia were risk assessed for their safety within the environment, which was constrained by the existing layout.

Access and flow

- In 2015 Spire Dunedin hospital met the indicator of 92% of NHS patients waiting times for admitted patients beginning treatment within 18 weeks of referral for all months except December.
- Patients discussed their dates for surgery at their initial outpatient's appointment. All of the patients we spoke with told us they had short waits for their surgery.
- The pre-operative assessment service was understaffed at the time of our inspection. This meant not all late booking patients had access to a face to face pre-operative assessment until close to their operation

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date. Senior managers told us that there were 45 cancellations on the day of surgery in 2015. Theatre staff confirmed that patients who were booked late and received their pre-assessment too close to the admission date had contributed to the high cancellation rate. Senior managers had plans to carry out the pre-assessment of patients before booking into theatre lists. However, there was no identified time frame for this.

- Two bed meetings were held every week when the admissions and discharges were discussed and planned. The potential need to overflow into the additional ward space was discussed, staffing levels agreed and suitable patients for transfer identified.
- Theatre staff worked flexibly to ensure that scheduled operations went ahead where possible. During our inspection, theatre staff had worked in theatre until past midnight. They said they were happy to do so as they wanted to complete the procedure and it did not frequently happen.

Meeting people's individual needs

- Due to the range of clinical specialities covered, patient's individual requirements were identified during the pre-assessment appointment and their care planned to meet their individual needs.
- The hospital gave an example of responding to a patient's individual needs, when a patient with a learning disability was invited to come in to look around the hospital and met the staff prior to their surgery. This was to ensure they felt more familiar with the hospital and the staff.
- If a patient needed 'one to one' care post-operatively, care was planned to meet this need. A nurse was assigned to 'special' the patient to ensure adequate supervision of their care took place.
- The patients we spoke with all said that they had received timely access to information and there were various patient information leaflets available, these included 'The Importance of Hydration' and information about MSSA and MRSA patient screening. All documents on display racks were published in English and staff were not aware if other languages or pictorial information could be obtained if needed. This meant patients for whom English was not their first language, or had difficulties with reading may not have written information about their care and treatment.

- Staff had access to interpreter services provided by an external translation service to support patients whose first language is not English. This meant that the patients would be fully informed about their plan of care and able to consent to any treatment appropriately.
- Hospital staff knew that in the event of an expected patient death the deceased would be taken to the undertaker of the patient or their relative's choice directly.
- In the Patient-Led Assessments of the Care Environment (PLACE) between February to June 2015 the hospital scored 74% for the care environment for patients living with dementia, the England average was 87%. Since this assessment, the hospital had appointed a dementia lead who had been running awareness-raising sessions for staff. A dementia clock, low profile bed and dementia-friendly toilet sign were also available to meet the needs of patients living with dementia.

Learning from complaints and concerns

- Ward staff had recently completed training in dealing with complaints, and other staff had had customer care training. The aim was to deal with issues before the complaint became official. Learning from the complaints had shaped the care within the ward, for example, the nurses undertook hourly pain assessment rounds in response to a complaint of inadequate pain relief.
- Senior ward staff carried out ward rounds regularly to identify any issues raised by patients. This was to ensure patients concerns were addressed in a timely manner. Senior staff told us that most ward complaints were about information relating to delays to theatre. To minimise this, nurses kept patients informed of how the theatre list was progressing and the likely time of their operation.
- Comments and complaints from patients were shared with the nursing team on the ward. During 2015 there were 26 complaints, most of which were stated as related to poor staff communication. Senior managers asked to see any patient that was unhappy in an effort to resolve the patients concerns.
- We saw the Annual Clinical Governance Report illustrated and discussed the complaints from 2015; learning was also identified with one example of a patient having an incorrect bill. Actions were taken to ensure the issue did not occur again.

Surgery

Are surgery services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

We rated well-led as good because:

- Staff were aware of the values of the organisation and were passionate about good patient care. There was a clear statement of vision and values driven by quality and safety. Staff had strategy ‘built into’ their appraisal process.
- Staff spoke positively about the ‘no blame’ culture of the team and of the visibility and support of managers. Staff described the hospital as having a “family feel”.
- There was a comprehensive process in place to identify, understand, monitor and address current and future risks. Performance issues were escalated to the relevant committees through clear structures and processes. The hospital governance structure was well established and included the Medical Advisory Committee (MAC), the Clinical Governance (CGM) and the Clinical Effectiveness Committees (CEC) covering both clinical and non-clinical compliance to statutory and organisational policy.

However,

- The current system of managing and mitigating risks did not consistently have detailed actions and timescales. Only 19% of risks on the hospital risk register had key actions and dates identified.

Vision and strategy for this this core service

- All staff we spoke with were aware of the hospital wide values and were able to describe them to us. Nurses were able to describe the hospital vision for care which was called the six C’s care, compassion, courage, communication, commitment and competence.

- The hospital had a strategy to create more diversification in surgical services that were offered due to market challenges. Further plans were in place to ensure theatres were utilised effectively and further plans for an additional theatre were being evaluated.
- All staff we spoke with were passionate about good patient care and believed they consistently put the patient first.
- The staff talked about organisational strategy discussions being part of their appraisal process. Senior team leaders spoke about how they were routinely invited to join the strategy group, to help prepare the hospital plan for the future. An example was given of outline plans to carry out more specialised urology cases to take up the capacity left by orthopaedics not doing so much activity on site.

Governance, risk management and quality measurement for this core service

- The hospital governance structure was well established and oversaw quality, audit and risk activity performance. The structure included the Medical Advisory Committee (MAC), the Clinical Governance (CGM) and the Clinical Effectiveness Committees (CEC) which covered both clinical and non-clinical compliance to statutory and organisation policy. MAC meetings were attended by a variety of specialities. We saw from meeting minutes that over five consultants and senior members of staff had attended the meetings which met the meeting guidelines.
- Quality measurement and performance dashboards were maintained by senior clinical staff of each service. Outcomes were discussed at the clinical governance meetings and comparisons made with other Spire hospitals. All clinical staff had access to the performance dashboards to which enable them to assess the hospitals performance.
- Risks to patient safety were identified at local, hospital and organisational wide levels. The hospital was in the process of transferring from one system to another. Risks were documented on a risk register and within local ‘risk libraries’. Heads of departments managed risks locally, but there was inconsistent management with hospital wide risk registers regarding timelines and actions to mitigate the risks. Only 19% of risks on the hospital wide risk register had any key actions with dates identified. The current process did not fully

Surgery

engage staff in a clear process for managing and mitigating risks and staff did not have a clear understanding of how to use the hospital wide risk register. However, all staff were aware of their local risks which were recorded in the departmental risk library.

