Spire Southampton Hospital

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
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 Southampton hospital is operated by Spire Healthcare Limited. The hospital has 67 beds which includes seven critical care beds. Facilities include six operating theatres, a seven-bed critical care unit, a six 'podded' oncology unit, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. We inspected surgery, medical care, critical care, services for children and young people, diagnostic imaging and outpatients services.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 16 and 17 July 2019. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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

Services we rate

Our rating of this hospital stayed the same. We rated it as Good.

We found areas of good practice across all services:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The hospital controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. Most staff managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it.
- Most managers monitored the effectiveness of the service and made sure staff were competent.
- Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, and most respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs. People could access the service when they needed it and did not have to wait too long for treatment.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.
- Most of the hospital services engaged well with patients to plan and manage services and all staff were committed to improving services continually.

We found areas of outstanding practice in services for children and young people:

- The service was proactive in developing resources which had been adapted by the provider and shared across the hospital group: for example, the fasting instruction cards. The latest innovation had been the 'app' to help children and young people prepare for their hospital stay. One member of the children and young people's staff team had been supported and encouraged to implement the 15 Steps process.

We found areas of outstanding practice in Surgery:

- The hospitals bariatric Tier three weight management service won a UK Association for the Study of Obesity best practice award in 2018.

However, we found areas of practice that required improvement in critical care

- Nursing staff in the critical care unit did not always follow the local safety standards or pathways for invasive procedures.
- There was lack of strong leadership of the critical care service to provide assurance the service was managing risks and delivering evidence based care and treatment.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notices that affected critical care services. Details are at the end of the report.

Name of signatory

Nigel Acheson
Deputy Chief Inspector of Hospitals (London and south)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (including older people's care)	Good 	Medical services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The service provided elective endoscopy, interventional cardiology procedures and oncology services. We rated this service as good because it was safe, effective, caring, responsive and well led.
Surgery	Good 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Staffing was managed jointly with medical care. We rated this service as good because it was safe, effective, caring and well-led.
Critical care	Requires improvement 	Critical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The hospital has a seven bedded critical care unit providing mainly level two with some level three care. The three level three beds are predominantly used for patients after cardiothoracic surgery. The four level two care beds for post-operative care are used for spinal and general surgery patients. In addition, there is one isolation room. We rated this service as requires improvement because safe, effective and leadership required improvement. Caring and responsive were good.
Services for children & young people	Good 	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, caring and responsive and well led.

Summary of findings

Outpatients

Good 

Outpatients were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good because it was safe, caring, responsive and well led. We did not rate effective.

Diagnostic imaging

Good 

Diagnostic imaging services were a small proportion of hospital activity.
The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as good. The service was caring, responsive and well led. However, improvement was needed in the safe domain. We did not rate effective.

Summary of findings

Contents

Good

Spire Southampton Hospital

Services we looked at

Medical care (including older people's care); Surgery; Critical care; Services for children & young people; Outpatients; Diagnostic imaging

Summary of this inspection

Background to Spire Southampton Hospital

Spire Southampton Hospital is operated by Spire Healthcare Limited. The hospital opened in 2007 and was registered with CQC in 2010. It is a private hospital in Southampton, Hampshire. The hospital primarily serves the communities of south Hampshire. It also accepts patient referrals from outside this area.

The hospital has had a registered manager in post since April 2017.

The hospital had a comprehensive inspection carried out in November 2016, following which it was rated as good overall. An inspection of the diagnostic imaging service was carried out in April 2019, following which a requirement notice regarding the governance of the diagnostic imaging was made.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, two inspection managers and eight specialist advisors with expertise in the core services inspected and leadership of healthcare services. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Information about Spire Southampton Hospital

The hospital has 67 inpatient beds provided across four inpatient wards, a critical care unit and day care unit. The hospital also provides an oncology suite (The Chalybeate Suite) consisting of eight recliner chairs. There are six operating theatres, an endoscopy suite and a cardiac catheter lab. The outpatient department includes 16 consulting rooms, three treatment rooms and a minor operations suite. Diagnostic imaging includes x-ray, ultrasound, digital mammography screening, computerised tomography (CT) and magnetic resonance imaging (MRI) scans. The hospital is registered to provide the following regulated activities:

- Surgical Procedures
- Treatment of Disease, Disorder or Injury
- Diagnostic and screening services
- Management of supply of blood and blood derived products

During the inspection, we inspected the following core services; surgery, critical care, services for children and young people, medical services (including oncology, endoscopy and cardiac catheter lab), outpatients and diagnostic imaging.

We spoke with 72 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 28 patients and seven relatives. During our inspection, we reviewed 43 sets of patient records.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times, and the most recent inspection took place in April 2019 which found that the diagnostic services at the hospital was not meeting all standards of quality and safety it was inspected against.

Track record on safety

- Two Never events
- Clinical incidents 1107 no harm, 223 low harm, 154 moderate harm, no severe harm, two deaths
- 168 non-clinical incidents

No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)

No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)

Summary of this inspection

No incidences of hospital acquired Clostridium difficile (c.diff)

Two incidences of hospital acquired E-Coli

111 complaints

Services accredited by a national body:

- UKAS Accreditation - Pathology
- SGS Accreditation - Sterile Services
- VTE Exemplar Status
- Macmillan / MQEM Accreditation - cancer care
- Bupa accredited bowel centre

Services provided at the hospital under service level agreement:

- Night security

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Are services safe?

Requires improvement 

Our rating of safe stayed the same. We rated it as **Requires improvement** because:

- On the inpatient wards, staff did not fully understand new systems and processes for completion of venous thromboembolism risk assessments and completion of ward controlled drug registers.
- In surgery there was a risk of injury to staff from the uneven flooring in the autoclave area and the flooring .
- The flooring in communal areas of inpatient wards and some clinical areas posed a risk to effective cleaning of those areas
- In the critical care service, there was a high dependence on the use of agency nurses which was above the national recommended rate for critical care units. There was a lack of assurance that agency staff working in the critical unit had completed an induction to the area they were working in.
- The critical care unit did not ensure infection risk was consistently well controlled. There was a risk that equipment that was not clean would be used in the care and treatment of patients. There was lack of assurance that the facilities and systems to care for patients with suspected communicable diseases were effective.
- Records in the critical care unit did not evidence consultants reviewed patients twice a day.
- in the diagnostic imaging service much of the imaging equipment was over ten years old. This increased the risk of equipment breakdown and poor image quality.

However,

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Except for some areas in surgical services, the hospital controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Summary of this inspection

- Except for the uneven flooring in the autoclave area, the design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration
- Patient records were clear, stored securely and easily available to all staff providing care.
- The service mostly managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.
- The service did not always have enough of its own substantive nursing and support staff. They relied on agency and bank nurses; however, all staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Are services effective?

Good

Are services effective?

Our rating of effective stayed the same. We rated it as **Good** because:

- Medical, surgery, children and young people, outpatients and diagnostic imaging services provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service adjusted for patients' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Summary of this inspection

- Medical, surgery, children and young people, outpatients and diagnostic imaging services monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

However,

- Nursing staff in the critical care unit did not always follow the local safety standards or pathways for invasive procedures.
- Other than for cardiac surgery, the leaders of the critical care unit did not use available information to benchmark their performance and patient outcomes against similar critical care units.

Are services caring?

Good

Are services caring?

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

However,

Summary of this inspection

- In the critical care unit staff did not always ensure bedside curtains were fully closed before providing care and treatment to patients.

Are services responsive?

Good

Are services responsive?

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.
- It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

However,

- Access to the children's spinal surgery services was temporarily suspended, due to lack of registered nurse children (RN Child).

Are services well-led?

Good

Are services well-led?

Our rating of well-led stayed the same. We rated it as **Good** because:

- Most leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

  • The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Summary of this inspection

• Staff felt respected, supported and valued, promoted equality and diversity in daily work and had an open culture where patients, their families and staff could raise concerns without fear.

• Most leaders operated effective governance processes and most staff at all levels were clear about their roles and accountabilities. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

• Most leaders and teams used systems to manage performance and risk. Risk registers were maintained with most of them reflecting most of the risks staff shared with us. They had plans to cope with unexpected events.

• The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure. Data or notifications were consistently submitted to external organisations as required.

• Leaders and staff actively and openly collaborated with partner organisations to help improve services for patients.

• All staff were committed to continually learning and improving services.

However,

- There was lack of strong leadership of the critical care service.
- There was lack of a governance structure to support monitoring and evidence of the critical care service performance.
- Processes to manage risks in the critical care service did not identify all risks expressed by staff and identified on inspection.
- There was no formal feedback processes to gain the views of patients to help improve the critical care service.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Diagnostic imaging	Requires improvement	N/A	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Good

Medical care (including older people's care)

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

Are medical care (including older people's care) safe?

Good

The hospital provided oncology, endoscopy and cardiac catheterisation services. We spoke with 10 members of staff. We spoke with five patients. We reviewed 10 patients records and five patient medicine charts.

Our rating of safe improved. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service provided mandatory training in key skills to all staff and worked hard to ensure they achieved compliance. Staff told us they were given time to complete their mandatory training and were prompted by senior staff to make sure they were up to date.

Mandatory training was monitored hospital wide on the clinical scorecard, this allowed for benchmarking across the Spire Healthcare Limited network. For quarter one 2019, the hospital was above the hospital target and on track with the Spire Healthcare Limited network.

Staff were expected to complete mandatory training in anti-bribery, health and safety, fire safety, information governance, manual handling, and safeguarding adults and children, infection control, equality and diversity and compassion in practice.

The hospital resident medical officers (RMO) were trained in advanced life support (ALS) and European Paediatric Advanced Life Support (EPALS) as a minimum. They were trained in safeguarding to level 3.For detailed findings on mandatory training, please see the surgery section.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff understood their responsibilities and adhered to safeguarding policies and procedures, including working in partnership with other agencies. In every department, staff had access to relevant contact details of people within and outside of the trust who they could approach for additional advice. Staff described how they would identify adults and children at risk of, or suffering, significant harm and when they would make a safeguarding referral.

Safeguarding adults and children level 2 had been completed by 100% of staff on oncology, endoscopy and the cardiac catheter laboratory services.

For detailed findings on safeguarding, please see the surgery section.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

There were hand sanitiser gels available for staff to decontaminate their hands in the clinical areas. The practice we observed showed staff on the wards and in the

pre-operative assessment clinic decontaminated their hands in line with World Health Organisations (WHO) Five moments of Hand Hygiene (2009). All the patients we spoke with on the oncology unit told us they saw staff decontaminate their hands before and after patient contact. All clinical areas reported on hand hygiene compliance as directed by Spire Healthcare Limited's hand hygiene policy.

Hand hygiene audits had shown a 98% compliance rate. This was better than the hospital's compliance target rate of 95%.Staff were expected to attend infection prevention and control training yearly as part of their mandatory training programme. In oncology, endoscopy and cardiac catheter laboratory services, 97% of staff had completed this training.

Staff followed a cleaning schedule and maintained a record providing assurance of cleanliness. The endoscopy unit's cleaning checklists showed full compliance on days endoscopy was open. The oncology department had documented evidence of weekly cleaning. There was documented evidence of daily cleaning checks.

Clinical staff adhered to the 'bare below the elbow' policy when providing care and treatment. The hospital assured themselves of compliance with good hand hygiene practice through quarterly audits, which involved checks on usage of hand gel. This audit consistently met the hospital group target from January 2019 to June 2019.

The hospital scored 100% for cleanliness, compared to the national average of 98%, for the patient-led assessment of the care environment (PLACE) audit carried out from February to June 2018 The hospital had policies and procedures to manage infection prevention and control. Staff were able to access the relevant policies and procedures. We saw in date policies and processes for the management of waste and decontamination that reflected current national guidance.

For detailed findings on cleanliness, infection control and hygiene, please see the surgery section.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The facilities, environment and equipment were well maintained across all the departments we visited. The servicing of equipment was tracked and logged electronically, and recent work had been done to improve this IT system. We examined eight items of equipment. All had stickers which identified the last service date had been within a year and when the next service was due. The 'management of endoscopes' risk assessment was up to date.

The endoscopy decontamination area had the single sinks for washing and rinsing endoscopes. The endoscopy lead said that a previous problem with the ventilation in the theatre where endoscopy procedures took place had been corrected.

The service met the standards set by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. It had the necessary number and size of endoscopes and this enabled the scheduled endoscopy lists to proceed uninterrupted.

Maintenance and repair contracts were in place for endoscopes, a machine that processed the water for rinsing, the washer disinfector and drying cabinet. We saw maintenance records were up to date during our inspection. The service undertook an 'annual health check' for the endoscopes.

Staff told us that if the endoscope washer broke down, the company was responsive. They gave advice over the telephone or came out to repair the equipment that day or the next day.

Patients in the oncology unit had access to scalp coolers, and staff were trained to use this equipment.

There were resuscitation trolleys outside the endoscopy unit, in the cardiac catheter laboratory, and the day admission ward. Records showed that the trolleys were checked daily to ensure the contents were complete and in date. Both trolleys had tamper evident tags to prevent access by unauthorised personnel.

There was enough equipment in the cardiac catheter suite, and items had labels reflecting when they were last safety tested. The theatre manager explained that larger specialist equipment in the cardiac catheter laboratory was serviced by a contractor under servicing arrangements.

Sharp instruments were managed safely. We checked sharps containers across all areas we inspected and saw all

were stored correctly and safely. Sharps bins were correctly assembled signed and dated in line with HTM 07/01. Sharps were managed in line with EU/2010/32, prevention of sharps injuries.

Sluices on wards had locks to control entry and all were locked. Inside all the sluices were locked cupboards, which contained hazardous cleaning chemicals (COSHH) and were therefore not accessible by the public.

Fire extinguishers on the oncology ward had all been checked within the last three months and we saw clear signage for the fire exits which were easily accessible and free from clutter.

Consumable equipment, for example, syringes, needles and dressings, were managed to maintain cleanliness and efficacy. The consumable items we checked were stored in unbroken packaging and were within their expiry date.

Waste was managed well. In all areas we inspected staff complied with the Department of Health, Health Technical Memorandum 07/01, safe management of healthcare waste (2013). All waste was segregated in different coloured bags and posters were displayed explaining which item went into which waste stream.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff reviewed and managed individual patient risk. Patients attending for an endoscopy, oncology or a procedure in the cardiac catheter laboratory were asked to complete a pre-assessment health check questionnaire. A registered nurse checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for the planned procedure. The assessment nurse advised of any medical risk factors that the consultant would need to be aware of, so they could revise the treatment plan if required.

The medical and nursing staff in endoscopy completed a 'five steps to safer surgery' checklist in endoscopy and the cardiac catheter laboratory. This is a recognised system of checks before, during, and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed staff performing the checklist correctly during our visit. Hospital observational audits, which were undertaken in endoscopy, showed 100% compliance with safer surgery checklist from January to June 2019.There was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response. All people admitted acutely were regularly assessed using the National Early Warning System 2 (NEWS). This system was based on a simple scoring system in which a score was allocated to physiological measurements undertaken when patients present to or are being monitored in hospital. We reviewed five NEWS 2 observation charts and saw none required escalation. Medical and nursing staff were aware of the appropriate escalation action to take if a score indicated a patient deterioration.

All staff were aware of the sepsis six protocol and had received training as part of their mandatory training. The resuscitation lead was the lead for sepsis and had provided wards with a sepsis box, this contained information and vital equipment to hand during an emergency. All the staff we spoke with knew where this box was kept.

If staff in the endoscopy operating theatre, the cardiac catheter laboratory, or the oncology service required extra assistance urgently, they used emergency call systems to summon assistance.

The nurses completed an oncology nursing assessment, as part of a specifically designed care pathway, for oncology patients. Patient assessment included information about the risks of chemotherapy, and how these risks were managed.

Oncology nurses provided patients with information on discharge, should they have any concerns when not attending for treatment. Patients received a wallet sized card with contact telephone numbers in and out of hours. The card also gave clear advice to patients. This included helpful information to have when calling the hospital and information about symptoms related to their treatment.

There were no patients having procedures when we visited the cardiac catheter laboratory. However, we saw audits on the 'five steps to safer surgery' checklist which showed observed practice was safe.

The chemotherapy unit provided a 24 hour telephone advice service which was always staffed by the hospital's oncology nurses. We saw the telephone triage tool that was used which was based on UK Oncology Nursing Society (UKONS) recognised guidance designed to promote safer

decision making. Patients were advised to contact the 24 hour line for any queries and concerns. Staff told us that this meant that in an emergency if a patient was unable to get through to the 24 hour line they would still be able to receive an appropriate assessment.

Nurse staffing

The service did not always have enough of its own substantive nursing and support staff, they relied on agency nurses. However, all staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave agency staff a full induction.

Staffing featured highly on all the departments risk and the hospital risk register due to a national shortage of staff. Substantive staff employed by the hospital included permanent and bank nursing staff. Bank and agency staff were frequently used to provide flexible and safe staffing levels It was decided that long term agency would be used, and they would receive a full induction on to the wards and be fully integrated as part of the team.