- The pharmacy department held detailed risk assessments (for example, handling chemotherapy, lone working, RMO dispensing), to ensure safe administration of medication.
- The hospital did not have a system for archiving risks that had been closed and taken off the risk register, to enable recurring risks to be revisited for organisational learning. Heads of departments discussed their own risks at the clinical governance meetings.
- The theatre manager reported that she attended the Spire Theatre Managers Network and had visited two other Spire Hospitals to share learning and best practice. The two deputy theatre managers also planned to visit other Spire Hospitals to share best practice.
- The monthly management strategy meetings were well attended with named leads and key action points monitored.

Leadership / culture of service related to this core service

- Staff we spoke with said they were proud to work for the hospital. They were committed to the hospital and there were many longstanding members of staff.
- Staff commented positively on the 'team spirit' and 'family feel' within the hospital.
- The majority of staff said that senior leaders were visible and approachable and that they were positive role models to others.

- However, the last staff survey report in 2015 showed that staff in certain departments, particularly in theatres were not satisfied with the leadership and culture at this hospital. Since this report had been published, focus groups had taken place, and there had been some staff changes and it was felt the negative culture had improved.

Public and staff engagement

- Staff asked NHS patients to complete Friends and Family Test satisfaction surveys about the quality of care provided. In addition, the organisation ran twice yearly patient satisfaction questionnaires. Following the survey in February 2016 the main areas for action were to improve pre-operative assessment, improve privacy and dignity in the day unit and to maintain or improve the management of patients' pain.
- All staff were asked to complete an annual staff satisfaction survey. However, only 40% of theatre staff had chosen to respond. The theatre manager attributed these results to the frustration caused by shortage of staff.
- The staff recognition award scheme had just been developed and launched prior to our visit.
- The 2015 GP satisfaction survey showed that 88% of GPs rated the hospital as excellent/very good. 96% of GPs said they would definitely/likely or quite likely recommend the hospital to colleagues.

Innovation, improvement and sustainability

- Due to market challenges the hospital had explored diversification in other areas. For example specialist urology services and further expansion of bariatric surgery.

Outpatients and diagnostic imaging

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

Information about the service

The outpatient department at the Spire Dunedin Hospital provides a wide range of outpatient specialities including neurology, gynaecology, ophthalmology, ear nose and throat (ENT), urology, vascular, dermatology, orthopaedics, maxillofacial, cosmetics, and general surgery. The diagnostic imaging service provides access to plain film x-ray, magnetic resonance imaging (MRI), computerised tomography (CT), mammography, ultrasound, bone densitometry and fluoroscopy.

Healthcare is provided by staff at the hospital to patients with private medical insurance, those who self-pay, and through National Health Service (NHS) contracts. Between January 2015- December 2015, the outpatient department at the Spire Dunedin hospital provided 2561 NHS funded new patient's appointments and 3982 follow ups. They also provided 8,410 new appointments for insured or self-pay patients and 17,492 follow up appointments. They saw 365 children aged between three to fifteen and 283 young adults aged 16-17 years old and the majority of their patients were adults. There were 13 consulting rooms and two treatment rooms situated within the main hospital and two other addresses on Bath Road which was on the same road. There are also cardiology facilities which comprised of two outpatient consulting rooms with a treadmill, providing echocardiogram and lung function tests. The physiotherapy department had a gymnasium area with fitness equipment and four treatment areas and provides in and outpatient services. These included Pilates, sports massage and acupuncture.

The outpatient department provided appointments from 8am to 8pm from Monday to Friday with some additional clinics on Saturdays. The operating times within diagnostic imaging services is between 8.30am and 9pm Monday to Friday.

As part of our inspection we visited the Spire Dunedin on 12 & 13 April 2016. We also carried out a routine unannounced inspection on 22 April 2016. Spire Dunedin also runs a satellite Clinic at The Bell Surgery, Henley-on-Thames which provides consultation and was not inspected during this inspection.

We observed care and spoke with 17 patients, four relatives and visitors. We also reviewed 16 comment cards from patients and staff. We spoke with approximately 21 staff including doctors, nurses, managers, healthcare assistants, radiologists, physiotherapists, administrative support and the housekeeping team.

We checked the clinical environment and equipment; we reviewed trust policies and procedures, staff training records, audits and performance data. We looked at computerised records and reviewed data provided by the trust.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the outpatient, diagnostic and imaging services as good. We found outpatients, diagnostic and imaging services were good for safe, caring, responsive and well-led. We did not rate effective as we do not currently collate sufficient evidence to rate this.

Patients were positive and complimentary about the care they received from staff, access to appointments and the efficiency of the service as a whole. Staff were encouraged to report incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) incidents and followed their internal procedures to report to the radiation protection team and the Care Quality Commission as required.

There were appropriate systems in place to keep patients safe. Staff were aware of their responsibilities to raise concerns and report incidents and near misses. There were clearly embedded systems and processes to keep patients and staff safe and safeguarded from abuse. Staff received up-to-date training in all aspects of health and safety.

Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation. There was evidence of local and national audits, including clinical audits in diagnostic and imaging service and reviews were undertaken at regular intervals. Staff were qualified and had the appropriate skills to carry out their roles effectively, and in line with best practice. Staff were supported to deliver effective care and treatment, through ongoing training and appraisal.

We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect at all times when providing care and support. Patients and their relatives' feedback were positive.

Staff managed, and scheduled, clinics appropriately. This ensured good availability of appointments for patients across all specialities. Services were planned and delivered in a way which met the needs of the local

population. Waiting times, delays, and cancellations were minimal and managed appropriately. There was openness and transparency in how complaints were dealt with.

There was a clear statement of vision and values, which was driven by quality and safety. Staff knew and understood the vision, values and the service's goals. There was nurse led clinics for breast care patients. For example, there was a one stop clinic for dermatology and breast which meant it could reduce the time to diagnosis and treatment ensuring any treatment that was needed could be started without delay.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good 

By safe we mean that people are protected from abuse and avoidable harm.

Overall we have rated safe as 'good'.

- Staff followed their internal procedures to report and record incidents and the learning was shared to improve services. In diagnostic imaging, staff were confident in reporting ionising radiation medical exposure (IR (ME) R) incidents which included reporting to the radiation protection team.
- The environment was visibly clean and well maintained. Staff followed infection control procedures to minimise risk of cross infection. Equipment was clean and well maintained and had been regularly serviced. The resuscitation trolleys were checked daily and staff had received training in basic life support.
- Medicines were mostly maintained securely. Patient group directions (PGDs), which allowed trained non-medical staff to prescribe medicines, were in date and used appropriately.
- Procedures were followed to safeguard patients from risk of harm. There were sufficient numbers of adequately trained and skilled staff to provide care to patients.
- Records were well maintained and patients' records and test reports were available at clinics.

However,

- The drug fridge was unlocked in one of the clinics we inspected. This was remedied when we raised this with staff.
- There were no suitable arrangements in place to review or monitor the use of Patient Group Directions (PGDs) within the radiology department. The PGD process and use was not being audited.
- The service also provided gynaecology clinics. Nursing staff did not have an understanding of female genital mutilation (FGM) or action they would need to take to protect patients.
- The availability for chaperones was not always effectively managed for all the clinics.

Incidents

- There was a system to report incidents in the outpatient department. We noted there was no adverse incident reported in the department according to data received. We were not assured incident recording was consistently managed in outpatient's department.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Staff followed the hospital procedures to report incidents to the radiation protection team and the Care Quality Commission
- In the outpatient areas staff were aware of their responsibility to report incidents. All staff reported incidents through an electronic reporting system. In outpatient staff said they would go to their manager who would complete the report on the system.
- Staff felt confident to report incidents, accidents and near misses. The department had reported one Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) or magnet related events incidents in the last 12 months. This was referred to the regional service for investigation and no further action was required.
- There was a lead radiographer who was responsible for the monitoring of radiation protection and any incidents. Staff were monitored using dosimeters (a device used for a device that measures exposure to ionizing radiation) and records of this were maintained. The records showed this was managed effectively.
- The radiology and imaging department did not have any nuclear medicine provision. However some patients had a procedure where tissue removal carried some radioactive components. These were carefully monitored by the radiation protection officer who checked on the level until it was safe for disposal.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had an understanding of the Duty of Candour and actions they should take following an incident of avoidable harm to a patient. In the radiology department staff were able to tell us of a recent example where the duty of candour was used following an incident.

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- Minutes of meetings in outpatient, radiology and physiotherapy departments demonstrated that outcomes and learning from incidents had been shared at meetings and changes in practice had been made where required. For example the process for the prescription of eye drops relating to take out (TTO) medicines given to patients on discharge.

Cleanliness, infection control and hygiene

- The outpatient, diagnostic imaging and physiotherapy departments were visibly clean and well maintained.
- Staff adhered to 'bare below the elbow' guidance and used appropriate protective personal equipment (PPE), where required whilst delivering care.
- The last outpatient department (OPD) infection prevention and hand hygiene audit was carried in February 2016 showed compliance of 95%. There was no action plan to address the shortfall.
- Personal protective equipment (PPE) such as gloves and aprons were readily available for staff in all clinical areas, to ensure their safety and reduce risks of cross infection when undertaking procedures.
- Equipment was well maintained, and records of checks were recorded. All equipment we looked at was visibly clean and they used 'I am clean' stickers to identify that the item had been cleaned which included the date this was carried out. These included wheelchairs which were available in the corridors for patients' use
- Over the last 12 months there had been no reported cases of healthcare-associated infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), clostridium difficile (C.diff) or, Methicillin Sensitive Staphylococcus Aureus (MSSA) for the outpatients and diagnostic imaging department. MRSA, MSSA and C.diff are all infections that have the capability of causing harm to patients. MRSA is a type of bacterial infection that is resistant to many antibiotics. C.diff is a form of bacteria that affects the digestive system
- Staff, including domestic staff were knowledgeable about the cleaning process they would follow such as steam cleaning carpets and disposal of infective waste.
- Domestic and clinical waste was disposed of correctly. There were appropriate facilities for disposal of clinical waste and sharps such as needles located in the outpatient and diagnostic imaging department. All sharps bins were assembled correctly, signed on assembly and staff ensured these were not overfilled.

- Seating in the waiting rooms was visibly clean. Staff told us they were able to be cleaned to prevent the spread of infection.

Environment and equipment

- There was a process in place for the emergency resuscitation equipment to be checked daily. We saw where this was adhered to in outpatient, diagnostic and imaging. This meant the equipment was ready for use in an emergency situation and staff were aware of their locations.
- Resuscitation trolleys were maintained safely and securely and were also tamper evident. Resuscitation equipment included those for child and adult and anaphylactic drugs were available for the treatment of potentially life-threatening allergic reaction that can develop rapidly.
- The diagnostics department carried out care and treatment in line with the Ionising Radiation (Medical Exposure) Regulations (IR (ME) R). Local radiation protection rules were available for staff to refer to and checks on equipment was carried out.
- The imaging department had assessed exposure to radiation and staff wore radiation detection badges that were sent externally to be routinely analysed to ensure safe levels were maintained.
- All diagnostics and imaging equipment had routine quality assurance and calibration checks in place to ensure the equipment was working safely and effectively.
- In diagnostic imaging there was clear and appropriate signage to alert patients to potential radiation hazards in relevant areas as required.

Medicines

- Medicines in the outpatient department (OPD) were stored, managed, administered and recorded safely.
- There was an in-house pharmacist who supported the staff with medicines management. This service was available between 9-5 and with an on call system to at other times including weekends. Access to the in house pharmacy (where medicines were stored) was restricted as two staff were required to access the pharmacy when the pharmacist was not available.
- Medicines that required refrigeration were stored in a locked fridge. Keys were held by the senior member of

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staff and temperatures were checked and recorded routinely. There was one fridge which was unlocked at one of the sites we visited. Staff locked the fridge when we raised this with them.