There was good oversight of staffing across the departments, the hospital used a safer nursing care tool. This tool ensured that the hospital had the right staff with the right skills in the right place. The tool enabled staff to assess patient acuity and dependency and use this information to ensure there were enough staff members to meet patient needs.Staffing requirements were addressed daily. Each morning at the safety huddle, staff and the deputy matron discussed and documented the staffing requirements. A traffic light system of red, amber and green (RAG) was used to identify the level of staffing in place. Any amber or red triggers would be escalated to the senior management team huddle at 10am each morning where they took measures to reduce these to green. Any red escalations were reported on the electronic incident system as a 'red flag staffing events'.

There were four registered nursing staff working in the endoscopy service, which included the endoscopy senior nurse and one healthcare assistant specifically dedicated to supporting gastrointestinal endoscopy procedures. The endoscopy lead nurse confirmed the staffing skill mix and competencies were appropriate and were as planned for the endoscopy procedure lists that were scheduled. There had been no gastrointestinal endoscopy lists cancelled due to not having enough appropriately skilled staff.

There were four registered nurses the oncology team. Two chemotherapy-trained nurses were always on a duty when a patient was booked for a chemotherapy treatment. The cancer services lead confirmed the skill mix and competencies of staff enabled the needs of patients attending the unit to be effectively met. We spoke with a bank nurse that could demonstrate competence and skill to support oncology patients.

Two cardiac nurses and a cardiac radiographer formed the permanent team in the cardiac catheter laboratory. The cardiac nurses advised if other staff were needed for a cardiac catheter laboratory procedure staff would be planned according to the procedure.

For detailed findings on nursing staffing, please see the surgery section.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted levels of resident medical officers to meet the required skill mix and gave agency resident medical officers staff a full induction.

There was one lead full time resident medical officer (RMOs) and two further RMOs who worked regularly at the hospital. Two bank RMOs who had previously been employed by the hospital covered any gaps. If agency RMOs were required, the hospital used a recognised agency who ensured the required competencies and training had been completed.

Senior staff in endoscopy, the cardiac catheter laboratory, and oncology advised us that all the consultants also carried out work in the NHS. Clinical care was booked according to consultant availability.

For detailed findings on medical staffing, please see the surgery section.

Records

Good

Medical care (including older people's care)

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. We reviewed patient records and found there was a good standard of record keeping. All paper records were legible, contemporaneous, and signed. Management plans and daily ward rounds were clearly documented, and evidence of escalation and NEWS 2 recordings were clear.

We reviewed 10 patient records in endoscopy, five on cardiac catheter lab and five in oncology. Nursing and medical staff had completed accurate, legible records, which were up to date and stored securely.

The hospital undertook a health record keeping standards audit of 20 patient records every quarter in the day care unit. The compliance results had ranged from 95% to 100% from April to June 2019.We reviewed three of the cardiac catheter laboratory sets of records and found that patients admission observations were documented.

The patients being admitted for a cardiac catheter or an endoscopy procedure completed the 'assessing you for admission form', which the nurse then reviewed. Nursing staff then completed the appropriate patient pathway.

Endoscopy staff kept electronic tracking and traceability records of the endoscopes

Medicines

The service used systems and processes to safely prescribe, administer, and store medicines.

Patients attending the oncology day unit received intravenous chemotherapy, the hospital had systems to manage the medication for this process. This included two registered nurses always being on duty when chemotherapy was administered. There was a dedicated chemotherapy medications chart for prescribing and recording administration of medication.

We reviewed the storage of controlled drugs (prescription medicines that are controlled under Misuse of Drugs legislation). Within the oncology unit, endoscopy and cardiac catheter laboratory, controlled drugs were transported and stored securely and were administered with records kept according to legislative requirements.

However, although meeting legal requirements, the recording of controlled drugs on the ward where medical patients were sometimes cared for, was not always fully completed. Staff told us the hospital had recently introduced this new style controlled drug register onto the wards. They explained this had been introduced with no training, support or guidance provided to staff about how to complete the record. Following the inspection, the hospital told us that for the purpose of the ward controlled drug record, only the supplied section was required to be completed, which was in line with legal requirements and the hospital's medicine management policy. The other sections being only relevant to theatres where the same style controlled drugs register was used. The hospital told us that they would replace the ward controlled drug register for a register that met the need of the wards.

Patients receiving chemotherapy treatments are at higher risk of neutropenic sepsis. Staff had access to an algorithm based on NICE guidelines on the treatment of neutropenic sepsis, this included timeframes for antibiotic administration.

A patient having an endoscopy, or a procedure in the cardiac catheter laboratory, may have the procedure carried out under sedation. Endoscopy and cardiac catheter laboratory staff ensured medicines were available in case a patient had an adverse reaction to sedation. In the oncology unit, emergency medicines, including extravasation kits were available for use. An extravasation kit is equipment used to remove an intravenous (IV) drug or fluid that has leaked from a vein into the surrounding tissue. Extravasation kits were in date. Staff were aware of the procedure for managing extravasation and the procedure to follow.

Anaphylaxis kits, for treating a severe allergic reaction, were available on the day care unit that was accessible to both endoscopy and oncology. The kits had the contents clearly marked and were in date.

Chemotherapy spillage kits were available in the oncology department. A senior nurse in oncology also showed us spillage kits that were given to patients for use at home, in case of a spillage.

Medicines were stored in locked cupboards. Medicines that required temperature-controlled storage were stored in a locked fridge. During our inspection, we saw that minimum and maximum temperatures of these were checked and

recorded. These checks were not carried out daily, but when there was an endoscopy or cardiac catheter laboratory list. When we checked the recordings, they were all within the acceptable range. Staff were aware of actions to take if temperatures were not within the minimum and maximum range, and there was guidance on the record sheets.

Policies and procedures were available and accessible to staff. Policies viewed as part of our inspection were in date and in line with best practice and national guidelines. Staff completed VTE assessments on the patients' care pathway documents according to Spire Healthcare Limited's policy. However, VTE assessment was also included on recently introduced prescription charts. The hospital told us these were not required to be completed. The provider had recognised having two systems had the potential to cause confusion and the VTE risk assessment on the prescription chart was being reviewed to consider whether it should be removed from the prescription chart.

For detailed findings, please see the surgery section.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

During the period of April 2018 to March 2019 the hospital reported a total of 1486 incidents, 168 non clinical incidents and 26 surgical site infections. We did not ask the provider for a breakdown of these figures to indicate how many or if any of these incidents had occurred in the medical services.

Managers on the wards and across the departments told us they investigated incidents and shared lessons learned with teams and the wider service. We saw how information was cascaded from senior levels through to teams on the wards by newsletters and minutes of governance and departmental meetings. This reflected what staff reported to us on the wards, in the pre-operative assessment unit, interventional radiology and theatres.

Staff said they felt encouraged to be open and honest and to report incidents. Staff told us how they reported, and they received feedback from incidents they raised via safety briefings, theatres briefings and newsletters.

For detailed findings on incidents, please see the surgery section.

Are medical care (including older people's care) effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

Overall, the service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Patients received care in line with the national guidance. Patients received care in line with National Institute for Health and Care Excellence (NICE) guidance. Staff completed VTE risk assessments in the patient records.

The oncology unit had been awarded the Macmillan Quality Environment Mark (MQEM) in 2014 and reaccredited in 2017, a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. The MQEM recognised that the hospital provided a welcoming and comfortable environment for people with cancer. It also acknowledged that the oncology unit respected privacy and dignity for patients and those close to them, and that the facilities helped improve well-being. Staff provided care that took account of National Institute for Health and Care Excellence (NICE) guidelines and best practice. For example, the hospital used the national early warning system (NEWS2) to assess and respond to any changes in a patient's condition, in line with NICE guidance CG50.

The endoscopy service was actively working towards Joint Advisory Group (JAG) accreditation. The hospital had recruited a senior staff member with experience in JAG accreditation. The service had been assessed against the JAG global rating scale (GRS). The GRS is a quality

improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. The latest action plan (April 2019) highlighted the department had 14 outstanding indicators from a list of 160 indicators.

Staff booked procedures in line with British Society of Gastroenterology (BSG) guidance. This meant that enough time was given for each procedure to be carried out to ensure that staff did not fail to detect abnormalities.

The oncology unit and the cardiac catheter laboratory followed best practice guidance in the care of their patients using NICE guidance. A clinical review undertaken by Spire Healthcare Limited in May 2019 confirmed the hospital complied with the neutropenic sepsis policy.

Patients who required the insertion of catheters and vascular access devices had their risk of infection assessed according to standards in NICE QS61 Statement 5: Vascular access devices and statement 4: Urinary catheters. Staff used 'care bundles' which directed staff in the completion and documentation of specified procedures. These steps were necessary for the safe insertion, maintenance and removal of the device when no longer needed, which when performed collectively and reliably, had been proven to improve patient outcomes.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Patients due to attend for gastrointestinal endoscopy, were given detailed advice on how to prepare for the procedure that included administering a laxative and advice regarding dietary and fluid intake.

The hospital advised patients they could have clear fluids up to two hours before their admission time. The sister on one of the wards explained how staff would liaise with the anaesthetist for a list if there were delays, to ensure any patient was not without fluids for several hours.

Following a procedure in endoscopy or the cardiac catheter laboratory, staff offered patients a drink and light snack prior to discharge. There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets, including religious and cultural diets.

The chef visited patients in the oncology unit to discuss their dietary needs if required.

The patient led assessment of the care environment (PLACE) in 2018 rated the quality of ward food as 100%, this was above the England average of 90.3%. The patients we spoke with had been happy with ward food Hydration scores were audited quarterly the hospital shared with us during quarter one, 2019 compliance was 85%, which was above the hospital target of 65% and above the Spire Healthcare Limited network which was 58%. Patients were asked for feedback on the quality of food, results from April 2019 showed an 84% positive feedback from patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management to ensure following surgery patients were given effective pain relief. Staff told us they would access the acute pain analgesic ladder for patients which offered advice on appropriate analgesics in relation to an individual pain score. A patient in oncology told us that at one point they were uncomfortable, they alerted staff that helped to change their position, and the pain was reduced. Patients completed an inpatient survey and were asked if they thought hospital staff had done everything to control their pain. The hospital provided us with data which showed during quarter one 2019, 80% of patients responded 'a great deal' to pain being managed (where the patient had pain to manage).

Staff offered patients undergoing a gastrointestinal endoscopy a throat spray to reduce discomfort and or intravenous sedation, to minimise any discomfort or pain. Medical staff also performed gastrointestinal endoscopies under a general anaesthetic where appropriate.

Medical staff performed colonoscopies under intravenous sedation, to ensure a person was relaxed and comfortable during the procedure.

In the cardiac catheter laboratory interventions were performed with a local anaesthetic and/ or under sedation or a general anaesthetic.

Good

Medical care (including older people's care)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The hospital had an audit schedule which identified when audits were required. The schedule outlined if an audit was organisationally or externally required, a recommended audit or stipulated as required in a Spire Healthcare Limited policy.

Local audits were managed by the hospital at a local level and all audits were discussed when relevant at the monthly clinical effectiveness meetings. Minutes from the meeting were shared during the Governance meetings.

The clinical scorecard enabled the hospital to benchmark its clinical performance indicators against other Spire Healthcare Limited hospitals. The scorecard compared the audit result to the hospitals target, Spire Healthcare Limited network results, the previous quarters score and if the service/audit had improved.

The scorecard included all the hospital activity and was presented under the CQC domains of safe, effective, caring, responsive and well led. This was easy to read, and we saw how these were displayed on the wards, therefore at a glance staff could see their performance. The provider also had a quarterly cancer dashboard which reported audit results and benchmarked similar cancer services across the Spire Healthcare Limited Group. This ensured that relevant and specific outcomes and clinical standards were being regularly reviewed. We reviewed the clinical scorecard for quarter one, 2019 which had 47 categories over the five domains, 27 of which had either stayed the same or improved, 14 had achieved a lower score since the last quarter, and three were new categories and had not been rated.

Oncology patients were discussed in a multidisciplinary 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 as patients returned for review and further chemotherapy treatment cycles, that was recorded in patient medical notes.

Cardiology procedures include coronary angiography, cardiac electrophysiology and cardiac device implantation (including pacemakers and defibrillators). There were no percutaneous coronary intervention (PCI) performed at the hospital. The clinical service manager registered cardiac ablations (a treatment that aims to control or correct certain types of abnormally fast heart rhythms) undertaken in the cardiac catheter laboratory with the National Institute for Cardiovascular Outcomes Research (NICOR).

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Medical staff performed endoscopy procedures, supported by nurses with specific endoscopy skills. Staff working in endoscopy were competent in various aspects of endoscopy including supporting the patient through a procedure, management of specimens and the decontamination of endoscopes.

Staff working in the cardiac catheter suite laboratory had undertaken specific training. This included a competency that detailed the care of a patient in the cardiac catheter laboratory before, during and after the procedure.

Staff working in oncology had completed specific competencies including the care and management of central venous access devices to administer chemotherapy and aseptic technique. Nursing staff in oncology updated their knowledge about the administration of chemotherapy medications annually which had been valuable for their practice. They shared this best practice knowledge with all oncology staff.

Staff working across the medical services confirmed they had regular supervision meetings with their line manager and received an annual appraisal.

Consultants and anaesthetists worked under a practising privileges agreement, which gave them the authority to undertake private practice within the hospital. Granting and maintenance of practising privileges was governed by the Consultant Handbook (Clinical Policy 16).

Practising privileges were formally reviewed every two years. This review considered compliance with the consultant's agreed scope of practice, satisfactory participation in annual appraisal and processes required

for revalidation, and compliance with the Consultants' Handbook. This process also includes consideration of feedback from key staff across the hospital, known as 'soft intelligence' and a review of any incidents and complaints.

For detailed findings on competent staff, please see the surgery section.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

There was effective multidisciplinary team (MDT) working in oncology, the cardiac catheter laboratory and the endoscopy unit. During our inspection, the administrative, pre-assessment, endoscopy, oncology, and cardiac catheter laboratory medical and nursing staff worked well together to ensure the patient pathways were effective.

The cancer services lead advised us that all oncology patients having chemotherapy treatment, had options discussed at a cancer multidisciplinary team meeting. The hospital audited their compliance with all patients being discussed at a cancer MDT meeting, and from January to June 2019 this achieved 100%. The hospital also included audit of compliance with evidence of MDT in the patient records. The hospital results were 100% compliance from January to March 2016, and 95% compliance from April to June 2019.

The medical staff liaised with colleagues in the NHS, if the findings following endoscopy procedures indicated that further medical treatment would be required.

Staff at the hospital worked alongside local GPs to share and invest in learning. 'Hot Topics' that local GPs wanted training on were now delivered alongside a GP monthly newsletter.

Seven-day services

Key services were available seven days a week to support timely patient care.

For patients who were receiving chemotherapy there was seven-day support available through a 24-hour contact number staffed by the senior nurse on duty at the hospital, if patients wanted to discuss or report any adverse side effects.

Patients could phone the oncology and endoscopy staff for advice at any times, and they could contact the consultant via their secretary if required.

For detailed findings on seven-day services, please see the surgery section.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

There were health promotion and awareness information leaflets displayed around the hospital. These were Spire Healthcare Limited's own information and information from other health charities.

For detailed findings on health promotion, please see the surgery section.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff acted within the legal framework to obtain patient consent for treatment. Written consent was completed pre-operatively in the endoscopy and oncology units and verbally checked again on admission. We observed how staff explained what they were going to do and obtained verbal patient consent for the care and treatment they provided therefore fully involved patients in their care.

Patients and their relatives/carers living with dementia, learning disabilities or autism were given extra time during the pre-admission process to make sure the correct consent was obtained. For those rare patients who attended the hospital without capacity, staff followed procedures to obtain consent. The registered nursing staff we spoke with were knowledgeable about using the deprivation of liberty safeguards (DoLS).

Are medical care (including older people's care) caring?

Good

Medical care (including older people's care)

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed all staff were caring and compassionate to their patients' needs. Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.

We saw examples of staff taking measures to ensure patients' privacy and dignity were respected.

We saw how staff took the time to interact with people who used the services and those close to them in a respectful and considerate way in oncology. Staff introduced themselves by name and explained to patients what their roles were. We observed multiple examples of staff engaging in conversation with patients and relatives. Patients told us staff addressed them by their preferred names and showed interest in what was being discussed.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. We saw how patients had time to ask staff questions and how staff took the time to answer all their questions and alleviate concerns. We spoke with five patients and they all spoke highly of the nursing staff and how they had helped them during their visit.

Patients, particularly in oncology, described how they felt emotionally supported. A breast care specialist nurse was available if needed. One patient said, 'a nurse was waiting for me after my first chemotherapy session because she was concerned how I coped. That was just the right thing for me to have."

If a consultant found a cancer following an endoscopy, patients were referred to the NHS, where clinical nurse specialists provided emotional support for patients as part of their ongoing care.

An oncology patient told us how they had been anxious about their treatment and the oncology staff spent considerable time with providing them with assurance. They told us that "it felt as if I was being cared for by a member of my family."

The hospital had a sacred space for patients, relatives and staff to access. This was a light and airy room which was in a quieter area of the hospital. This had prayer books and equipment to support prayer for various denominations. Access was 24 hours a day.

Patients also involved their close relatives, as they wanted to. The relatives we spoke with also felt well informed and cared for by staff, and able to support their loved ones.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients told us staff were always willing to spend time to explain their care, treatment and condition and any advice given. Patients explained what treatment they were receiving and were happy that the doctors and nurses kept them up to date with their treatment plan.