- Prescription pads were kept secure and the pharmacy department held one prescription pad that was controlled by them.
- In radiology, contrast agents and drugs were stored securely. Stock was checked regularly and requests for further supply were made by email to in house pharmacy.
- In the outpatient department, staff confirmed all the prescriptions issued by the hospital were private prescriptions.
- There were some Patient Group Directions (PGDs) used at the service. A PGD provides a legal framework that allows registered health care professionals who have completed appropriate additional training and signed the PGD to supply and/ or administer a specified medicine (s) to a pre-defined group of patients, without them having to see a doctor. A PGD is used in situations that offer an advantage to patient care, without compromising patient safety.
- PGDs were used by medical imaging (e.g. Klean-prep). The PGDs were written and authorised in line with legislation. The PGDs were in date with a review date of 2017. Staff had their competencies assessed in order to use PGDs.
- However the pharmacist could not tell us about the governance process for PGDs within the hospital and who had ownership and control of the PGDs use at the service. The PGD process and use had not been audited.

Records

- Medical records in the OPD were paper based. We reviewed 11 sets of patients' records. All records were legible, signed and dated. Records contained all the relevant information including letters to the patients' GP.
- If a patient was booked for clinic for a first appointment and the notes were not available, staff told us they would contact the referring GP or hospital and request a copy of the referral to be faxed through before clinic along with any previous results. As the notes and files were prepared 24 hours ahead; this allowed them time to request and chase up the notes prior to clinics.
- We observed notes were legible and files were bound and in good order. Records and patients' notes were maintained safely and securely with restricted access.

- Records and treatment plans were detailed. This reduced the risk of confusing or conflicting information being given to patients.
- During clinic times, patient's records were kept in the consulting rooms and then returned to be stored.
- Staff told us in the event of patients' notes not being available, any previous clinic letters and operation notes from their system, and diagnostics results would be printed and a file made up.
- Spire healthcare is registered with the Information Commissioners Office (ICO). Consultants were advised to register themselves as independent practitioners, but were considered employees of Spire Healthcare with practising privileges.
- There had been concerns regarding the practice of patients' records which were removed and taken off site. This could pose risk of information not being available if required. A senior manager told us this had now ceased and this was monitored.
- There was no audit undertaken of medical records which were not available in OPD when patients attended appointments.

Safeguarding

- There were no safeguarding concerns reported to CQC in the reporting period January 2015- December 2015.
- The hospital had two leads for adult and children safeguarding. Staff were aware of what constituted abuse and the steps they needed to take to protect vulnerable patients from avoidable harm or abuse.
- Policies and procedures in safeguarding were available to staff to refer to and inform their practice. Staff could access the hospital's safeguarding policies and procedures via the intranet. The safeguarding policy was updated in January 2016 and approved by their group medical director.
- Data from the annual clinical governance report showed that in 2015, 98% of staff had completed adult safeguarding e learning and 96% of staff completed child protection e-learning modules. The safeguarding leads also delivered face to face safeguarding training for staff. Some staff had also attended further safeguarding training appropriate to their role. For example all consultants and some nurses had attended level 3 safeguarding children training. As from April 2016, the service was introducing staff competencies to include consultants' level 3 competencies.

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- The service also provided gynaecology clinics. Nursing staff did not have a clear understanding of female genital mutilation (FGM) or action they would need to take to protect patients. The gynaecology clinics were consultant led.

Mandatory training

- There was a process for all new staff to undertake mandatory training as part of their induction to the service. Mandatory training was completed using an on-line learning package. The training included, immediate life support (ILS), basic life support (BLS), infection prevention and control, manual handling, fire safety and information governance.
- Staff compliance with mandatory training reported in February 2016 was 81%. This was lower than the hospital's target of 95%. For information governance training the service had achieved 96%. Action had been put in place and staff were sent reminders on a monthly basis. Contracted staff who did not complete their training would not be considered for bonus.
- The ILS completion rate showed that 82% of clinical staff had completed this training in February 2016. ILS training was carried out on an annual basis. BLS training was also completed annually, this was aimed at those staff that did not have ILS training and 45 staff members had completed this in 2015.

Assessing and responding to patient risk

- Staff had completed training in resuscitation and emergency equipment was available at strategic points including outside the radiology department.
- In interventional radiology, staff followed a thorough risk assessment process in line with their procedures. Prior to any procedure commencing, the clinician used a modified WHO safety checklist, to address key clinical risks within the environment, there were clear patient protocols in place. This was audited to assure the provider that the WHO checklist was adhered to.
- The provider had an appointed radiation protection supervisor and a radiation protection adviser (RPA) in accordance with IR (ME) R regulations. This meant that the hospital had an independent annual audit of the imaging and ionising services. The radiation protection supervisor conducted audits and produced risk assessments in accordance with IR (ME) R requirements.

- Radiation exposure details in the form of diagnostic reference levels, local rules and guidelines were displayed in imaging rooms. This meant staff could quickly reference guidance to increased risks associated with radiation exposure.
- In the diagnostic and imaging department there were clear illuminated signs which alerted patients, where radiation exposure would be taking place. There were also signs and posters to remind women who may be pregnant to inform the radiographer before their X-ray.
- There was a process for the management of patients who may collapse or become acutely ill. The process was for nursing staff and the resident medical officer (RMO) would attend any emergency in OPD and radiology departments. Patients would be stabilised and/or transferred to the acute trust as required via 999 call system.

Nursing/ Radiography staffing

- In the outpatient department there was no acuity tool used to plan staffing levels. There were low level of vacancies (3) across the outpatient department and recruitment was underway to fill the vacant posts. They service did not use agency staff in the outpatient department. Staff told us the roster was planned according to the clinics. They used their own staff and bank staff to cover sickness and leave. Sickness rates were below 20% in outpatient department.
- The diagnostic and imaging department had a constant level of staff stability. There was a high level of nursing staff turnover in outpatients which was equal to 40% during 2015. However there was no turnover reported for care assistants.
- There was not always nursing staff present in the outpatient clinics. For example the respiratory clinic and orthopaedic clinics did not have nursing staff allocated. This meant that there was not always a chaperone immediately available to the patient if they required somebody else present throughout their appointment. However staff member was called to assist if a chaperone was requested. Staff said they called staff from other clinics which was not satisfactory as this left other services not fully staffed. We observed this occurred during the inspection where staff were called from another clinic to assist.
- Nurse staffing levels were appropriate for patients attending the breast clinics.

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- Radiographer staffing levels were adequate as they had 19 radiographers who worked sessional rotas, providing support and service. Currently the staff vacancy was low which was for 18hrs in radiology and imaging. There were three specialist CT/MRI radiographers and two general radiographers who were trained to undertake mammography.
- Radiology department and had two healthcare assistants who also acted as chaperone for patients.

Medical staffing

- The service reported 100% compliance with verification of professional registration for doctors and dentists with practicing privileges. This refers to medical practitioners being granted the right to practice in an independent hospital after being approved by the medical advisory committee (MAC).
- There were sufficient consultants to meet the service needs and cover outpatient's clinic specialities. Most clinics were consultant led and appointments were booked at times when the consultants were available so adequate medical cover was guaranteed.
- The ultrasound service was consultant led and specialist radiographers assisted them.
- There was a Resident Medical Officer (RMO) within the hospital 24 hours a day to assist in emergency in OPD and radiology, with immediate telephone access to the responsible consultant if required. They could also attend at short notice in case of an emergency as staff said they lived within 30 minutes' drive from the hospital.

Major incident awareness and training

- Training in major incident awareness was available to all staff including new staff during their induction.
- There was a business continuity plans in place which managers said they would refer to if a major incident was declared. Arrangements included a back-up generator in case of power failure which would provide power for 48 hrs. All elective surgery would also be cancelled.
- There were regular fire drills and this included twice yearly scenarios for evacuation.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We report on effectiveness for outpatients below. However, we are not currently confident that, overall, CQC is able to collect sufficient evidence to give a rating for effective in outpatients department. We have not rated this section of the service.

- There was evidence of National Institute for Health and Care Excellence (NICE) guidelines being adhered to in cardiology, ophthalmology and the breast unit. In Radiology and imaging staff followed the Royal College of Radiology standards to ensure care was provided according to national standards ensuring patients' protection.
- There was good evidence of multidisciplinary team (MDT) working practices which had positive impact on patients care. In diagnostic an imaging, seven day services were available for inpatients providing a 24hour service for X-ray, and scans both during the week and at weekends.
- Staff followed the consent procedures and there were clinical protocols and comprehensive consent documentation in place. Staff had an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards which ensured that decisions were made in the patients' best interests.
- Staff in OPD had completed appraisals and the service benefited from advance nurse practitioners in breast care and nurse led clinics.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC).

However,

- There was no evidence of the outpatient department taking part in national audits.

Evidence-based care and treatment

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- Staff involved in diagnostic imaging demonstrated an understanding of their role with regards to Ionising Radiation (Medical Exposure) regulations 2000 (IR(ME)R) and protecting patients from the risks of unnecessary exposure to radiation.
- Radiology and imaging services followed the control of optical radiation at work regulations, 2010.
- Outpatients adhered to the relevant National Institute for Health and Care Excellence (NICE) guidelines to treat patients. These included clinical guidance for cardiology, ophthalmology and the breast unit.
- The diagnostic and imaging service took part in national audits and regular reviews of their service such as mammography.
- An IR (ME) R review of radiology equipment was undertaken on a yearly basis. Staff referred to the Royal College of Radiologists standards for the administering of intravascular contrast.

Pain relief

- Patients were assessed for pain during assessments as required. Staff gave patients' advice and support in managing pain. Patients were issued with pain control if needed which was prescribed and dispensed from the in house pharmacy. None of the patients we spoke with required pain relief at the time of our inspection.
- Staff told us pain assessment was carried out as part of their pre- assessment process and following minor procedures.

Patient outcomes

- Imaging services audited the report turnaround times such as results of investigations to meet their target of 24 hrs. Other audits included IR (ME) R auditing dose reference leads which was collected for general adults in radiology. A mammography audit and peer review were also completed in 2015 which indicated good outcomes.
- The Radiation Protection Adviser (RPA) acted as the IR (ME) R Medical Physics Expert with regard to Diagnostic Reference Levels (DRLs).
- In line with DRLs standard procedures the service monitored the average patient dose radiation level based on national recommendations. The RPA also reviewed these annually.

- Staff monitored patients following their outpatient treatments. Staff said patients were contacted by phone the following day after outpatient treatment to check if they had experienced any complications following their treatment.
- There was no evidence of the outpatient department taking part in any national or local audits except for infection control.

Competent staff

- Staff undertook role specific training to maintain and develop their skills. Advanced practitioners included a breast care specialist who ran nurse led clinics and offered care, advice and support to breast patients.
- In diagnostic and imaging service we reviewed nine sets of staff's competencies records. These included CT scan, mammography, magnetic resonance imaging (MRI) and all were up to date and clearly documented. These included areas where staff needed to improve and objectives were set and reviewed.
- The hospital had a system in place to ensure registered nurses maintained their registration and were able to meet revalidation requirements.
- In diagnostic and imaging, staff appraisals and competencies assessments were effective and well managed and staff undertook additional training to maintain their skills.
- Data provided by the hospital showed that 100% of nursing and medical staff and allied healthcare professionals were appropriately registered with their professional body and had received regular appraisals.
- Medical staff were employed substantively by other organisations such as the NHS and held practising privileges at this hospital. Practising privileges refer to a medical practitioner being granted the right to practice in an independent hospital. Practising privileges were granted or rejected by the provider's Medical Advisory Committee.
- Practising privileges were reviewed by the chairperson of the medical advisory committee (MAC). This included a review of appraisals, General Medical Council (GMC) registrations and medical indemnity insurance. Medical staff included consultants who specialised in areas such as ophthalmology, gynaecology, respiratory, neurology, cardiology, orthopaedic and dermatology.