We observed signs prompting patients to request a chaperone if they would like one present when examined. We saw in a set of oncology records we reviewed, that a request for a chaperone had been met, and staff had documented this.

Patients were provided relevant information about their condition and treatment. Patients in the oncology unit stated staff kept them informed about their care, involved in any decision-making, and listened to them.

For instance, patients receiving chemotherapy treatments were advised of the risk of neutropenic sepsis (due to a temporary reduction of white blood cell count during treatment) and given information to allow them to recognise any signs or symptoms of sepsis after treatment.

Good

Medical care (including older people's care)

Patients undergoing an endoscopy procedure were provided with relevant information by staff, both verbal and written, to make an informed decision about their care and treatment.

The oncology lead told us there was a charitable organisation that provided breast cancer support including therapies such as massage and acupuncture. We spoke to two patients who had accessed the service and found it "enormously beneficial."

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Are medical care (including older people's care) responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital provided elective medical (endoscopy and cardiac catheter laboratory) procedures to NHS and private patients, with oncology service provided for insured and self-pay patients only.

The hospital worked with the local clinical commission groups (CCGs) and the local acute NHS trust to plan services to meet the needs of the local population.

The CCGs monitored the hospital's performance for NHS patients at quarterly contract meetings. The hospital had an admissions and discharge policy which was version controlled and in-date. This detailed the criteria for NHS patients that could be safely treated at the hospital. These criteria had been agreed with the CCG that commissioned NHS care at the hospital.

The hospital pre-planned all admissions to allow staff time to address any issues that may be identified for further investigation.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Patients received information relevant to their procedure prior to their attendance. For example, the information about gastroscopy included preparation and time to arrive, the two ways the procedure could be performed, the examination process and after care. For a colonoscopy, the information included guidance on preparation, arrival time, the procedure and aftercare.

Patients day procedure pre-admission questionnaire included an assessment of people's individual needs, which included a question to check if any additional support was needed, to support effective communication and understanding. Staff told us they would explore with patients further if a need was identified.

Staff in oncology showed us the chemotherapy pathway, which also included a prompt for staff to ask a patient if they had any special needs or disabilities.

Staff offered breast cancer patients 'breastacise' classes with one of the specialist physiotherapists. This treatment was offered at a different Spire Healthcare Limited location in the local area.

Staff offered patients finishing chemotherapy the opportunity to attended conditioning classes at a different Spire Healthcare Limited location, to promote fitness levels after treatment had finished.

The oncology lead consultant explained if patients became palliative, staff would refer them to the local hospice team. If patients deteriorated rapidly, end of life care could be provided at the hospital.

Good

Medical care (including older people's care)

Staff in the medical service understood the needs of people with dementia, and there were dementia champions on the wards to support staff and patients as needed.

Staff told us that a professional interpreting service was available at the hospital if required. The interpreting service was also able to produce reading material in braille and provide sign language interpreters and pictorial information on request.

Although at the time of our inspection the hospital did not have a dementia strategy, staff did have access to a dementia lead nurse. Staff we spoke with were aware of and had access to resources to make reasonable adjustments for patients with additional needs. Staff could also use a 'dementia box' which had specific items that may provide comfort to a patient in an unfamiliar environment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Waiting times from referral to treatment and arrangements to admit, treat and discharge NHS patients were monitored by the NHS trust and were in line with 18-week targets. Private patients did not have their waiting time or referral to treatment monitored.

NHS consultants referred oncology patients to the hospital following diagnosis at an NHS hospital. A patient could have a chemotherapy treatment from Tuesday to Friday. There was no waiting list for this treatment.

The cardiac catheter laboratory only undertook planned, non-emergency procedures. A named hospital consultant cardiologist, or a consultant interventional radiologist, booked patients for the appropriate procedure following assessment in outpatients.

Following a GP referral for an endoscopy procedure, consultants saw patients in the outpatient department. They checked patients met the admission criteria, carried out assessments and discussed a plan of treatment. This meant staff could plan the flow of patients. Consultants carried out endoscopy procedures within two to four weeks of referral to the hospital.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The hospital director was responsible for overseeing the management of all complaints received by the hospital with clinical complaints overseen by the matron. The day to day administration and investigation of complaints was delegated to the complaints co coordinator. The complaints coordinator worked with the relevant head of department, senior manager or consultant to ensure a thorough investigation was carried out once a complaint was received to address the patient's concerns.

New complaints were escalated to the senior management team and were reviewed by senior managers during the investigation and resolution stages. Complaints were signed off by a senior manager who was responsible for writing to the patient.

Complaints were discussed at the hospital management team meeting (HMT) meeting. We reviewed the minutes for these meetings and saw how complaints were part of the standardised agenda. During this meeting a presentation was given on total numbers and themes.

During the reporting period of April 2018 to March 2019, there had been 111 complaints reported to the hospital.

For detailed findings on learning from complaints and concerns, please see the surgery section.

Are medical care (including older people's care) well-led?

Good

Our rating of well-led stayed the same. We rated it as **good.**

Leadership

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good

Medical care (including older people's care)

Each medical service, oncology, endoscopy and cardiac catheterisation had a dedicated member of staff to manage the day to day running of the service. The medical services were mostly led by a clinical services manager who reported to the deputy matron who in turn reported to the matron. The oncology service was led by the cancer services lead, who reported directly to the deputy matron.

Department leaders were visible and approachable. Staff in the oncology, endoscopy and cardiac catherisation lab spoke highly about their leaders. They said they were supportive and would try to address any problems highlighted by staff and escalated them to the senior leadership team when appropriate. Staff were supported by the local and hospital leadership to develop their skills. Leadership training was provided, and staff were supported to attend training and conferences relevant to their area of work.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a local vision which reinforced the Spire Healthcare Limited's vision, this was to be a 'A regional centre of excellence in private healthcare provision.' This vision was underpinned by a strategy which aimed to deliver clinical excellence.

Staff working in the medical services demonstrated their commitment to the hospital vision, by working to improve the performance of their individual units. The endoscopy service was continuing to work towards achieving JAG accreditation. The oncology service was committed to retaining its accreditation of the Macmillan Quality Environment Mark (MQEM) that it initially achieved in in 2014 and retained in 2017. The recently appointed manager in the cardiac catheter lab was introducing process to make the service run more effectively.

Staff appraisals considered objectives linked to the hospital strategy, hospital targets, departmental improvements and targets. Staff were also measured against how well they demonstrated the hospital values and behaviours.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were proud to work at the hospital and in general whilst there were some frustrations there was nothing that really worried them.

The culture across all the areas of the medical service was centred on the needs and experience of people who used the services. Staff of all levels showed patient care and treatment was a priority and told us they wanted to provide the best possible service.

There was a culture of openness and honesty amongst the staff we spoke with across the whole medical services. Staff we met said they liked working at the hospital and felt they all had good teams of colleagues who were supported by their line managers.

The hospital had a freedom to speak up guardian. All staff we spoke with knew who the hospitals freedom to speak up guardian was and how to contact them.

Staff did not receive training on the duty of candour as part of the mandatory training requirements. However, the hospital told us that they gave all staff training packs about their responsibilities towards the duty of candour legislation. All staff we spoke with could tell us about being open and honest when things went wrong.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework included a network of meetings and working parties. Senior staff told us this ensured safe delivery and effective oversight of the clinical and non-clinical services in the medical services with a clear flow of information. Managers described the governance framework and how the information flowed two ways from staff to the senior management team and back.

Good

Medical care (including older people's care)

Each service held departmental meetings, during which staff said they discussed performance, identified areas for improvements and planned the actions to take to bring about improvements. Our review of records of these meetings showed staff reviewed risks, incidents, complaints and compliments, audits and the actions taken in response to these.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were standardised processes across the hospital for the management of risks. Each department carried out risk assessments for all aspects of the delivery of the medical services. Following set criteria, risks of a pre-determined level were escalated to the risk manager for consideration to be added to the hospital wide risk register. This meant high level risks were monitored by the hospital management team, but lower level risks were managed by the staff delivering the service.

Staff had a good awareness of the various risks for each medical service and the action being taken to reduce the level of risk. Our review of department meetings showed risks were reviewed during these meetings.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had access to the information they required to manage their staffing to ensure they could meet the needs of the services.

The service collected and collated patient feedback information and had access to safety information, complaints and incidents to inform assessment of the quality and the management of risks in their service.

Engagement

Leaders and staff actively and openly engaged with patients, staff to plan and manage services.

The service used several methods to engage with and seek feedback from patients. This included comment cards and the use of the friend and family test.

Staff were encouraged to provide feedback and were listened to. Staff said they had confidence their managers listened to their views and used their views and opinions to make improvements to the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The endoscopy service was continuing to work towards achieving JAG accreditation. The endoscopy service had supported a new, less invasive bariatric procedure to support obese patients to lose weight. The new lead for the cardiac catheter lab was working to streamline process to improve the effectiveness of the service.

Good

Surgery

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

Are surgery services safe?

Good

Our rating of safe improved. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The service provided mandatory training in key skills to all staff and worked hard to ensure they achieved compliance. Staff told us they were given time to complete their mandatory training and were prompted by senior staff to make sure they were up to date.

Mandatory training was monitored hospital wide on the clinical scorecard, this allowed for benchmarking across the Spire Healthcare Limited network. For quarter one 2019, the hospital was above the hospital target and on track with the Spire Healthcare Limited network.

Staff were expected to complete mandatory training in anti-bribery, health and safety, manual handling, safeguarding adults and children, infection control, fire safety, information governance, equality and diversity and compassion in practice.

The hospital set a year-end target of 95%. In theatres there were 85 members of staff and at the time of our inspection mandatory training had been completed by 98% of the team.

There were 59 members of staff across the three wards and mandatory training had been completed by 98% of the teams.

The hospital resident medical officers (RMO) were trained in advanced life support (ALS) and European Paediatric Advanced Life Support (EPALS) as a minimum.

Theatres had a staffing notice board which showed which staff member was trained in which emergency procedure. The notice board also listed who was trained in paediatric life support, immediate life support and advanced life support. Each theatre was assigned a combination of these teams and this was clearly identified on the theatre allocation board.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff understood their responsibilities and adhered to safeguarding policies and procedures, including working in partnership with other agencies. In every department, staff had access to relevant contact details of people within and outside of the hospital who they could approach for additional advice. Staff described how they would identify adults and children at risk of, or suffering, significant harm and when they would make a safeguarding referral.

We spoke with the safeguarding leads for adults and children, both of whom had been trained to level 4. They were extremely passionate about their roles and responsibilities and worked together to ensure safeguarding was a top priority in the hospital.

Safeguarding training had been established on-line; of which the safeguarding children course they initiated had been implemented company wide.

The safeguarding leads told us they met with community teams to hear about safeguarding case reviews and they also attended the safeguarding forum, which was held at another independent hospital group. This provided an opportunity to share learning.

Face-to-face training was still offered to staff as it was recognised not everyone learned through the on-line route. Because they wanted to be sure the on-line adult training was transferring knowledge to the expected level they were conducting face-to-face training and had done this with approximately 40 staff. Training included female genital mutilation (FGM)and training and a video provided on PREVENT (anti-terrorism).

A safeguarding checklist had been developed and this was said to be integral to the safeguarding policy on children. Safeguarding activity was reported formally through the governance arrangements. There had not been any adult safeguarding alerts in the past year.

Safeguarding resource files were available for staff and these were noted to be detailed and informative in supporting staff to identify and report such matters if they were to arise. Spire policies nationally had been rewritten based on the approach used locally centered on the quality of arrangements between Southampton City Council and Hampshire Safeguarding Board.

The safeguarding leads said they had been involved in best interest decisions, and they noted there was a degree of lack of confidence when making such decisions at pre-assessment. However, they felt there had been good outcomes where they had been involved.

Section 11 audits were completed annually, and this was sent to the safeguarding children's board and the Clinical Commissioning Group. This is where all local agencies and organisations who provide services to children and young people are asked to self-assess the extent to which they meet the safeguarding requirements and standards as set out in Section 11 of the Children Act 2004.

Safeguarding adults and children level 2 had been completed by 100% of staff on the wards and 98% of staff who were required to complete safeguarding children and young people level 3. In theatres, safeguarding adults and children level 2 had been completed by 98% of the team. The provider informed us after the inspection that in theatres staff were 96% compliant with safeguarding adults and children level 3.

Cleanliness, infection control and hygiene

The service did not control infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. However, whilst staff kept equipment and the premises visibly clean, carpets in corridors and flooring in some areas in theatres did not ensure adequate cleaning could always be achieved.

There was an onsite decontamination unit, for surgical instruments, which had external accreditation and an annual audit. However, when we visited the autoclave area and the corridor behind theatres we saw the laminate did not reach the edges of the walls leaving gaps and areas which could harbour infection and could be difficult to clean. To facilitate cleaning, flooring should be impervious, smooth and seamless, and where possible hard flooring should be run up the walls for a short distance.

We were told the flooring had been risk assessed and appropriate cleaning was completed. The hospital had plans to replace this flooring during a quiet period, and we were told this did not pose an immediate risk to infection due to being in areas where dirty instruments were brought to be processed and waste was removed from theatre.

Staff told us that a major refurbishment programme was planned for December 2019. However, in the interim period the service mitigated this risk by twice a day cleaning with an antibacterial sanitiser of the areas in need of repair. Since our inspection, speciality wall covering to close the identified gaps had been scheduled to be completed in September 2019.

The removal of carpets from all clinical areas (rooms) had been a hospital priority, with the last carpets being removed from these areas in September 2019. All the clinic rooms and bedrooms we visited on the wards and the pre-operative assessment unit were in line with guidance, flooring was complete and intact, visibly clean, impermeable and run up the walls. However, the ward corridors still had carpets and some areas had stained patches and looked visibly unclean. To mitigate the infection risk of carpets in the hospital corridors, a risk assessment had been completed which identified actions and plans should a spill occur. A programme of monthly

deep cleaning was identified as a control and spot checks performed weekly. We reviewed the cleaning records for January to July 2019 which had been fully completed, with notes of issues raised and reported.

It had been recognised there were not enough clinical hand wash sinks in the ward areas, as the patient rooms did not have a clinical hand wash sink. This had been risk assessed and it have been agreed staff could use the hand wash basin to wash their hands.

The hospital reported no incidences of methicillin-resistant Staphylococcus aureus (MRSA) or methicillin sensitive Staphylococcus aureus (MSSA) two incidences of E-Coli and no cases of Clostridium difficile (C-diff).

The head of clinical services/matron for Spire Southampton hospital was the director of infection prevention and control (DIPC). There was a lead infection, prevention and control (IPC) nurse supported by a corporate consultant microbiologist.We reviewed the Hospital Infection Prevention and Control Plan, which was part of the responsibilities of the hospital infection prevention and control lead nurse and the DIPC. This set out the responsibilities of the service to meet the Health and Social Care Act 2008; Code of Practice on the prevention and control of infections and related guidance, including amongst other specifics: the governance arrangement's around IPC audit, surveillance, patient screening, antimicrobial use, and meetings.

The IPC committee held quarterly meetings and representatives attended from departments across the hospital including theatres, pharmacy, radiology and estates. The participants included IPC leads; the deputy matron; microbiologist; decontamination lead; engineer; pharmacist; representative from pathology department; housekeeping and head of clinical services. The agenda for these meetings included water safety; antimicrobial stewardship surveillance, infection rates, audit results; training and any incidents. This committee reported and escalated concerns to the clinical governance meeting and the medical advisory committee (MAC). We reviewed minutes for the February 2019 meeting which were clear, detailed and included discussion of surveillance results, adverse events, policies and procedures, changes or updates in practices and where staff were not always compliant with hospital standards. Infection incidents for the quarter were discussed and any emerging themes were identified. We saw the terms of reference for the committee had been considered and agreed in February 2019. It was noted in these minutes that a daily walk about was being undertaken to check standards of cleanliness were being achieved.

A member of staff was identified as Infection Prevention Control (IPC) link person in each hospital area, who held a competency passport relating to infection prevention and control. These members of staff took the lead role for IPC audit in their area and were given protected time to undertake this role. Meetings were held for the IPC link staff which fed into the IPC team meeting.

There was an antimicrobial prescribing policy and audits were completed. Senior staff told us compliance was good. We saw that when one consultant had been found to be non-compliant with the prescribing guidelines, the microbiologist had met with them to discuss their practice.

All areas across the wards, interventional radiology, pre-operative assessment unit and the theatre department were visibly clean and free from dust. All soft furnishings were wipeable and in a good state of repair with no rips or damage. The hospital had six theatres, four of which were laminar flow. Laminar flow theatres work to prevent airborne bacteria from getting into open wounds, as well as removing and reducing levels of bacteria on exposed surgical instruments, surgeons and the patient's own skin.

The intraoperative phase of patient care and preparation was in line with the National Institute for Clinical Excellence (NICE) clinical guidance 74. Staff scrubbed aseptically for theatre, wore the correct sterile gowns and gloves and administered the correct antiseptic skin preparation.

Theatre staff wore 'scrubs' (loose clothing of the type worn by theatre staff) to prevent cross-contamination from their clothing. We observed how theatre staff wore disposable gowns over their theatre clothing when leaving their department.

Theatre, wards and the pre-operative assessment unit (POAU) had their own cleaning schedules. Since our last inspection adequate theatre cleaning to support infection control and safe operating practices had improved. Each theatre had an end of day checklist outside each theatre. Each list included set up of the Layup room and cleaning tasks associated with all equipment. We reviewed three theatre checklists, and all were signed and up to date.

Cleaning schedules were in every cubicle in POAU which included the end of the day clean and re-stock. We reviewed one of these which was signed and up to date.

We reviewed the cleaning schedules for Ward 3 and saw this had been fully completed for the week and month so far.

Equipment in the theatres area was cleaned regularly and once cleaned had a green 'I am clean sticker' attached. We reviewed the equipment store in the theatre department and saw how this was full of equipment. There was potential that equipment at the back may have been missed and not cleaned, however this was not the case. We saw how all pieces of equipment were pulled out and cleaned weekly and equipment stored at the back had a I am clean sticker dated to the day before our inspection.

Patients who required the insertion of catheters and vascular access devices had their risk of infection minimised by the completion of specified procedures. These care bundles/pathways were necessary for the safe insertion and maintenance of these devices and their removal as soon as longer needed, therefore reducing the risk of infection.

There were hand sanitiser gels available for staff to decontaminate their hands in the ward areas. The practice we observed showed all staff on the wards and in the pre-operative assessment clinic decontaminated their hands in line with World Health Organisations (WHO) Five Moments of Hand Hygiene (2009). All the patients we spoke with on the wards told us they saw staff decontaminate their hands before and after patient contact. All clinical areas reported on hand hygiene compliance as directed by Spire Healthcare Limited's hand hygiene policy.

Hand hygiene audits had shown a 90% compliance when the expected level of compliance was 95%. Additional training had been provided and the issues raised at ward huddles/meetings.

Staff were expected to attend infection prevention and control training yearly as part of their mandatory training programme. This had been completed by 99% of theatre staff and 100% of ward staff.

The hospital participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The assessments involved local people known as patient assessors, assessing how the environment supported the provision of clinical care. The hospital scored 100% for cleanliness.

Environment and equipment

Overall, the design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, the uneven flooring in some areas of the theatre department needed repair.

The facilities, environment and equipment were, well maintained across all the departments we visited, with exception of the autoclave area and the dirty corridor behind theatres. We saw how the flooring was uneven with pits and bumps under the laminate. Staff told us that the uneven flooring meant lining the trollies up to move equipment into the auto clave area was difficult and often involved manual handling the heavy trollies. We were told the flooring was part of the quality improvement plans and the flooring was due for replacement in December 2019. A working party had been set up to ensure efficient and safe planning of the work as there would be an impact on patients' access to surgery in this hospital during a short period of time. This risk was documented on the hospital risk register along with mitigation and an action plan to reduce the risk to staff. Actions taken by staff at the hospital included the purchase of new trollies, staff manual handling training and regular expert health and safety assessments.

The wards were very warm during the summer months, staff told us the temperature was uncomfortable to work in especially when wearing gloves and aprons. The senior management team relaxed the uniform policy when the temperature was uncomfortable to work in. We were told to counteract some of this heat, additional fans had been purchased for every room and in the corridors. When the temperature rose excessively, patients would be moved to a cooler room on the other side of the Ward, if there was one available. We were told there were no plans to have air conditioning fitted at the time of our inspection. There was a risk assessment with actions to reduce the risk that included a relaxation of the uniform policy for staff and provision of extra water and ice lollies.

The servicing of equipment was tracked and logged electronically, and recent work had been done to improve

this IT system. Theatre staff explained they now had a warning one month prior to a piece of equipment requiring service. This enabled dedicated staff to contact the equipment company if external, or local technicians to service the equipment. If for some reason this was not achieved the piece of equipment would be removed and stored in a dedicated space until fit for use. We examined eight items of equipment all had stickers which identified the last service date had been within a year and when the next service was due.

The wards, POAU, interventional radiology and theatre department had resuscitation trolleys. The trolleys were tamper-evident to reduce the risk of equipment being removed and not available in an emergency. Staff carried out daily and monthly checks of the equipment to ensure it was ready for use in an emergency. We checked four trolleys across the departments and saw all were checked in line with policy and no dates had been missed for the month so far. We saw information was located with or above the trolleys, providing guidance for staff about the emergency procedures and action to take, such as sepsis.

Anaesthetic equipment was available and appeared clean and well maintained. We reviewed two log books and saw they had been checked in line with national guidance, therefore staff could be assured equipment was safe and fit for purpose.

Sharp instruments were managed safely. We checked sharps containers across all areas we inspected and saw all were stored correctly and safely. Sharps bins were correctly assembled signed and dated in line with Health Technical Memorandum 07/01. Sharps were managed in line with EU Directive 2010/32, prevention of sharps injuries.Sluices on wards had locks to control entry and all were locked. Inside all the sluices were locked cupboards, which contained hazardous cleaning chemicals (COSHH) therefore not accessible by the public.

Fire extinguishers on ward 2 had all been checked within the last two months and we saw clear signage for the fire exits which were easily accessible and free from clutter.Consumable equipment, for example, syringes, needles and dressings, were managed effectively across all areas we visited. The consumable items we checked were stored in unbroken packaging and were within their expiry date.

In all areas we inspected staff complied with the Department of Health, Health Technical Memorandum 07/01, safe management of healthcare waste (2013). All waste was segregated in different coloured bags and posters were displayed explaining which item went into which waste stream.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Comprehensive risk assessments were carried out for patients who used the services and risk management plans were developed in line with national guidance such as National Institute for Health and Care Excellence (NICE). All patients who were admitted to the hospital received risk assessments such as venous thromboembolism (VTE), malnutritional screening assessment (MUST), pressure area and a falls assessment. Once assessed and if found to be at risk, management plans were put in place such as falls preventions action plans and pressure ulcer care plans. Staff on all the wards reviewed their patients daily.

Those patients who required insertion of feeding tubes, catheters or central venous lines had care pathways. These identified the reasons for and the safe insertion of the tube/line and directed staff to provide ongoing monitoring.

A recent high harm after falling had highlighted some issues in the monitoring of at-risk patients. A scrutiny panel reviewed the incident and found that sometimes staff left the patient they were observing or were asked to help with other tasks. Bright yellow lanyards were required to be worn for any staff undertaking a 1:1 observation. This identified that the staff member was conducting a 1:1 and must not be removed from the patient's side until the lanyard had been handed over to another member of the team. This ensured there were no breaks in observation.

There was a hospital wide standardised approach to the detection of the deteriorating patient and a clearly documented escalation response. All people admitted as inpatients were continually assessed using the National Early Warning System 2 (NEWS). This system was based on a simple scoring system in which a score was allocated to

physiological measurements undertaken when patients present to or are being monitored in hospital. We reviewed four NEWS 2 observation charts. Three required no action, and one which did where staff had escalated correctly.

All staff were aware of the sepsis six protocol and had received training as part of their mandatory training. The resuscitation lead was the lead for sepsis and had provided wards with a sepsis box, this contained information and vital equipment to hand during an emergency. All the staff we spoke with knew where this box was kept.

Patients who were seen at the pre-operative assessment unit were assessed using the American Society of Anaesthesiologists ASA classification. The score was reviewed in line with the national ASA Classification System. Staff in pre-operative assessment unit told us if necessary patients would be referred to their GP for further follow up and/or treatment.

NHS England published national Safety Standards for Invasive Procedures (NatSSIPs) in 2015, to support organisations in providing safer care and to reduce the number of patient safety incidents related to invasive procedures in which surgical never events could occur. The NatSSIPs had enhanced the World Health Organisations (WHO) Surgical Safety Checklist, which included safety-briefing, sign in, time out, sign out and debriefing. This did not replace the existing WHO Surgical Checklist, but rather enhanced it by looking at additional factors.

We attended two full procedures in theatres which enabled us to observe the complete WHO surgical safety checklist pathway. We observed all staff being fully engaged with team/safety briefings, sign in, time out and de brief. Swabs, needles, instruments and sharps were counted to prevent foreign body retention and subsequent injury to the patient by two members of staff, a registered perioperative practitioner or senior health care assistant appropriately trained/scrub trained.

Theatres had a staffing notice board which showed which staff member was trained in which emergency procedure. This showed who was trained in Paediatric life support, Immediate life support and advanced life support. Each theatre was assigned a combination of these teams and this was clearly identified on the theatre allocation board.

During our inspection of the department there were no patients having in interventional radiology. However, we saw audits on the WHO surgical safety checklist which showed observed practice was safe.

Spire Southampton hospital took a hospital wide approach to assessing and responding to risk on a daily level. Wards held early morning handovers from the night staff to the day staff. We attended one of these and saw the safe handover of patients and allocation of work was completed. Any issues from this handover would be picked up at the hospital wide safety huddle.

We attended the morning safety huddle in the theatre, this was attended by all theatre staff on shift for that day and included recovery, critical care and resuscitation staff. This huddle identified who was allocated to which theatre and what level of resuscitation training they had. Each list and theatre team were discussed and any equipment issues, staffing and agency, breaks and who would cover them identified and allocated. Staff were also given a 48-hour Flash Report. These set out learning from other Spire Healthcare Limited hospitals and included never events/ serious incidents which occurred and the learning from them. As in the ward structure any issues identified during this huddle would be taken to the hospital wide safety huddle.

We attended the hospital wide safety huddle which was chaired and recorded by the deputy matron. A representative from every department was expected to attend and this included, governance and risk, the resident medical officer, critical care, the resuscitation team, pre-operative assessment unit (POAU) and theatres. Any issues would be highlighted during this meeting, escalated and actioned. We attended two of these meetings and saw issues such as staffing, short term sickness, incidents and daily operational concerns discussed. The safety huddle minutes were displayed in the main area in theatres reception and on the ward, so staff could access these at any time.

The pre-operative assessment unit lead attended a weekly meeting with the heads of the departments to discuss the numbers of patients coming into the hospital their medical history. and any special requirements. This ensured that should there be any concerns these would be known about and mitigated prior to admission.

Theatres had processes to monitor medical equipment representatives and visitors into the theatre department. There was a recognised provider system and all visitors had to sign in at reception.

Posters titled 'when you need advice ask the right person' were displayed around the hospital. These identified the lead for safeguarding, tissue viability, dementia, infection control and diabetes.

Patients who had cardiac surgery on ward 1 were all monitored with telemetry. There was a main monitor based at the nurse's station which showed each patient's reading. The ward could take 16 patients at one time. On day one of our inspection there were nine patients on the ward, one ward sister and two cardiac competency nurses and one HCA. Every ward sister on the unit was trained in ALS, each trained staff member was trained to ILS and each HCA was trained to BLS.

Nursing and support staffing

The service did not always have enough of its own substantive nursing and support staff. They relied on agency nurses; however, all staff had the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave agency staff a full induction.

Staffing featured highly on all the departments risks and the hospital risk register. This meant agency staff were frequently used to make staffing safe. It was decided that long term agency would be used, and they would receive a full induction on to the wards and be fully integrated as part of the team. From May 2018 to April 2019 trained agency use in the theatre and all inpatient departments was almost always above 20% peaking in March at 30%.

Theatres had just appointed three new health care assistants and 12 overseas nurses had recently been recruited to the wards. They had yet to start on the wards and were taking exams to help with their language skills. The hospital had provided three months accommodation for these staff to help them settle and integrate more easily.

There was good oversight of staffing across the departments. The hospital used a safer nursing care tool. This tool ensured that the hospital had the right staff with the right skills in the right place. The tool enabled staff to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity /dependency terms.

The acuity score for each patient was reviewed three times throughout the day to determine real time patient needs and on a regular basis for the two-three days ahead. Weekend staffing reviews took place each Friday afternoon. If any gaps in staffing were identified or changes to acuity scores required additional nursing staff, staff would be sought from either the nurse bank of substantive staff who provided flexible working hours, shift swaps to another day or the use of pre-approved agency nurses.

Staffing requirements were discussed and documented each morning at the safety huddle, led by the deputy matron. A traffic light system of red, amber and green (RAG) was used to identify the level of staffing in place. Any amber or red triggers would be escalated to the senior management team huddle at 10am each morning and measures would be put in place to reduce these to green. Any red escalations were reported on the electronic incident system as a 'red flag staffing events.'

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There was one lead full time resident medical officer (RMOs) and two further RMOs one was a cardio-thoracic registrar with intensive care and anaesthetic experience with a standard full-time contract and one further RMO had a modified contract. Two bank RMO's who had previously been employed by the hospital covered any gaps. If agency were required, the hospital used a recognised agency who ensured the required competencies and training had been completed.

The RMO lead told us they had worked full time since August 2017 at the hospital. They worked 24-hour shifts Monday to Friday, with five-week rotational weekend cover of 48-hours. The fifth weekend was on-call. At night they slept in and were only called when necessary; they reported that generally they did get a good rest. We observed how the RMO was asked each morning at the

safety huddle (which was documented) if they had enough rest overnight. If they have been woken, a replacement would be provided within four hours in line with Spire Healthcare Limited's contract.

All RMOs who worked on the ward setting had a daily timetable outlining minimum expectations of their role and areas to cover. Where work deviated excessively from this, issues could be raised directly to the Lead RMO or deputy matron. A disturbance log was also part of this daily timetable to log any long periods of disturbance (bleeps) through the night from nursing staff. This provided evidence should the hospital need to replace an RMO due to lack of rest.

We asked about access to consultants and were told each consultant covered their patient, with the expectation they would be available 24 hours a day or have arranged cover by another consultant with practising privileges. Anaesthetists were expected to cover surgical patients during the first 48-hours post-surgery.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient records demonstrated a multidisciplinary collaborative approach to patient care and were well maintained. We reviewed five sets of patients records and found there was a good standard of record keeping. All paper records were legible, contemporaneous, and signed. Management plans and daily ward rounds were clearly documented, and evidence of escalation and NEWS 2 recordings were clear.

Paper records on the wards and on the pre-operative assessment (POAU) units were stored securely. Either in lockable records trolleys or in locked cupboards. For example, the notes in POAU were locked away in a filing cabinet in an office.

Considerable work had been carried out to improve medical records under the direction of the administrative manager. They told us how the medical records room had moved and was set out to aid easier access. If there were situations where patient records were not made available an incident report was created and the matter was investigated. Temporary notes were created and then merged later. Records committee meetings were held monthly to keep oversight of this area.

Medicines

The service used systems and processes to prescribe, administer, and store medicines. However, some new systems recently introduced to support the management and prescription of medicines, were not fully understood by all staff.

Staff had not been clear how to work with the new systems recently introduced. This was in relation to record keeping for venous thromboembolism (VTE) assessments and controlled medicines on the ward. Staff completed VTE assessments on the patients' care pathway documents according to Spire Healthcare Limited's policy. However, VTE assessment was also included on recently introduced prescription charts. The hospital told us these were not required to be completed. The provider had recognised having two systems had the potential to cause confusion and the VTE risk assessment on the prescription chart was being reviewed to consider whether it should be removed from the prescription chart.

The pharmacy manager had changed the process of recording when CDs had been supplied, administered or destroyed, by implementing a new record book. During our inspection we saw there were missing entries and signatures. When we asked why, staff told us they had not been trained on how to correctly complete the record book. This meant the record was not correct and the ward procedure was not followed.

Although meeting legal requirements, the recording of controlled drugs on the ward, was not always fully completed. Staff told us the hospital had recently introduced this new style controlled drug register onto the wards. They explained this had been introduced with the no training, support or guidance provided to staff about how to complete the record. In the three months prior to inspection there had been 10 occasions where information required was missing. Following the inspection, the hospital told us that for the purpose of the ward controlled drug record, only the supplied section was required to be completed, which was in line with legal requirements and the hospital's medicine management policy. The other sections being only relevant to theatres where the same

style controlled drugs register was used. The hospital told us that they would replace the ward controlled drug register for a register that met the need of the wards. Policies and procedures were available and accessible to staff. Policies viewed as part of our inspection were in date and in line with best practice and national guidelines.

Medicines were stored securely in locked trolleys and doors were locked to treatment rooms with access restricted to appropriate staff. Controlled drugs were stored securely. Regular balance checks were performed in line with provider's policy.

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent before administering medicines. We saw that nursing staff introduced themselves to patients before offering them medicines, they explained what they were giving, and observed the patient take them. A pharmacist visited the wards Monday to Friday to review prescriptions and advise medical staff when doses needed to be revised. The pharmacist reviewed medicines and information provided to discharged patients.

The service made sure patients received their medicines as intended, and this was recorded appropriately. We reviewed four medicine prescription charts and saw medicines were administered in a timely manner, where doses were delayed or missed for any other medicines, there were documented reasons.

Emergency medicines and equipment were readily available and at the time of our visit, all medicines we looked at were in date. All emergency medication boxes that were kept on or near the resuscitation trollies in sealed boxes. Records showed that daily checks of medicines stock on the resuscitation trolleys had been performed to ensure that they were fit for use in accordance with trust policy. Stationery used for prescribing was stored securely and managed appropriately.

We checked a selection of medicines across all the wards we visited, all of which were in date of their manufactured expiry date.