Multidisciplinary working (related to this core service)

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- The multidisciplinary team (MDT) worked well to support the planning and delivery of care in the outpatients and diagnostic imaging departments. Staff told us they were part of a small team and relied on each other for the provision of a seamless service.
- The radiology department, for example, provided out of hours support for theatre cases to ensure prompt imaging, and worked flexibly to provide any urgent imaging service if required.
- Staff told us that they were proud of good multidisciplinary team working, and we saw this in practice. Staff were courteous and supportive to each other. Senior staff attended the weekly senior team meetings and discussed patients of specific needs or requirements.
- Nursing staff reported they had good access to senior medical staff and could discuss patient related concerns with them.
- There was a service level agreement with the local NHS in place which involved multidisciplinary teamwork to ensure continuity of care for patients. This included emergency transfers as required.
- Reports and letters were sent to the patients' GPs within 24 hours. This meant that GPs had access to up-to-date information about patients.
- Monthly multidisciplinary meetings were held to share good practice and concerns to enable learning across the teams.
- Physiotherapists and pharmacy formed part of the multidisciplinary team.

Seven-day services

- The OPD operated between 8:30 and 6pm Monday to Friday with some clinics scheduled on Saturdays to meet demand. Staff worked flexible hours to provide cover for clinics and provide appointments to meet patient's needs.
- Radiology services were available 8am to 8pm Monday to Friday, and held clinics on Saturdays when required. On call radiology staff provided an out of hours service seven days a week. Staff told us that they could always access a consultant radiologist to report on imaging out of hours. Any urgent request for a radiology opinion could be transferred through their PACS system and viewed remotely by a radiologist. The turnaround time was 24 hours for imaging service which was provided by Berks imaging.
- The physiotherapy department provided services five days a week with flexible times to meet patients' needs.

Access to information

- All Choose and Book patients, these were mainly NHS patient were sent a leaflet explaining the benefits of good hydration and this was documented when sent out to allow the service to audit these. Other patients were provided with this information when they attended the hospital.
- Staff provided patients with a variety of information pertaining to infection control procedures and screening. For example patients were provided detailed written information relating to methicillin resistant staph aureus (MRSA)
- There was also information such as leaflets about a rapid access spinal pain clinics, counselling and psychotherapy services.
- Staff told us they were able to access information on their local intranet which included policies and guidance.
- The Electronic Reporting system (EMS) has been introduced in October 2015 enabling procedure reports electronically and published immediately for consultant, patients' records and GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The consent process for patients was well structured and staff demonstrated a good understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- We viewed three patients' records which showed written consent had been obtained and we observed verbal consent was sought from patients prior to examination.
- Staff in radiology explained that they would request a capacity assessment if they were concerned a patient lacked capacity. They used standardised consent forms as needed prior to care and treatment being provided.
- For the period up to December 2015, 89% of clinical staff had completed Mental Capacity Act training.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Good 

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

We rated caring as good.

- During the announced and unannounced inspections; we observed caring and compassionate care and interactions from nursing, medical and radiography staff. Patients and their relatives were treated with dignity and their privacy respected at all times.
- Consultants told us they planned adequate time for consultations and clinics and patients were supported if they were given bad news.
- Patients understood the care and treatment choices available to them and were given appropriate information and support as needed.
- Patients told us that they involved in the decision making regarding their care and treatment and staff recognised when a patient required extra support to be able to be included in understanding their treatment plans.

Compassionate care

- Patients were overwhelmingly positive about their care and treatment. One patient said the staff were “really wonderful” and they were treated with dignity and respect by all staff members. They said the staff were knowledgeable and very friendly. Other comments included “fantastic care” and that the care was “second to none.”
- Staff recognised when patients need extra support and care and treatment was provided in a compassionate way.
- Chaperone signs were displayed across outpatient and diagnostic imaging waiting areas. Patients were invited to request a chaperone if they wished to be accompanied during their procedure or appointment. Staff told us this would be provided during consultation if requested.

- Consultants told us they planned adequate time for consultations and clinics. This meant that patients were supported and given sufficient time if they were given bad news.
- The Friends and Family test had been completed. The results for February 2016 showed 94% of all patients completing the survey said that they would recommend the hospital to family and friends.
- Staff respected patients’ confidentiality at all times and ensured discussions took place in treatment rooms. At the reception desk, confidentiality was maintained and no personal questions or details were discussed.

Understanding and involvement of patients and those close to them

- All the patients we spoke with felt well informed and involved in the decision making regarding their care and treatment.
- We observed three consultations with the patients’ consent. There was clear communication and patients were given time to ask questions. Staff used different techniques to ensure effective communication such as diagrams and images on the computer.
- Patients were given explanation about the choice of treatment they were offered and also discussed where other treatment options may not be suitable.

Emotional support

- Staff used quiet rooms for patients who had been given bad news and this facility was also available in the physiotherapy department.
- Throughout our visit we observed staff giving reassurance to patients with additional support given when it was required, especially if patients were anxious.
- In diagnostic and imaging, they had the support of a healthcare assistant who was able to provide chaperone and remained with the patient for as long as necessary.
- Clinical nurse specialist and physiotherapy staff provided emotional support for breast care patients as part of their ongoing care.
- Patients could be referred to psychologist if needed to promote emotional well-being. We observed staff explaining to patients about the care and treatment that would be undertaken in order to reduce any anxiety.

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Patients and relatives who we spoke with told us that staff were very supportive, and explained treatment plan, and equipment which helped to reduce their anxiety.

Are outpatients and diagnostic imaging services responsive?

Good 

By responsive, we mean that services are organised so that they meet people's needs.

We rated responsive as good.

- Services were planned and delivered to meet the needs of the local population. Patients could choose appointments which suited them.
- There was a service level agreement with the local NHS trust providing extra services and support. Patients were treated equally regardless of whether they were NHS patients or self-funded patients.
- The national standard for referral to treatment for patients to wait less than 18 weeks was consistently being met. Cancer waiting times for urgent referral appointments within 2 weeks were also being met.
- The service offered a one stop clinic for breast and dermatology care. The rapid access spinal pain clinic offered patients an appointment within a week which included diagnosis, expert advice and a treatment plan.
- Chaperone signs were displayed across outpatient and diagnostic imaging waiting areas. Staff told us this would be provided during consultation if requested.
- The service had information on how to raise concerns and procedures were followed to respond to any concerns raised.
- The radiology department saw a very low number of paediatric patients and there were no specialised facilities for them. There was limited facility for children in outpatient and other clinics.