Medicine fridges were kept in treatment/clean utility rooms which were temperature monitored to ensure medication stored in these rooms did not exceeded the manufacturers recommendation for storage. Medicines which required refrigeration were stored in fridges which were temperature controlled. The fridge temperatures were monitored daily and recorded on a dedicated sheet, which informed staff of the process to go through should the fridge not work properly. We checked fridges in theatres and across the wards, all temperatures checked for the whole of July, no gaps were noted.

Storage and security of medicines were audited quarterly by pharmacy, this included, controlled drugs storage and medical gas storage. We reviewed audits for the wards in January and June 2019 which were both 94% compliant. We reviewed the audit for recovery in March 2019 which was 87% compliant. The electronic audit form identified actions that needed to be completed to achieve compliance and these had been identified and allocated to the ward sister.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

During the period of April 2018 to March 2019 the hospital reported the following number of incidents (we did not receive numbers just for surgery core service but hospital wide):

- No harm incidents-1107
- Low harm incidents-223
- Moderate harm incidents-154
- Severe harm incidents-0
- Death-2 (Unexpected-0)
- Never Events–2 (One in interventional radiology and one in CT)
- Non-clinical incidents-168
- Surgical Site Infection-26

In October 2018, a never event occurred in interventional radiology. This was a wrong site injection. Never events are serious patient safety incidents that should not happen if

healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

A root cause analysis (RCA) was completed, and findings showed failings in certain areas such as consent and lack of information available during the procedure. High priority actions were taken immediately this included redesign of the imaging request form, improvement in consent recording, World Health Organisation (WHO) surgical safety checklist update and consultant radiologists to be informed of the change in the updated processes. The deputy matron was trained in human factors, which helped to bring perspective into the investigative processes around incidents. This was shared with all departments of the hospital as an internal flash report.

Managers on the wards and across the departments told us they investigated incidents and shared lessons learned with teams and the wider service. We saw how information was cascaded from senior levels through to teams on the wards by newsletters and minutes of governance and departmental meetings. This reflected what staff reported to us on the wards, in the pre-operative assessment unit, interventional radiology and theatres.

Staff said they felt encouraged to be open and honest and to report incidents. Staff told us how they reported, and they received feedback from incidents they raised via safety briefings, theatres briefings and newsletters.

Clinical effectiveness meetings were held monthly, during which the previous months incidents, clinical audit and alerts were discussed. The latter were sent to the respective heads of departments and shared with other wards. 'Flash alerts' regarding incidents which may affect all hospitals were originated from the provider's central office. These were shared during safety huddles, which were used as an opportunity to make staff aware of any safety matters.

The lead RMO met with the matron and governance lead twice monthly to review incidents, any lapses in services and any root-cause analysis. When an RCA had to be completed learning was shared across the hospital. We saw in the staff room two RCA outcome learning sheets relating to issues after patients had been transferred to the acute trust due to deterioration.

We heard about an example of action taken because of learning arising from incidents of falls. Where patients needed closer observation because of a risk of falls nurse wore a yellow lanyard which was handed over to another nurse taking responsibility for the patient. A visible sign was also used to alert staff and patients had a small yellow cone, which reminded them to ask staff for help rather than mobilising alone.

The hospitals held a duty of candour (DoC) register. Duty of candour, Regulation 20, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation, which was introduced in November 2014. 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. The register provided an audit trail for the patient, the incident, the reference date, the tracked status of investigation, letters sent and if meetings were offered and taken up. Since January 2019 there had been 28 matters across the whole of the hospital where senior staff needed to discharge their statutory duty of candour.

Mortality and morbidity (M&M) meetings were held quarterly for many of the speciality services and these fed into service improvements. We reviewed a range of M&M minutes from 2018 to June 2019, which included discussions on deaths, infections, returns to theatres for the orthopaedic, bariatric treatment, urology and cardiac departments. All demonstrated good level of attendance and discussion of cases, learning and improvements and root cause analysis (RCA). However, we were told some areas such as the plastic surgery/ cosmetic teams did not hold an M&M, whilst no deaths had been reported, staff told us they would welcome discussion around topics such as infection rates.

We saw the clinical scorecards were completed with information for the five domains of safe, effective, caring, responsive and well led. The scorecards enabled all Spire Healthcare Limited hospitals to compare and benchmark their services. The June 2019 dashboard included information on unplanned theatre returns, unplanned readmissions, transfers out, infection control, VTE and falls, deaths and never events.

Safety Thermometer (or equivalent)

Good

Surgery

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and the public.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

From June 2018 to June 2019, ten months of data was submitted for ward 1 (cardiothoracic surgery) which showed ten months of harm free care.

From June 2018 to June 2019, 11 months of data was submitted from ward 2 which showed 11 months of harm free care.

From June 2018 to June 2019, ten months of data was submitted for ward 3, which showed ten months of harm free care.

Are surgery services effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

Overall, the service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Patients received care in line with the national guidance such as National Institute for Health and Care Excellence (NICE) guidance. For example, patient records showed they had been assessed for the risk of venous thromboembolism (VTE) on admission, throughout their stay and on discharge. This was in line with NICE guideline NG 89 Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism.

The hospital had been awarded VTE Exemplar Status, an accreditation awarded to hospitals across England who have an existing track record of excellence in VTE prevention and care, offer practical support and advice to other centres by sharing their resources, and collaborate on clinical research into VTE prevention"

Patients who required the insertion of catheters and vascular access devices had their risk of infection assessed according to standards in NICE QS61 Statement 5: Vascular access devices and statement 4: Urinary catheters. Staff used 'care bundles' which directed staff in the completion and documentation of specified procedures. These steps were necessary for the safe insertion, maintenance and removal of the device when no longer needed, which when performed collectively and reliably, had been proven to improve patient outcomes.

Evidence based care started for patients during their pre-operative assessment. Each room in the pre-operative assessment unit (POAU) had a folder which contained the most up to date guidance for example the pre-operative association and the Royal College of Physicians and Surgeons (RCP&S), the Joint British Diabetes society for in patient care, NICE guidance, NG45 routine pre-operative routine tests for elective patients and a hand book of peri-operative medicines. The national Autistic Societies 'My Hospital Passport' for patients living with autism was printed out ready to be given to patients attending the clinic. This passport was designed to help autistic people to communicate their needs to doctors, nurses and other healthcare professionals.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The hospital followed National guidance by the Royal College of Anaesthetists (RCA) and the Royal College of Nursing (RCN) that patients should receive clear fluids up to two hours and food up to six hours of surgery.

The wards used an evidence-based tool that enabled nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity /dependency terms.

We reviewed meeting minutes from the infection control committee and the wards meeting minutes and saw how updated NICE guidelines and policies were embedded into the minutes for all to read. To ensure staff were delivering

the most up to date care, a 'Policy of the Week' was displayed in the main area in theatres, the policy at the time of our inspection was the consent to investigation and treatment.

At the time of our inspection the hospital had a new dementia strategy, and staff had access to a dementia lead nurse. Staff we spoke with were aware of and had access to resources to make reasonable adjustments for patients with additional needs. Ward 2 had a room which was used for those people living with dementia, this was close to the nurses' station and had a blue coloured toilet for ease of identification. Staff could also use a 'dementia box' which had specific items that may provide comfort to a patient in an unfamiliar environment.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs

Patients were advised about appropriate pre-operative fasting in the pre-operative assessment unit (POAU) and lengths of fasting times reflected where patients were on the theatre list. Staff in the POAU would email the wards and the kitchens should a patent attend the clinic and have a food allergy or a specific dietary requirement. As part of the nursing inpatient admission documentation, all patients were screened with a validated nutritional screening tool, which identified patients who were malnourished, or at risk of malnutrition.

Recovery and the ward areas ensured the effective management of nausea and vomiting. We saw staff enquire about patient's appetites and offer anti-sickness medication for patients who reported feeling nauseated. We also saw how staff returned to check the medication had worked and if necessary offer an alternative anti-sickness medicine. For patients able to take their own fluids, drinks were available on bedside tables and within reach.

The hospital offered gastric bypass surgery and recognised how important food health was for those patients recovering. The service had a nurse specialist who facilitated the patients journey from pre-operative appointments to discharge. This included referrals to dietitian, ongoing monitoring of the patient on the ward. The nurse specialist held support group meetings which ex patients attended. These meetings offered extra support, information and education to patients who had received surgery. The first support group had a visiting psychologist talk about how to cope with Easter and advertising. Another session, the nurse specialist worked with the kitchens to show ex-patients what healthy snacks they could eat.

The hospital provided specialist foods, such as kosher and halal, to meet patient's religious needs.

Hydration scores were audited quarterly and the hospital shared with us during quarter one, 2019 compliance was 85%, which was above the hospital target of 65% and above the Spire Healthcare Limited network score which was 58%.

Patients were asked for feedback on the quality of food, results from April 2019 showed an 84% positive feedback from patients.

The hospital participated in Public Health England Surveillance and the Patient Led Assessment of the Care Environment (PLACE). The hospital scored 94% and above for its food on the wards and across the organisation.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management to ensure following surgery patients were given effective pain relief. Staff told us they would access the acute pain analgesic ladder for patients which offered advice on appropriate analgesics in relation to an individual pain score.

Ward staff assessed patients' pain and the effectiveness of pain management regularly using a nationally recognised numerical scoring system. We observed nurses checked patient's pain levels during routine observations and interventional rounding.

We heard staff asking patients if they had pain and after administering analgesics returned to check if they had been effective.

Quarterly audits were undertaken to ensure staff were recording patients pain levels in recovery and on every set of observation on the ward. We reviewed October 2018, January and April 2019 records audit data and 100% of observations were recorded.

Information was given to patients pre-operatively to explain what sort of analgesia they could expect to receive during their operation. This included explanations of epidural, spinal, general and patient controlled analgesia.

Patients completed an inpatient survey and were asked if they thought hospital staff had done everything to control their pain. The hospital provided us with data which showed during quarter one 2019, 80% of patients responded 'a great deal' to pain being managed (where the patient had pain to manage.

Physiotherapists worked alongside consultants and nurses to explore other avenues of pain control and had delivered a presentation on the use of ice as an alternative modality for pain relief. Work was also underway to look at patient's perception of therapy intervention when they were in pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The hospital collected clinical performance indicators (CPI) which were reviewed by the hospital governance committee and reported in the governance report. CPIs were organised as hospital wide and at speciality level, reported on and analysed per quarter. This report went into the detail and provided a narrative around for example why a patient returned to theatres.

The hospital had an audit schedule which identified when audits were required. The schedule outlined if an audit was organisationally or externally required, a recommended audit or stipulated as required in a Spire Healthcare Limited policy.

Local audits were managed by the hospital at a local level and all audits were discussed when relevant at the monthly clinical effectiveness meetings. Minutes from the meeting were shared during the Governance meetings.

The clinical scorecard enabled the hospital to benchmark its clinical performance indicators against other Spire Healthcare Limited hospitals. The scorecard compared the audit result to the hospitals target, Spire Healthcare Limited network results, the previous quarters score and if the service/audit had improved.

The scorecard included all the hospital activity and was presented under the CQC domains of safe, effective, caring, responsive and well led. This was easy to read, and we saw how these were displayed on the wards, therefore at a glance staff could see their performance. We reviewed the clinical scorecard for quarter one, 2019 which had 47 categories over the five domains, 27 of which had either stayed the same or improved, 14 had achieved a lower score since the last quarter, and three were new categories and had not been rated. The clinical score card reflected national standard expectations for example, in quarter one, 85% of the hospital patients had been fasted within the timeframes identified by the Royal College of Anaesthetists (RCA) and the Royal College of Nursing (RCN) and Spire Healthcare Limited policy. This was above the target of 65% and above the Spire Healthcare Limited networks score for quarter one.

The hospital monitored any unplanned transfers of care to another hospital, readmission to the hospital and returns to theatre. All occurrences were logged on the hospitals incident system and investigated. During the reporting periods of April 2018 to March 2019 the hospital reported;

- 32 unplanned transfers to another hospital (all hospital)
- 45 unplanned re-admissions to the hospital (within 28 days of discharge)
- Three unplanned returns to the operating theatre (all hospital)

  The hospital benchmarked this quarterly in their scorecard which gave a red, amber or green (RAG) rating. The unplanned returns to theatre were RAG rated as red, readmission rates to Spire Southampton hospital rated amber and unplanned transfers rated green.

Patient Related Outcome Measures (PROMS)

The hospital submitted Patient Related Outcome Measures (PROMS), which helped the service measure and improve

the quality of care patients experienced during and after elective surgery. In the PROMS survey, patients were asked whether they felt better or worse after receiving the following operations:

- Hip replacements
- Knee replacements

The PROMS data showed that post-operative scores for both procedures for all patients were higher than the national average for the past three years, showing good improvement in how patients felt after their surgery.

The hospital tracked the completion of questionnaires. The clinical scorecard for quarter one recorded the number of questionnaires completed was 83%, this was above the target of 70% and the overall Spire Healthcare Limited network of 80%.

The hospital worked alongside the local acute trust to deliver cardiac and thoracic surgery. The cardiac surgical team at Spire Southampton hospital had been performing coronary artery bypass grafting, valve repairs and replacement since 1984.

Approximately 450 cardiac surgical operations were completed every year. The average stay in the hospital was six days. The first 24 hours following surgery was spent in the critical care department and the remainder on the cardiac surgical ward.

The hospital reported its outcomes to the Society for Cardiothoracic Surgery (SCTS) and the Institute for National Centre for Cardiovascular Outcomes Research (NICOR). The survival rates were 'risk adjusted' to consider the illness of the patient and the complexity of the operation. For the period April 2014 to March 2017, the risk adjusted hospital survival rate for Spire Southampton hospital patients was 99.57%. The data showed that excellent clinical outcomes were achieved on a comparatively high-risk patient population and the hospital was proud to be the best private hospital for cardiac outcomes in the UK and told us that patients would travel from afar to be treated by the hospital.

The hospital was one of the three hospitals in the UK who received a letter of congratulations from the Society for Cardiothoracic Surgery in 2017 and one of only two hospitals in the UK who had received a letter of congratulations from the Society for Cardiothoracic Surgery in 2018 for achieving survival rates higher than expected for patients undergoing cardiothoracic surgery

National Registry (NJR)

The hospital entered information onto registers such as the national joint register (NJR) and the breast and cosmetic implant registry (BCIR). These registries were set up by the Department of Health and Welsh Government in 2002. Information was collected on all replacement operations and monitored these registries ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects. This allowed for longer term national reporting of outcomes.

Surgical Site Infection Surveillance (SSIS)

The hospital reported surgical site infections (SSI). The aim of the national surveillance program was to enhance the quality of patient care. This was achieved by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice.

The SSIS provides an infrastructure for hospitals to collect data on 17 surgical categories spanning general surgery, cardiothoracic, neurosurgery, gynaecology, vascular, gastroenterology, and orthopaedics.

The hospital reported on 13 categories which included hip and knee operations, spinal, breast and urology. Out of 7881 operations there were 26 surgical site infections over the reporting period of March 2018 to February 2019, this showed a 0.3% infection rate.

Commissioning for Quality and Innovation (CQUIN)

Through the Commissioning for Quality and Innovation (CQUIN) payment framework, improvement and innovation goals were agreed for NHS patients. This was a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. The hospital reported quarterly on;

- Antimicrobial Resistance
- Staff Flu Vaccinations
- Alcohol and tobacco

- Best practice pathways

The hospital reported quarterly over 2019-2020 and were on their way to achieving their targets.

Private Healthcare Information Network (PHIN) and Q-PROMs

The hospital was in the process of starting submissions to the Private Healthcare Information Network (PHIN). PHIN is a not-for-profit organisation that exists to make more robust information about private healthcare available than ever before, and to improve data quality and transparency.

The hospital told us it did not collect cosmetic patient reported outcome measures (Q-PROMS) data. This was a recommendation from the Royal College of Surgeons for cosmetic surgery providers to routinely collect data for specific cosmetic surgical procedures. This monitored the patients own measurement of how their quality of life had improved since surgery.

The hospital was one of the three hospitals in the UK who received a letter of congratulations from the Society for Cardiothoracic Surgery in 2017 and one of only two hospitals in the UK who had received a letter of congratulations from the Society for Cardiothoracic Surgery in 2018 for achieving survival rates higher than expected for patients undergoing cardiothoracic surgery.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Consultants and anaesthetists worked under a practising privileges agreement, which gave them the authority to undertake private practice within the hospital. Granting and maintenance of practising privileges was governed by the Consultant Handbook (Clinical Policy 16).

Practising privileges were formally reviewed every two years. This review considered compliance with the consultant's agreed scope of practice, satisfactory participation in annual appraisal and processes required for revalidation, and compliance with the Consultants' Handbook. This process also includes consideration of feedback from key staff across the hospital, known as 'soft intelligence' and a review of any incidents and complaints.

There was an efficient central system held corporately for the management of information required for practicing privileges. We were told by the personal assistant to the hospital director they received a weekly report from head office. We viewed the system and were able to see up to date information indicating 100% compliance with the submission of information from consultants who used Spire Southampton hospital. Automated reminders were sent to consultants where they needed to provide evidence of training, appraisals and revalidation for example. This included a multi-source feedback for cosmetic surgeons which formed part of their 360-degree feedback, this was the responsibility of each doctor and signed off by their appraiser and checked by their responsible officer in their main place of work.

We spoke with the medical advisory committee (MAC) chair and MAC governance lead. They explained how they reviewed practising privileges and demonstrated they were strong on managing doctor's behaviours. They confirmed they would deal with performance matters where required, including suspending or cancelling their practising privileges. The interim hospital director explained a proactive approach to swiftly deal with behaviours and activities which were outside of the expected standards or agreement.

During the reporting period of March 2018 to February 2019, 30 members of staff had their practising privileges removed, 18 were because of choice, eight due to non-submission of mandatory documents and four were due to suspension.

At the time of our inspection, there was a 100% completion rate of validation of professional registration for doctors. The hospital knew when this was due for renewal as a report was received from a central system. This indicated when re-validation or Disclosure and Barring Service checks were required by individual staff member. Emails were then sent to line managers to indicate this. We saw the information was up to date at the time of inspection.

The lead Resident Medical Officer (RMO) had a foundation in surgery and spent a year in locum work whilst undertaking further education and research. Both the hospitals RMO's were trained in advanced life support (ALS) and European Paediatric Advanced Life Support (EPALS) as a minimum. They were trained in safeguarding to level 3.

The lead RMO received professional support and mentorship by a respiratory physician and all substantive RMOs' met every couple of months for peer support. The hospital matron undertook the lead RMO's performance reviews. During the review meetings they discussed training and development needs and any funding for professional development was provided by the service. The lead RMO carried out the six-monthly reviews of the other RMO's, which they reported worked well.

All substantive RMO's completed training via Spire Healthcare Limited's mandatory training system. Both the lead RMO and deputy matron had administrator's access to their profiles to ensure regular checking of outstanding / completed modules. They maintained a matrix log to easily track the progress of each employed RMO.

When the hospital employed an agency RMO, the agency would be expected to provide a full and comprehensive CV which included the mandatory training modules completed and date. This would be reviewed by both the agency and the lead RMO prior to their first shift. The agency would monitor and enforce ongoing completion of this training in line with Spire Healthcare Limited's national contract.

All bank RMOs who worked at the local acute trust as a substantive member of staff had to provide the deputy matron with evidence of their mandatory training and any module not covered would be requested to be completed via the hospitals e-learning for a complete profile.

The lead RMO was working on updating the RMO handbook, which was to include a navigational map of the hospital. The locums needed a lengthy induction and a checklist was provided to cover off such areas as routines, sick notes and take-home medicines for example.

Every member of staff received a yearly appraisal and the hospitals appraisal year ran from January to December. At the time of our inspection, 100% of the inpatients departments registered nursing staff, health care assistants and 96% of other staff had received their appraisal. In the theatre departments 95% of registered nursing staff and 100% of operating department assistants (ODPs) and health care assistants had received their appraisals.

The hospital expected staff to keep updated in their areas and each member of staff had a competency folder. These formed part of the discussion during appraisal and we checked a selection of these across theatres, and the inpatient wards and saw they were all up to date, not full of old out of date certificates and fully completed.

There were systems and processes in place to support student nurses who worked on wards and departments. Students were allocated mentors, so they had a point of contact during each shift.

Part of the quality improvement plans for the theatre department was the recruitment of a practice educator. Once recruited, theatres would begin clinical half days which would be built into the theatre list scheduling. Clinical half days would facilitate a structured programme for staff of updates, equipment training and learning. Once recruitment was successful and quality improvement work had been completed around list scheduling the clinical half days would be set to start in quarter one 2020.

Theatres used lasers for vascular and urology treatments. We reviewed the laser safety folder which contained training certificates of those staff who were certified to use lasers. This was not up to date and some staff had records which showed training was last completed five-years ago. This was discussed at the time of our inspection and the staff were booked on to their update training in September and would not use the lasers until that time. Following the inspection, the provider told us that the staff who had not updated their training were not using the laser and the laser treatment for vascular and urology services were no longer being offered, therefore the staff training was cancelled.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

In line with the National Clinical Enquiry into Patient Outcome and Death (NCEPOD). Patients received relevant care from multidisciplinary (MDT) and multispecialty healthcare teams to treat their condition as well as any underlying co-morbidities. We observed how staff of different kinds worked together to assess, plan and deliver care and treatment.

Multidisciplinary (MDT) working started when patients visited the pre-operative assessment unit (POAU). Staff worked with the local GP surgeries and would contact them

should they pick anything up during a pre-assessment appointment. The team on POAU had a process in place with their local GPs which they told us worked well. GPs would update the POAU once a patient had been reviewed and could or could not be scheduled onto a list.

The service ensured arrangements for discharge were considered prior to elective surgery. Staff on the pre-operative assessment unit started the conversations about discharge. For those patients having day surgery someone to collect them needed to be arranged prior to admission. For those patients who may require help after discharge were encouraged to start arranging this as early as possible.

The inpatient physiotherapy team worked alongside the staff to deliver a flexible service which met the needs of their patients, by often working late to ensure the safe discharge or mobilisation of a patient.

Staff told us they had an MDT team meeting at midday where all patients were reviewed with the nurses and physiotherapists. There was an agenda to this daily review and it included assessing diet and fluids, mobility, any recovery issues, and a discharge review.

Staff at the hospital worked alongside local GPs to share and invest in learning. 'Hot Topics' that local GPs wanted training on were now delivered alongside a GP monthly newsletter.

Seven-day services

Key services were available seven days a week to support timely patient care.

There was access to key diagnostic services 24 hours a day, seven days a week to support clinical decision-making, this included critical imaging and reporting, MRI was available Monday to Saturday 8am to 10pm.

Consultants responsible for patients were always required to be contactable when their patients were at the hospital. RMOs provided 24-hour care seven days a week.

Patients could phone the ward staff for advice at any times, and they could contact the consultant via their secretary if required.

If a patient required a return to theatre out of hours there was an on call surgical team and theatre dedicated to providing this service.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff identified patients who may need extra support before, during and after their operation. The pre-operative assessment unit (POAU) supported people to be as fit as possible for surgery and staff told us they would discuss eating well, exercise and relaxation. In the POAU there were leaflets from the Royal College of Anaesthetists (RCOA) on getting; fitter, better and sooner.

There were health promotion and awareness information leaflets displayed around the hospital. These were Spire Healthcare Limited's own information and information from other health charities.

Staff supported patients to maximise their independence following surgery by using the enhanced recovery after surgery (ERAS) programmes to enable patients to be actively involved in their recovery. Part of this pathway included encouraging patients to be as healthy as possible before their planned operation.

The bariatric nurse specialist (a nurse specialising in supporting obese patients receiving bariatric services to lose weight) started educating patients during the pre-operative assessment appointment and would follow patients through their surgery with health education advice and healthy living choices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff acted within the legal framework to obtain patient consent for treatment. Written consent was completed with the consultant at the consultation stage, and checked both in the in the pre-operative assessment unit (POAU) and verbally checked again on admission, as part of the World Health Organisation (WHO) safe site surgery checklist. We

observed how staff explained what they were going to do and obtained verbal patient consent for the care and treatment they provided therefore fully involving patients in their care.

Patients and their relatives/carers living with dementia, learning disabilities or autism were given extra time during the pre-admission process to make sure the correct consent was obtained. For those rare patients who attended the hospital without capacity, staff followed procedures to obtain consent. The registered nursing staff we spoke with were knowledgeable about using the deprivation of liberty standard (DoLS).

The POAU used comprehensive leaflets from the Royal College of Anaesthetists (RCOA) to explain to patients the possibility of post-operative confusion, and that behaviour and memory could be affected.

Staff in the POAU gave an example of when a patient with limited capacity attended the department for an assessment of a minor procedure. The patients attended with their relative and advocate and the correct/specific consent procedure was followed.

However, because the patient had no capacity it was not safe to leave the ward unattended. This was discussed at the scheduling weekly meeting and a deprivation of liberty safeguard (DOLs) was applied for, from the local authority in advance of the patient attending the hospital. This meant the patient could have the surgery required and could be kept legally safe in the hospital.

Staff received training in the deprivation of liberty standard (DoLS) and the Mental Capacity Act. At the time of our inspection 93% of theatre and 98% of ward staff had completed their training.

Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We observed all staff were caring and compassionate to their patients' needs. Patients and relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff.

We saw examples of staff taking measures to ensure patients' privacy and dignity were always respected. Curtains were drawn when required and doors were closed.

We saw how staff took the time to interact with people who used the services and those close to them in a respectful and considerate way in theatres, interventional radiology, on the wards and in the pre-operative assessment unit. Staff introduced themselves by name and explained to patients what their roles were. We observed multiple examples of staff engaging in conversation with patients and relatives. Patients told us staff addressed them by their preferred names and showed interest in what was being discussed.

Patients were encouraged and supported by staff. We saw staff asking patients if they required assistance on multiple occasions and were very encouraging when patients were struggling. Some patients commented staff went above and beyond to help them after their operation. Patients told us they were happy with their care and treatment. We spoke with five patients and all had been complimentary about their treatment. They all said staff at all levels had treated them well and were friendly.

The hospital took part in Friends and Family test for NHS patients, and more recently their own inpatient survey. This was monitored in the clinical scorecard and could be benchmarked with other Spire Healthcare Limited hospitals. The score card for the period 1 April to 30 June 2019 showed that all seven indictors in the scorecard were scoring just below the hospital target and below the Spire Healthcare Limited network overall score.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. We saw how patients had time to ask staff questions and how staff

took the time to answer all their questions and alleviate concerns. We spoke with one patient who spoke highly of the nursing staff and how they had helped with her anxiety after her operation.

The hospital had a sacred space for patients, relatives and staff to access. This was a light and airy room which was away located in a quieter area of the hospital. This had prayer books for different denominations, a Quran, a compass and prayer mat. Access was 24 hours a day.

Patients were empowered and supported to manage their own health, care and wellbeing to maximise their independence. Patients were asked for their thoughts and feelings regarding treatment plans and had direct input into setting goals and objectives. This was evident when we spoke with the patients, the lead physiotherapist and all the nursing staff on the wards and in the pre-operative assessment unit (POAU).

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients told us staff were always willing to spend time to explain their care, treatment and condition and any advice given. Patients explained what treatment they were receiving and were happy that the doctors and nurses kept them up to date with their treatment plan.

For those patients living with cognitive impairments or autism the pre-operative assessment unit had a 'This is me' booklet for relatives or carers to complete prior to their admission into the hospital. This enabled staff to understand the care requirements of patients admitted into the hospital with specific needs.

The hospital recognised how important relatives were to the rehabilitation and recovery of their patients and allowed flexible visiting. The hospital had introduced visitor and relative's information leaflets because of feedback. These were developed by the reception team and informed visitors of local hotel, pubs, restaurants, and recreational grounds for children. In addition, a welcome to Spire Southampton hospital letter for visitors was developed which gave visitors/ relatives information on visiting times and which room their relative was in.

Are surgery services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital provided elective surgery to NHS and private patients for a variety of specialities, this included bariatric services (services to support obese patients lose weight), breast surgery, cardiology, cardiac, general surgery, gynaecology, orthopaedics, vascular, cosmetic, spinal and urology surgery. The hospital worked with the local clinical commission groups (CCGs) and the local acute NHS trust to plan services to meet the needs of the local population.

During the reporting periods of March 2018 to February 2019, the majority of the hospital inpatients services were provided to non-NHS funded patients with a smaller proportion to NHS choose and book patients.

The hospital had good working relationships with the local NHS trust, they worked together to provide services to those patients who would otherwise have to travel to receive the operation and care they required. For example, a bariatric service had been developed on site and was accessible by NHS and privately funded patients. This type of surgery was not offered at the local NHS trust. Other outsourced contracts with the local NHS Trust were in place for speciality services such as, cardiothoracic surgery, complex spine surgery, orthopaedic surgery, urological robotic procedures for prostate cancer.

The CCGs monitored the hospital's performance for NHS patients at quarterly contract meetings. The hospital had an admissions and discharge policy which was version controlled and in-date. This detailed the criteria for NHS patients that could be safely treated at the hospital. These criteria had been agreed with the CCG that commissioned NHS care at the hospital. The hospital pre-planned all admissions to allow staff time to address any issues that may be identified for further investigation.

Good

Surgery

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff accessed an external interpretation service. Posters were displayed around the hospital to inform staff of the contact numbers to call. Staff told us that to comply with the Accessible Information Standard, Spire Healthcare Limited had a contract for information to be available in different formats to ensure patients of all abilities had access to important clinical information.

The service understood the different needs of the people it served and acted on these to plan, design and deliver services. For example, disabled parking spaces and toilets were available and there were lifts to all floors. Some of the inpatient's rooms had wet rooms with showers that were easily accessible to accommodate wheelchairs and patients with walking aids. For those bathrooms which still had baths there was a refurbishment programme underway and this had been added on to the hospital risk register.

Investment in a new staff car park allowed additional capacity for patients and their relatives and ensured as much patient parking as was possible.

The pre- operative assessment process identified patient's needs prior to their admission. If a patient had specific dietary requirements these would be passed on to the kitchen and the wards. Staff on the wards told us if necessary those patients who had a learning disability or were very anxious about their treatment could have a look around the ward and familiarise themselves with the environment.

Staff would give patients specific information about their operation in the form of leaflets and advice. They had leaflets about how to prepare for their procedure before and after the operation and their discharge. A good variety of leaflets were available including information about avoiding pressure ulcers, deep vein thrombosis and being in hospital, pain relief, and patient transport.

The service provided specialist care for specific conditions and there was access to psychological and dietary services for obese patients.

There were clear instructions displayed about making complaints or giving compliments and wards displayed thank you cards from patients and their relatives and carers. Boards at the entrance to wards and around the hospital displayed patient safety and quality information.

Access and flow

Waiting times from referral to treatment and arrangements to admit, treat and discharge NHS patients were monitored by the NHS trust and were in line with 18-week targets. Private patients did not have their waiting time or referral to treatment monitored.

It was reported that the hospital had a total of 7881 patients admitted for various surgical procedures from the period March 2018 to February 2019. Of this number of inpatients (including day case) there were;

- 23 transfers to other hospitals
- 45 unplanned re-admissions
- 26 unplanned returns to theatre
- Six cancellations for a non-clinical procedure (all patients were offered another date within 28 days).

These metrics were monitored monthly and were included on the clinical scorecard. For quarter one, 2019 the hospital was slightly above the Spire Healthcare Limited network average for unplanned returns to theatre and re-admission to the hospital.

Theatre staff worked flexibly to ensure that scheduled and emergency operations ran on time. The theatre department provided an on-call team seven days a week. During our previous inspection, theatre staff told us they routinely worked late in theatre on at least two evenings per week. Senior staff told us that in response to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines for not operating on elective cases late at night, theatre staff are asked to incident report any elective cases that go to theatres after 8pm at night. There were no reports between 1 April and 30 June 2019, of patients being taken to theatres after 8pm.

It was reported that all electronic referral NHS patients followed an 18-week elective surgery pathway with the

hospital compliance target of 92%. The hospital had achieved a 97% compliance at the time of our inspection, with patient choice being the largest cause for extension of the pathway.

The speciality services commissioned by the CCG and delivered by the hospital such as bariatric surgery, cardiothoracic surgery, complex spine surgery had their waiting times managed by the NHS trust. Private patients did not have their waiting time or referral to treatment monitored. Waiting times were dependent on the patients' choice of consultant, specialty and health requirements.

Staff followed the hospitals admissions policy when admitting patients for surgery. Patients had their admission staggered in relation to where they were on a theatre list to ensure they were not waiting or being fasted for excessive and unnecessary periods of time.

- Patients were admitted at 6:30am for a morning operating list beginning at 8:00am
- Patients were admitted at 11:00am for an afternoon operating list beginning at 1:00 pm
- Patients were admitted at 3:00pm for an evening list beginning at 5:00pm.

The booking system was flexible, allowing patients where possible to select times and dates for treatment to suit their family and work commitments. The hospital offered a flexibility of appointment times including evenings and weekends.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

The hospital director was responsible for overseeing the management of all complaints received by the hospital with clinical complaints overseen by the matron. The day to day administration and investigation of complaints was delegated to the complaints co coordinator. The complaints coordinator worked with the relevant head of department, senior manager or consultant to ensure a thorough investigation was carried out once a complaint was received to address the patient's concerns.

New complaints were escalated to the senior management team and were reviewed by senior managers during the investigation and resolution stages. Complaints were signed off by a senior manager who was responsible for writing to the patient.

Complaints were discussed at the hospital management team meeting (HMT) meeting. We reviewed the minutes for these meetings and saw how complaints were part of the standardised agenda. During this meeting a presentation was given on totals and themes.

We reviewed the hospitals duty of candour (DoC) register. This provided an audit trail for the patient, the incident, reference date and tracked the status of investigation, letters sent and if meetings were offered and taken up. There had been 28 matters since January 2019 which met the DoC criteria.

We asked how the service identified when DoC should be applied and were told incidents were screened by the governance and risk team. The person raising the incident was also able to alert the team of this. Head office were then notified via the central governance team who then provided a higher level of scrutiny.

The service reviewed complaints provided by their patients and used this to make improvements. We were given an example related to pain management, which was an area where improvement had been identified. We saw an action plan was in progress, which showed what the learning was from feedback, the actions, target dates and progress made and responsible leads.