However,

- There was no flagging system to recognise people with a learning difficulty. A senior staff confirmed this needed to be further developed.

Service planning and delivery to meet the needs of local people

- The hospital had service level agreements with the local NHS trust for acutely ill patients requiring intensive care treatment.
- Staff could refer patients with cancer to the specialist services of a colorectal nurse and Occupational Therapist (OT) and with the local trust's multidisciplinary team for cancer patients.
- The location at 13 Bath Road provided consulting rooms and a treatment room to support Dermatology, Cosmetics, Plastics and Maxillofacial clinics. This had created additional space at 22 Bath Road for the Ophthalmology clinics.
- The hospital used five commissioning groups within their local area. Quarterly review meetings were undertaken where contracts and other matters were discussed.
- In 2015, the hospital introduced a "One Stop Lesion" clinic. This had been set for self-pay patients with non-suspicious lesions enabling them to consult a plastic surgeon and reducing waiting time for the lesion to be removed as appropriate.

Access and flow

- The provider met the target of 92% of incomplete admitted patients (waiting times for patients waiting to start treatment at the end of the month). This related to patients beginning treatment within 18 weeks of referral in the reporting period between January- November 2015 and this ranged between 93-98% except for December 2015 at 91%.
- Between January-December 2015, the outpatient department at the Spire Dunedin hospital provided 2561 NHS funded new patient's appointments and 3982 follow ups. They also provided 8410 new appointments classed as other funded and 17492 follow up appointments.
- During the same period they saw 365 children aged between three to fifteen and 283 young adults aged 16-17 and the majority of their patients were adults.
- Waiting times for outpatient appointments were low as referrals were on demand, self and through patients own GPs.

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- Waiting times for patients once they have arrived in the department was well managed with the average waiting times of about 20 minutes. Patients were kept informed of any delays which staff said was infrequent.
- Cancer waiting times for urgent referral appointments within 2 weeks were also being met.
- Patients accessed services via a GP referral through the NHS Electronic -Referral Service, self-referral and self-funding or through their healthcare insurance.
- Patients who did not attend their appointments were contacted and given another appointment. NHS patients who did not attend were given two appointments and if they did not attend they were referred back to their GPs.
- Radiology received referrals from consultants, GPs for ultrasound and clear imaging. The waiting list for an MRI scan, unless urgent, was on average two weeks wait.
- The rapid access spinal pain clinic offered patients an appointment within a week which included diagnosis, expert advice and a treatment plan in two visits, and available within one week.

Meeting people's individual needs

- Care was tailored to meet individual needs. This included a one stop service clinic for dermatology and breast care. This is an effective way of performing all tests at the One Stop Clinic which could reduce the time to diagnosis making sure any treatment that is needed can be started straight away.
- The waiting rooms in outpatients and diagnostic imaging were spacious, bright with comfortable seating facilities with separate reception areas for OPD and radiology and physiotherapy.
- In all clinical areas there was adequate provision to maintain a patient's privacy and dignity. Doors to clinic rooms were always closed during patient's consultation to maintain privacy and confidentiality.
- Patients were offered appointment times after work and at weekends to fit around their personal and work lives. Patients were treated equally regardless of whether they were NHS patients or self-funded patients.
- For patients who were living with dementia, staff were able to seek advice and support and they had local dementia champions. There were 25 staff that had completed the "excellent course" for dementia care and

further training was planned for 2016. Patients had access to a dementia link nurses from the ward and they service had nominated dementia champions to support patients and staff.

- The service had level access and designated parking spaces for patients with limited mobility. There was changing room provision in the diagnostic and imaging department for wheelchair patients. The staff told us the computerised tomography (CT) scanner was suitable for bariatric patients. The hospital had another hospital in the group locally with an open scanner which was available for these patients if required.
- In radiology department there were good changing facilities and gowns were provided, for an X-ray and MRI to maintain patients' privacy.
- The departments' consulting and imaging rooms were accessible to patients with limited mobility's and wheelchair users.
- There was an interpreter service available for patients whose first language may not be English. At the reception desks there was a sign in four languages welcoming patients to the service. The interpreter service was available over the phone and could be in person if needed. Staff said the service was effective and easy to access.
- The radiology department saw a very low number of paediatric patients and there were no specialised facilities for them.
- There was limited facility for children in outpatient and other clinics.
- There was no flagging system to recognise patients with a learning difficulty. Staff said they were able to seek support from colleagues and this should be further developed as staff's knowledge was variable.
- The MRI scanner was accessed via the car park for patients with limited mobility and wheelchair users. However there was no toilet facility in the MRI unit. This impacted on some patients who needed to consume a large volume of water for certain procedure with no toilet facility available

Learning from complaints and concerns

- Patients we spoke with told us they had "no complaints" about the service and were confident to raise any issues either with the consultant or the nursing staff. Information on how to raise a concern was available in the waiting area.

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- Complaints were discussed at the quarterly governance meeting and at the quarterly Medical Advisory Committee meetings. Specific complaints were also discussed at the Clinical effectiveness and audit meeting. Compliments from patients' feedback were shared with the head of department or member of staff named to share with their team.
- We were unable to ascertain the number of complaints as data was not available in the outpatient department. However the manager told us they received few complaints and these were dealt with in line with the hospital's policy. These were mainly related to communication delays in clinics.

Are outpatients and diagnostic imaging services well-led?

Good 

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

We rated well-led as good.

- The leadership, governance and culture promoted the delivery of person centred care. There was a clear governance and risk management structure with defined accountabilities for assurance.
- Staff understood the hospital's vision and values, driven particularly by quality. Staff were focused on providing the best service they could for all patients whether they were self or NHS funded.
- The senior team were knowledgeable about their service issues and continually made plans to improve the service.
- The senior management team provided clear leadership and motivation to their teams.
- The service proactively engaged staff and the public to comment and be involved with the development of the service.

However,

- Senior staff were not consistently aware of incidents that had been reported in the outpatients department.