There were seven complaints received by the care quality commission during the reporting period. None of which had been reported to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).

During the reporting period of April 2018 to March 2019 there had been 111 complaints reported to the hospital, we did not request a breakdown of those which related to the surgical core service.

Complaints were monitored monthly on the clinical scorecard, the latest results showed that for quarter one 95% of complaints had been responded to within the 20-day time frame as stipulated by hospital policy.

Are surgery services well-led?

Good

Surgery

Good

Our rating of well-led stayed the same. We rated it as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The hospital management team (HMT) consisted of the deputy matron, risk manager, engineering manager, hotel and service manager and accountants these in turn report to the senior management team (SMT). The SMT consisted of the matron (interim), theatre manager, head of sales, outpatient manager and the finance and commercial manager. All of which reported to the hospital director (interim).

The provider supported and developed leadership. Two development days had been held for senior leaders. The first provided an opportunity to explore and discover insight into their own personalities. They all held a leadership folder, which provided information and guidance around the importance of knowing themselves and their teams' individual qualities, strengths and weaknesses. The second day focused on staff retention, effective leadership. As a result, there was an expectation that staff have a one to one meeting with their line managers driven by the individual.

The leadership team worked hard to understand the reasons why people left and what to do to stop this from happening in the future. The team were made aware that 23% (90) of the workforce left the service, 22% (20) left before completing a year's service. At the time of our visit there were 47 vacancies to be filled, mainly in theatres.

Exit interviews had identified some of the attrition to be attributed to staff thinking it would be easier to work at the hospital than the NHS, when the reality was that it was busy but on a smaller scale. The induction process and mandatory training had also been identified as a contributory factor to losing staff relatively soon after employment. As a result, work had been undertaken in respect to staff retention and engagement. The leadership team had focused on meeting employee/employer expectations, considering what could be done differently to help retain staff and how they could involve staff in making improvements. We saw information which clearly stated how the service had previously recruited to the workforce and the approach that was now being taken, which was more rigorous and purposeful. For example, there was tracking of the weekly workforce plan and clear establishment of staff based on demands.

There had been recognition that the hospital structure had needed to change within the hospital and because of this meant some posts had resulted in new appointments, as well as new posts having been created. Some changes had been seen for their good and it was becoming more like 'a proper hospital' as a result. Safeguarding leads told us it was very rewarding seeing the positive changes taking place, although these were only part way through.

Members of the senior leadership team and others who spoke with us reported the hospital director and matron were visible; the deputy matron was described as 'amazing' by one person.

The three wards and the preoperative assessment (POAU) had ward sisters (band 6 equivalent) who managed the day to day running of the units. The wards and the POAU were led by a clinical services manager who reported to the deputy matron who in turn reported to the matron. Theatre staff reported to leads, equivalent to ward sisters (band 6 equivalent) in the NHS and were managed by a clinical services manager, (band 7 equivalent) who reported to the theatre manager.

The lead resident medical officer (RMO) was managed by the deputy matron and clinically supported by a consultant.

The managers of all the departments alongside the operations manager and finance and commercial managers reported to hospital director.

Ward leaders were visible and approachable. Staff on the wards, POAU and theatres were complimentary about all their leaders regardless of level. They said they were supportive and would try to address any problems highlighted by staff and/or escalate them when appropriate. All staff said the deputy matron, theatre manager and matron were available to speak with and were seen on the wards an in theatres frequently, in some cases the deputy matron worked clinical shifts.

The theatres teams had been through a period of change and were in the process of quality improvements. It had been recognised that for staff to safely perform invasive procedures regular academic study was imperative to the safety of theatres. Part of the quality improvement plan was to review the scheduling of theatres lists and this would enable an academic half day to be scheduled in for all staff to attend.

Staff in theatres had attended human factors training to optimize the safety performance between people and the systems they worked in. This had been delivered by an external company. Further work was planned once a practice educator had been recruited.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a local vision which reinforced the Spire Healthcare Limited's vision, this was to be: A regional centre of excellence in private healthcare provision. This vision was underpinned by a strategy which aimed to deliver clinical excellence by working in a way that demonstrated:

- A collaborative approach,
- A purposeful attitude,
- Personalised patient care and
- Innovative ways of thinking.

The hospital had a template for 2019-2020, which outlined the long-term strategy and the objectives set to achieve them, this was monitored during the quarterly hospital management (HMT) meetings.

We spoke with the human resources (HR) business partner, the role of which was currently held by an external consultant, and the recently appointed HR lead. They spoke passionately about the strategy they had developed and progress on this with respect to identifying accurate staffing levels to meet the services provided, recruitment processes and retention of staff.

We saw and heard about the HR operational strategy for 2019, which was focused on driving growth, coaching for performance, risk mitigation plans, including succession planning and employee engagement. Underpinning this was several areas of focus for example; improved welcome meetings and a review of induction, HR surgeries twice weekly, workforce planning meetings, leadership forums, increasing awareness of HR processes and diversity and equality.

The HR business partner had looked at workforce planning and held weekly workforce meetings with representatives from areas. A tracker for recruitment was now in use and this provided good level of oversight of progress. Work had been done on overseas recruitment and, on making sure those arriving in the country were welcomed, helped to integrate with their colleagues and the wider community, and that they had accommodation.

Part of the long-term strategy for the hospital was to be recognised as a regional centre of excellence for key specialities with evidence of excellent clinical outcomes, this was being achieved at the time of our inspection for cardiac services, as April 2014 to March 2017, the risk adjusted hospital survival rate for Spire Southampton hospital cardio-thoracic patients was 99.57%.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The hospital had a freedom to speak up guardian (FTSUG) who had held this responsibility along with their role within the onsite health clinics. They had attended one day's training delivered by Spire Healthcare Limited. Since this they had spent time speaking with staff to make them aware of their role and to raise the profile of speaking up. Posters were displayed throughout the hospital identifying the FTSUG. The FTSUG had links with other Spire Healthcare Limited staff holding the same role.

All staff knew who the hospitals freedom to speak up guardian was and how to make contact.

We asked the FTSUG how much time was provided to the role within their job specification and we were told it was

not formalised in this way, as it was difficult to put a time on it. We were told that the service was flexible according to need but if a patient safety matter was raised by a member staff it would be prioritised. Safety matters were then raised through the separate restricted access FTSU incident report. The hospital matron would be liaised with, without disclosing a staff name, unless staff member gives permission.

We were told staff could report anonymously into the FTSU incident reporting log without seeing other entries. However, anonymity meant it was hard to feedback actions. They relied to an extent on making observations in the relevant department to see if things had changed.

The FTSUG provided a brief report detailing how many concerns had been raised and any learning from these matters. This was sent to the Spire Healthcare Limited central FTSUG.

Work was in progress to have six FTSU ambassadors some non-clinical and others clinical. They were to be trained by the on-site FTSUG about the processes, confidentiality and how to log issues and resolve.

Data was collected and submitted to comply with Workforce Race Equality Standards (WRES). All independent healthcare organisations with NHS contracts are contractually obliged to take part in the Workforce Race Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and act where needed to improve their workforce race equality. We were shown the systems which collected Workforce Race Equality Standard (WRES) data. All Spire Healthcare Limited hospitals fed this information to head office as data submitted to NHS England came from provider level and not location level.

We were told by a member of the hospital management team that there were 'incredibly talented individual's' working at the hospital. Line managers were described as supportive and willing to listen. The culture was said to have changed and people were' 'happier, open and honest'. Another member of staff said the culture for a while was very distinct with two camps, one clinical and the other non-clinical, with the clinical team not always being heard. Everyone had worked hard to get along and improve this. It was reported to us that there was a feeling staff would challenge one another, and there were greater opportunities to share thoughts and ideas openly. Whiteboards were used to jot down ideas and share improvements. These stayed on the board until they were discussed.

Staff were very proud to work at the hospital and in general whilst there were some frustrations there was nothing that really worried them. The interim matron spoke about the level of complexities the hospital dealt with and of being proud that the staff were able deliver complex care in a small location.

Staff felt happy to recommend the hospital as a place for their families to come if the need arose. The lead RMO said team work mentality was 'fantastic', and staff worked together for the patient. There was a good appetite to improve, which made it feel like a safe place to be, and the foundations were there to improve further. Staff were described as resilient and by the interim hospital director. There was a degree of pride for the way in which staff responded to the findings of the most recent inspection. The culture across all the areas in the surgical department was centred on the needs and experience of people who used the services. Staff of all levels showed patient care and treatment was a priority and told us they wanted to provide the best possible service.

There was a culture of openness and honesty amongst the staff we spoke with across the whole surgical department. Staff we met said they liked working at the hospital and felt they all had good teams of colleagues who were supported by their line managers.

Theatres were in the process of a quality improvement programme and were going through a period of change. A theatre cultural change project had started and was well underway at the time of our inspection. Initially this had looked at culture and had explored elements of how staff spoke to one another. Staff told us things were beginning to settle and they 'felt they were finally being listened to'. The recovery team had time put aside to meet and talk and be honest and talk about any work issues.

Governance

Leaders operated effective governance processes, throughout the service and with partner

organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The interim matron told us health management schooling had influenced a plan to make governance more robust. This included the recruitment of a governance lead, which they felt would bring calibre to the senior management team. We reviewed a document titled: Spire Southampton – Governance/Improvement Plan 2019. This outlined several principles which included:

- Having an improved governance structure with the aim of ensuring the location used clinical audit as a process to embed quality improvement across the services.
- Continue to build and promote a prominent safety culture by improving staff education, training and development for investigating, learning from and managing incidents
- Continue to build and promote a prominent safety culture with an aim of increasing excellence reporting by 50%.

The governance team at the location and centrally were responsible for carrying out gap analysis related to professional guidance. Bulletins arising from central office listed any changes to guidance, medicine alerts, medical device matters and policy updates.

We spoke with the governance lead who worked in conjunction with colleagues within the governance and risk team. They confirmed that they co-ordinated the clinical governance committee (CGC), oversaw clinical incidents and attended clinical area huddles, which were held daily. The governance lead met with the medical advisory committee (MAC) chair and made them aware of any incidents at the location and similarly the chair shared information from the nearby trust. The hospital director met with the MAC chair weekly and any concerns were discussed.

The Health and Safety Committee and Clinical Governance Committee reported directly to the hospital senior management team (SMT) and hospital director. The clinical governance committee reported to the MAC, who in turn reported to the hospital director. There were 11 departmental meetings which feed into the clinical governance committee. These were as follows:

- Clinical Audit and Effectiveness (CAEC)
- Surgical Safety
- Falls Steering Group
- Radiation Protection (RPC)
- Health Record (HRC)
- Medicines Management (MMC)
- Pain Management (PMC)
- Infection Prevention Control (Incl. Water Safety)
- Children and Young People's Steering Group
- Sterile Services Management (SSM)

We reviewed several minutes from the respective committees including minutes of the MAC. Minutes from the Clinical Governance Committee meeting were very similar to those of the MAC in that there were standing agenda items. We noted the meetings were generally well attended and discussions included an update from individual departments as part of governance and compliance. There was an opportunity to review incidents, including never events, near-misses and those where duty of candour was applied. Clinical risks were given due consideration, as was feedback from patients on their experiences. It was noted in the February minutes that Freedom to Speak Up (FTSU) would be a regular agenda item.

We asked what had changed since the previous inspection and were told a network of governance leads had been formed and they held an annual conference in March 2019. Cluster groups had also been formed and they met quarterly. 'Zoom' had been created to enable governance leads to see slide presentations and hear updates if they could not attend in person or at the time meetings were held.

We spoke with the chair of the MAC and the governance lead who was on the MAC too. The chair was a consultant urologist and the governance lead was the associate medical director at the neighbouring trust. This assisted in having cross site linkage and investigative oversight. They reported the MAC to be well-attended, although a recent gap in GP attendance had only just been filled. Attendees knew it was onerous work, but they were able to put in strong challenges through their consideration of information in an objective and frank manner, leading to

good decision making. We were told there was high-level awareness of the good clinical outcomes for some specialities and innovative work in liver cancer. The latter had led to the service becoming the training reference point for other hospitals wishing to deliver the treatment.

Prior to the MAC the chair saw the governance information and the matron presented the governance report at the committee meeting. Quarterly reports were reviewed by the MAC and were then open to interrogation of findings, which was appreciated by the hospital.

Both MAC representatives attended mortality and morbidity meetings (M&Ms). Through these M&Ms they had started to look at unplanned admissions to ICU and returns to theatre.

We asked how clinical outcomes were evaluated and were told this was organised via external websites by specialty. Outcomes were linked to those from patients attending the neighbouring trust too as far as they were able, and the Clinical Oversight Group reviewed information presented by specialities. One of the difficulties was who should collect the data, but they were able to identify performance outliers and other issues, such as consent, which they felt could be challenging when risks were not always documented clearly on consent forms. There was an IT system which liked with the trust's, this enabled information to be shared.

Clinical Effectiveness meetings were held monthly, during which previous months incidents, clinical audit, alerts, dashboards were reviewed and any learning summaries were discussed. The latter were sent to the respective heads of departments and shared with other wards. 'Flash alerts', incidents which may affect all hospitals and originated from central office. These were shared during safety huddles, which were used as an opportunity to make staff aware of any safety matters. We reviewed 10@10 reports and found they included information such as daily walkabout feedback, updates from the senior management team (SMT), visitors, reminders or message of the week, meetings, safe staffing and 'thank you's'.

All areas in the surgical division held team meetings. We saw that the pre-operative assessment unit (POAU) held a monthly team meeting and an agenda was sent out two days prior to the meeting, this allowed for staff to add on any further topics for discussion, alongside a standard agenda. Monthly ward meetings were held for all the three wards to attend. Ward minutes were reflective of the five domains of safe, effective, caring, responsive and well-led. Information was recorded in reflection of these and covered such things as incidents, training, medicines, audit results, complaints and patient feedback.

However, whilst the hospital used systems and processes to safely prescribe, administer, and store medicines correct recording was not always adhered to. Staff had not been clear how to work with the new systems recently introduced. This was in relation to record keeping for venous thromboembolism (VTE) assessments and controlled medicines on the ward.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There was good awareness of the various risks held at the location and discussion with staff provided evidence of the routine discussion of such risks within meetings.

The service had a formal risk register, which clearly stated the date added, the department to which it related and the risk owner. Risks were described along with the key controls and assurances. Where there were gaps in the controls these had been stated. We noted risks were rated and updated with progress notes and the next review date had been identified.

There was a separate corporate risk register which held the top risks that could potentially impact on services.

We spoke with the risk manager who worked in conjunction with colleagues within the governance and risk team. Their main responsibility was the risk register, risk assessments, environmental audits, and they also helped with health and safety. The risk manager reported to matron.

Heads of departments (HOD's) owned their own departmental risk registers and were responsible for

completion. The risk register was then discussed in terms of the top risks at the senior management team (SMT) meetings and Clinical Governance Committee (CGC) and by the hospital management team.

We asked how risks were added to the register using an example which related to staffing in paediatrics. We were told if a risk needed to be escalated the service would need to complete a risk assessment and this would be reviewed by the clinical governance team. There was a risk that staff who did not recognise a potential or actual risk would not necessarily escalate risks.

All the staff we spoke with were risk aware and told us of their departments top five risks. Each area had these risks displayed for quarter one 2019, alongside the risk were actions to reduce the risk. For example, one of the top risks in theatres was the recruitment and retention of staff. The most up to date actions were identified and this identified what recruitments had been made and their start dates. This was also identified as being added to the hospital risk register. This meant staff knew their local risks, knew which ones had been escalated to the hospital risk register and the most up to date plans that were being followed.

We reviewed the theatre and the ward risk registers. Overall, they reflected what was on the departmental top five risks that were displayed around the departments. Clinical safety and risks were considered daily through a safety huddle, which was held at 9:15am with staff from all areas where care was delivered. These meetings provided an opportunity to share out roles and responsibilities, including the lead role for emergency situations, should they arise.

The hospital infection prevention and control committee had effective oversight on performance of antimicrobial prescribing and antibiotic stewardship. Initial oversight and scrutiny were addressed in the Hospital Infection Prevention and Control Plan (HIPCC). This set out the strategic plan for the year to ensure the hospital had in place, nationally and locally correct: systems, competency and processes to achieve these requirements. Part of the criteria was that the hospital ensured the appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance. This was to be achieved by several actions which had been allocated to a lead. The plan showed progress and updates and at the end of quarter had completed most of the objectives identified and was on target to achieve the rest. Microbial stewardship was discussed monthly at the infection prevention and control committee meeting.

The hospital had an in-date version-controlled business continuity plan. This identified the hospitals early response to a disaster event where the hospital's ability to accommodate staff or patients, provide essential services could be severely compromised or a major event restricts access to the local area.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The interim matron was the Caldicott guardian. Training had been provided on-line. Their main interaction was through medical records and they had a responsibility to ensure that the approved process was followed when accessing information. Requests for access to patient records had to be seen, agreed and the letter which accompanied them was checked by the interim matron.

An electronic staffing safe care tool was used by the hospital to analyse staffing ratios against the acuity of patients. This information was collected twice daily at the point of care, to monitor, manage and report on safety.

There were arrangements to submit relevant data to national audit programmes. The provider had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements.