Vision and strategy for this this core service

- Staff understood the vision and strategy which was to deliver high quality care and promoting choices for patients. Staff were able to tell us of the '6 C's' which included care and compassion and these values were aligned to the hospital wide strategy and vision.
- The service was working to improve operational efficiency and increase margins.
- The outpatient department carried out pre-op assessments three days a week and need to increase to five days. This was impacted due to lack of staff and active recruitment was in progress to extend this service, including pre-op clinics in the evenings and weekends.

Governance, risk management and quality measurement for this core service

- There was a clear governance and risk management structure with accountabilities for assurance being well defined. There were various sub-committees in place, such as clinical audit and effectiveness committee which linked with the clinical governance committee and the Medical Advisory Committee (MAC).
- The MAC met quarterly and minutes showed discussions included key governance issues such as incidents, complaints and practising privileges.
- The MAC was involved in clinical performance matters. Matters raised at clinical governance meetings were taken to the MAC for consultation. A recent example was whether patients with suspected Cord compression should be admitted to the site when they required daily transfer for radiotherapy to the local NHS trust. The MAC decided that patients with suspected cord compression should not be admitted to Spire Dunedin.
- The Clinical Governance committee and the Clinical Effective Committee held quarterly meetings. Minutes were shared with member of the committee for cascading with their teams and also fed back at departmental meetings.
- The service carried out a number of audits as part of their performance monitoring. These included external audit from insurers, medical records, care pathways and consent to care and treatment. The last patients' consent audit achieved 100% compliance in October 2015. These showed consents to care and treatment were appropriately sought and the consultants and patients had signed the consent forms prior to surgery.

Outpatients and diagnostic imaging

- Diagnostic imaging services held monthly governance meetings. During these meetings radiation protection issues were discussed. Quarterly radiation protection meetings were held and the minutes from both meetings were disseminated to all staff by email. Staff told us that they felt they were kept up-to-date in relation to governance issues.
- Clinical risks were managed through clinical governance group and clinical effectiveness committee, audits and quality assurance activities. Risks were held on the site's risk register and were discussed at monthly governance meetings. For example the risks associated with patients attending cardiac clinics had been recognised and systems were in place. The risk register recorded action needed such as emergency cardiac arrest testing outside normal operating hours.
- Senior staff were unaware of incidents that had been reported in the outpatients department and were unable to provide us with how incidents were monitored and followed up. We were sent copies of incident reports after our inspection.

Leadership / culture of service

- All staff we spoke to across outpatients and diagnostic imaging told us they were proud of their teams and the support from colleagues was the main reasons they enjoyed working for the service.
- Most staff had been in post for a number of years and really felt part of the outpatients or diagnostic imaging team, as well as part of the hospital.
- There were clearly defined and visible local leadership roles on a hospital wide level and at a local level. Senior staff in diagnostic and radiology provided clear leadership and motivation to their teams.
- All staff we spoke with told us they were supported and they had good working relationships with their immediate managers. Staff said that senior managers were visible and they felt confident to approach them with any issues. The senior management team demonstrated a proactive approach to improving the services, as noted in the hospital business plan.

Public and staff engagement

- Patients were invited to respond to annual satisfaction survey. The Result from the BUPA annual survey which

was carried out between April and June 2015 showed that 100% of patients completing the survey rated Dunedin as excellent/very good for the overall care they received

- All staff were invited were asked to participate in an annual staff satisfaction survey. The survey for 2015 showed staff engagement was 73%, down 2% from the 2014 result. The key areas identified by staff as requiring development were understanding and communication between departments. Senior leaders had developed an action plan to address this. This included senior managers attending at least one departmental meeting, to raise issues and provide updates.
- The consultants' survey for 2015 showed 96% of Consultants felt that staff went out of their way to make a difference.
- The hospital sought feedback from referring GPs on an annual basis. The 2015 GP satisfaction survey showed 88% of referring GP's rated Dunedin as excellent/very good. 96% of GP's said they would definitely, likely/quite likely recommend Dunedin to colleagues.
- All staff received a quarterly newsletter from senior Spire group managers. The newsletter was focussed on maintaining open communication and management told us one of the challenges was keeping staff engaged with the changes in services to meet local demands. This was managed through regular communication with staff and any development in service planned.
- The staff survey also identified areas which needed to be improved such as communication from senior management and training. An action plan had been developed to address these issues. These included senior management attending at least one departmental team meeting and provide updates. A review of the induction training course was planned and this would include producing basic training manuals which would be accessible to all staff.

Innovation, improvement and sustainability

- All staff focused on continually improving the quality of care. The service was committed in developing the nurse led breast care service and the one stop ophthalmology treatment of Lucentis, for the treatment of patients with wet age-related macular degeneration.

Outstanding practice and areas for improvement

Outstanding practice

- The rapid access spinal pain clinic offered patients an appointment within a week which included diagnosis, expert advice and a treatment plan in two visits, and available within one week.
- The hospital hosted 'Bosom Buddies', a breast cancer support group for patients who received treatment at the local NHS hospital and Spire Dunedin. Breast cancer patients were given a card about a 'Bosom Buddies' support group at their diagnosis appointment from clinical staff.
- The hospital had a poster advertising the 'Latissimus Ladies Luncheon Club' which was set up and run by the hospital's former breast cancer patients. The Latissimus Ladies former patients offered to sit with current patients during chemotherapy or before and after surgery.

Areas for improvement

Action the provider SHOULD take to improve

- Systems are in place to review, update and monitor actions against known risks recorded on the risk register.
- Ensure risks are assessed, recorded and mitigated against consistently.
- Consistent medicines reconciliation across surgical and medical services.
- Ensure medication charts are consistent across the service.
- Patients have chaperones available to provide support in all clinics in outpatients as needed.
- All medicines fridges are locked in the outpatients department to prevent unauthorised access.
- Nursing staff are trained and follow guidelines to recognise female genital mutilation (FGM)
- All staff in the outpatients department are aware of the assessment tool in order to help identify a patient whose condition might deteriorate.
- Audits are developed in outpatient departments to include did not attend (DNA) and patient group directives (PGD) and incidents reporting.
- Continued progress of action plan to achieve Joint Advisory Guidance accreditation in gastrointestinal endoscopy.
- Ensure Duty of Candour is applied in line with requirements.