Staff had their own email account and received regular updates on training courses they could attend and when their mandatory training had expired.

Staff could access the hospitals intranet system and told us there were enough computers for their needs. Staff showed us how they accessed policies and documents on the intranet. Information stored electronically was secure.

Computer access was password protected and we observed staff logging out of computer systems when they had finished. The hospital had a closed social media site for sharing of information, training and communications.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had made a commitment to undertake employee engagement, which included focusing on service quality, the executive leadership and senior management.

We reviewed a document which explained how these three areas would be addressed which included for example, a review of theatre and hostess staff uniforms, having members of the senior management team (SMT) available for difficult decisions, and equipment issues to be raised through heads of department. Executive leaders were to undertake a tour of the hospital on each visit and the Spire for You Scheme would be relaunched to recognise high achievement. Monthly staff forums would be used as a means of obtaining feedback from staff, and SMT members were to attend at least one huddle per week for each department.

Staff who spoke with us said it was a 'people hospital', with strong engagement. We were told by the operations manager a great deal of work had been undertaken around communication since the last inspection. Huddles were used for sharing information much more widely.

Work had been carried out around cleaning responsibilities, who had responsibility for what across different staff roles. Local work on the hospital vision had moved the focus on to doing less things but doing these better.

Patient engagement forums were held, the most recent was seven or so weeks before our visit. This was a multidisciplinary approach to gaining the views and feedback from patients. For example, they had explored the discharge process having listen to feedback that it started too late on in the patient stay. They had since started a process map to commence discharge arrangements earlier on in the patient journey.

The service reviewed information provided by people who had used the service and used this to make improvements. We were given an example related to pain management, which was an area where improvement had been identified. We saw an action plan was in progress, which showed what the learning was from feedback, the actions, target dates and progress made and responsible leads.

Staff at the hospital worked alongside local GPs to share and invest in learning. 'Hot Topics' that local GPs wanted training on were now delivered alongside a GP monthly newsletter. We were given examples of evening lectures offered to local GPs by specialist consultants on robotic urological surgery. This was mutually conducive and raised the hospitals profile through education.

The hospital engaged with the local clinical commission groups (CCGs) and the local acute NHS trust to plan services. The CCGs monitored the hospital's performance for NHS patients at quarterly contract meetings.

All the staff we spoke with told us they felt supported, respected and valued. Staff told us their colleagues and supervisors supported them. They believed the work they did was appreciated and valued by the hospital.

We saw how the hospital had invested in a display of their vision through photographing staff and sharing staff and patient feedback. These were displayed across the hospital and were a very visually striking and fun way of getting the Spire Southampton hospital message across.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We asked what had changed since the previous inspection and were told a network of governance leads had been formed to provide a joined-up approach to learning and improvement. An annual conference had been held in March 2019 and cluster groups had also been formed and met quarterly. 'Zoom' had been created to enable governance leads to see slide presentations and hear updates if they could not attend in person or at the time meetings were held.

Good

Surgery

The chair of the medical advisory committee (MAC) and the MAC governance lead told us there had been improvements in hotel services and in the pre-assessment service, the latter having more nursing staff and greater medical oversight. There was a separate pre-assessment for frail complex orthopaedic patients, with a multidisciplinary approach, which included input from geriatrician. This had been driven by a serious incident about 18 months previously, where it was identified through the investigative process that there had been a lack of holistic assessment.

The service held lunch and learn sessions for primary care, for example, bariatric weight management, dietetics, cancer, cardiac surgery, dermatology and general surgery. We saw evidence of planned sessions for June through to October. The hospitals bariatric Tier 3 weight management service won a UK Association for the Study of Obesity best practice award in 2018.

The hospital was proud to offer prostatic artery embolisation (PAE), which is a non-surgical treatment for enlarged prostates.

Requires improvement

Critical care

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

Are critical care services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

The unit provided mandatory training in key skills to nearly all staff and made sure staff completed it.

Data provided by the hospital showed that compliance with mandatory training for staff in the critical care department ranged from 90% to 100% which was much higher than the provider's mid-year target of 50%. Remaining staff had until December to complete their training to demonstrate full compliance. Mandatory training is important to ensure staff are updated in any change to practice and to act as refresher to current practices. Mandatory training included, fire safety, health and safety, infection control and manual handling.

The mandatory training was comprehensive and met the needs of patients and staff. The organisation provided mandatory training on an annual basis to staff via face -to -face and through an electronic platform. Staff felt supported in training and reported they were given the time to attend training as required. If needed, staff were able to access and complete electronic training away from the hospital, they would then be reimbursed for the time taken outside of working hours to complete this.

Staff were aware of the management of sepsis. Staff received annual training on sepsis management through their immediate life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Senior staff members could access team training levels through the electronic mandatory training system used. This would show managers both the overall compliance level as well as individual training levels. Individual staff members were also able to access their own training record through this platform.

Staff received information in changes to safety systems, processes and practices. A newsletter was issued to staff during team meetings. This informed staff of any patient safety alerts and any changes to practice that may have occurred that staff needed to be aware of. For medical staff, these alerts were sent through email.

Safeguarding

Staff understood how to protect patients from abuse and the unit worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Nursing staff and medical staff received training specific for their role on how to recognise and report abuse. Training records provided by the organisation showed training compliance for safeguarding adult level two training was 97%.

Staff followed safe procedures for children visiting the ward. Data provided by the organisation showed a compliance of 97% safeguarding children level two and 100% compliance in safeguarding level three training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff we spoke with had a good knowledge of the different types of abuse and care and responsibility also extended to those visiting the hospital. Staff also received training and had knowledge in the recognition of other types of abuse. This included female genital mutilation (FGM) and child sexual exploitation (CSE). We were informed that training also included PREVENT. However, staff we spoke with were unaware of if training in PREVENT was provided. PREVENT training is given to help staff safeguard vulnerable people from being radicalised in to supporting terrorism or becoming terrorists themselves.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff had good knowledge of their roles and responsibilities in relation to safeguarding. Staff were clearly able to describe the action they would take if they had a safeguarding concern. They were also aware of the safeguarding policy and where it was located. We observed the safeguarding pathway to be displayed on the notice board behind the administration desk on the unit.

Systems to highlight patients who may be at risk were in place. We were informed that staff would be alerted to a safeguarding concern through handovers and the daily safety huddle and that any such concerns would be identified and documented usually at the pre-operative assessment stage to allow for effective planning of the patient admission. There had been no adult safeguarding concerns raised in the 12 months prior to our inspection across the hospital.

Cleanliness, infection control and hygiene

The unit did not ensure infection risk was consistently well controlled. There was a risk that equipment that was not clean would be used in the care and treatment of patients. There was lack of assurance that the facilities and systems to care for patients with suspected communicable diseases were effective. However, staff followed infection control principles including the use of personal protective equipment when delivering care and treatment and equipment in use was clean.

There was a risk that equipment that was not clean would be used in the care and treatment of patients. Although staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned, our review of equipment stored in the isolation room showed that some of this equipment had been cleaned over a month ago. There was no assurance that staff would check the cleanliness of this equipment and complete a second clean of the equipment before using it.

There was lack of assurance that the facilities and systems to care for patients with suspected communicable diseases were effective. The unit had a separate isolation room which could be used to care for patients with a communicable disease. This room was also used for care and treatment of children and young people on the unit. The isolation room had been used on 52 occasions in the last two years with 20 of these being for the care of children and young people. We were also told by the hospital that the room was kept empty and was cleaned daily regardless of whether patients were booked. However, this was not reflected in our findings during the inspection, when the room was not empty and was being used to store equipment. It was not clear how long it would take for this room to be emptied and cleaned. We raised this concern with the hospital after our inspection and were informed the room could be cleaned prior to each admission and be ready within an hour.

Hand gel facilities were available on the entrance to the critical care unit. However, they were not always clearly signposted to indicate to visitors they were there and should be used on entering the building to help prevent infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to personal protective equipment in different sizes and we observed gloves and aprons being worn by staff when undertaking personal care.

Hand hygiene audits were completed monthly to assess compliance with National Institute of Clinical Excellence (NICE) Quality Statement 61 (Statement 3). This states people should receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. We reviewed the hospital hand hygiene audit results which showed the following results I April to 31 June 2019: 90%, 1 October to 31 December 2018:100%, 1 January 2019 to 30 March 2019: 100%. Where performance required improvement an

action plan was established with clear lines of responsibility. We also requested the units hand hygiene audits for the unit and found 100% compliance with hand hygiene for the month of June 2019.

There were low unit infection rates. We observed data for the hospital and found there had been no reported incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), hospital acquired methicillin-sensitive staphylococcus aureus (MSSA) or hospital acquired Clostridium difficile (c.diff). There were also no reported cases of ventilator associated pneumonia on the critical care unit in the previous 12 months to our inspection.

All ward areas were clean and had suitable furnishings which were clean and well-maintained. We found all clinical and non-clinical areas we visited, apart from the side room used as a storage room, to be visibly clean, well-organised and tidy. Cleaning was undertaken by designated cleaning staff who undertook day to day cleaning as well as the deep cleaning of rooms when required. The units score for cleanliness was better than the England average. We looked at the results of the patient-led assessment of the care environment (PLACE, 2018) and found that the score for cleanliness was 100%, which was better than the national average of 98.5%.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Data provided by the hospital showed us that records of cleaning were completed daily. Cleaning staff reported that these areas were audited and any areas needing improvement were fed back to them to support improvement.

Staff followed national guidance to minimise the risk of infections associated with central venous line insertion. QS61 Statement 5: states, people who need a vascular access device have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the device and its removal as soon as it is no longer needed. Audits were undertaken on a quarterly basis and reviewed the compliance with central venous line processes for ten patients. Data provide by the organisation showed 100% compliance with these processes for the period 1 April 2019 to 30 June 2019.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment was not in line with guidelines. Staff managed clinical waste well.

The design of the environment did not follow national guidance or meet the needs of children.

The critical care unit was not following the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance in that the reduced size of the bed spaces did not allow for clinical wash basins. There had been a lack of development since our last inspection and there were aspects of best practice that the unit could comply with. For example, high backed chairs were not available in the bed space, instead high-backed chairs without the required foot elevation were stored in the isolation room. There were no clocks with elapsed time control or pendants above the beds to provide syringe pumps or vacuum equipment required in critical care.

The unit sometimes cared for patients under the age of 18. In these circumstances, children would be cared for in the isolation room. Although this meant they were being cared for away from adults, in line with guidance, the room was not child friendly. The environment had not been adapted to support the needs of children and there were no toys or decorations to support any children that may be cared for. However, as the unit only routinely treated children over the age of 13 for an extended recovery period, they considered the environment was suitable for a period of up to 48 hours for a young person. The unit had only admitted 20 children and young people to the critical care unit in the two years prior to our inspection. This meant the side room was infrequently used for the care and treatment of children and young people. We were informed reasonable adjustments would be made for a smaller child should the need arise, such as coloured bedding and toys/books brought to the unit. These were available on the children's' ward and were used flexibly there to ensure different aged child's needs were met.

The unit was also adjoined by the recovery room. During the inspection, we found this resulted in noise within in the unit. This could be disruptive and disturbing for patients and relatives however there had been no formal complaints received in the past 12 months from patients or visitors.

The unit had enough suitable equipment to help them to safely care for patients. Staff were able to access equipment when needed through both the unit's storage facility and within the hospital. This equipment was maintained and serviced. Equipment was serviced and maintained by in house engineers and an external organisation. Staff reported both services met demand and that equipment was quickly removed from use and replaced or serviced when needed. Servicing was carried out on a yearly basis and the external organisation alerted them when this was required. We reviewed five pieces of equipment and found they all had a clear date of service and a clear date documented of when the next service should be undertaken.

Resuscitation trolleys were checked regularly. We reviewed the resuscitation trolleys in the unit and found them to be tamper evident and reviewed regularly. Paediatric resuscitation equipment was available in the adjacent recovery room.

Equipment was available for obese patients. Staff informed us they had access to equipment such as large chairs and beds to accommodate and support obese patients.

Staff disposed of clinical waste safely. Clinical waste was collected and removed by the cleaning team. We found waste disposed in colour segregated bags, these were not overfilled and clearly identified the different types of waste that should be disposed of in them.

Sharps and medical gasses were mostly stored securely. Oxygen cylinders were stored securely in locked trolleys and sharps were disposed of in signed and dated sharp boxes that were not overfilled. However, sharp boxes were not partially closed, sharp boxes have a partially closed mechanism to reduce accidental sharp injuries or access to disposed sharps.

Assessing and responding to patient risk

There was monitoring of staff compliance with tools to identify deteriorating patients. Staff completed risk assessments for each patient, acted to remove or minimise risks and shared this information with relevant staff.

There was a strict admissions criterion to ensure only those patients who could be cared for on the units were accepted. This included specific guidance on the process for patients undergoing elective surgery, such as pre-operative clinical risk assessments.Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The department was using a national early warning score. National early warning scores are used to detect and respond to the clinical deterioration in adult patients. Audit data provided by the department showed 94% compliance in quarter one 2019 and 96% compliance in quarter two 2019 for the completion of this data. However, the audit data only showed compliance with the recording of the score and not whether the score was calculated correctly. The audit results were also only based on 20 patients and it was not clear whether these audit results were based on critical care patients. We were told that the numbers of audited patients had increased to 30 in quarter two 2019, to provide greater assurance. The audit tool was designed to assess whether the scores had been correctly applied, and identify deterioration in adult patients.

Sepsis pathways were based on the sepsis six care bundle. Staff had a good understanding of the sepsis pathways and would contact the outreach lead on the unit, the consultant on call or resident medical officer for advice and support if needed. There was no specific sepsis six box containing all the equipment required if sepsis was suspected on the unit, staff reported this was because they had access to all the relevant equipment on the unit and the adjoining recovery unit.

The critical care unit provided a critical care outreach service to the hospital. This was provided by the senior nurse on duty in the unit and the critical care resident medical officer. In our previous inspection we identified that the outreach service did not meet current national guidelines. During this inspection we found the hospital had made improvements to this service. The outreach team was available 24 hours a day, seven days a week and each member was trained in advance life support. Bleeps were tested twice a day to ensure that the team could respond when needed. Staff reported that they would follow up patients who had been seen by the team within 24 to 48 hours. Staff reported that the service was responsive to their needs.

There were pathways for referring patients to NHS services if a patient's condition deteriorated. A service level agreement existed for deteriorating patients who required

additional medical advice and support. This agreement involved the patient being transferred to a local acute NHS trust. When patients were transferred there were set transfer pathways that should be followed.

Staff completed risk assessments for each patient on admission and updated them when necessary and used recognised tools. Comprehensive risk assessments were carried out for people. We reviewed records and found assessments of patients were completed this included venous thromboembolism (VTE) risk assessments. A review of those patients at risk and any incidents were discussed during the daily patient handover.

Patients were assessed for their risk of thromboembolism. A thromboembolism is a blood clot that occurs inside a blood vessel. We reviewed the most recent audit results for VTE assessments and found between April 2018 to March 2019 between 85% to 100% of patients had a VTE assessment undertaken. It should be noted that this data is hospital wide and not specific to the critical care department.

The unit did not have 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). There was no on-site psychiatrist to support patients on the critical care unit. We raised this with staff who reported that if they had concerns about a patient's mental health, they would contact the consultant in charge of their care who could make a referral to a psychiatrist at the local NHS organisation. This was enough to meet the needs of the unit.

Staff shared key information to keep patients safe when handing over their care to others. We observed a handover from a surgical nursing staff member to a critical care staff member. There was a clear description of the patient's medical history, their next of kin and their current mental state such as their anxiety towards surgery.

Nurse staffing

The unit did not have enough substantive employed nursing staff. Therefore the unit relied on the use of bank and agency staff to ensure they had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However the critical care unit staff were not paediatric trained. Managers reviewed daily staffing levels and skill mix, but it was not clear on inspection whether all agency staff were given a full induction.

Daily staffing numbers met the needs of the patients. The interim unit manager accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift and used bank and agency staff to meet this demand. The number of nurses and healthcare assistants on all shifts on each ward matched the planned numbers. Nursing staff to ratio ratios showed for the months of February 2019, March 2019 and April 2019 level three patients were staffed on a ratio of one nurse to one patient and level two patients on a ratio of one nurse to two patients. This was in line with Guidelines for the provision of Intensive Care 2015. This detailed that level three patients require a registered nurse/patient ratio of a minimum 1:1 to deliver direct care and level two patients require a registered nurse/patient ratio of a minimum of 1:2 to deliver direct care.

Staff reported that if six or more patients were being cared for, a band six or seven nurse would be allocated to become the unit's coordinator. During our inspection, there were no more than four patients in the unit at one time, so we were unable to evidence whether this occurred.

The number of bank and agency staff used on the unit did not meet the guidelines detailed in the Guidelines for the provision of Intensive Care 2015. This details that critical care units must not utilise greater than 20% of registered nurses from bank or agency on anyone shift when they are not their own staff. The unit had a high reliance on bank and agency nurses. Of the 27 employees on the unit, 17 were bank staff members. All of the bank staff used by the unit were employees of Spire Healthcare Limited and completed the same training and competencies as permanent staff.

There had been a significant increase in the use of both bank staff and agency staff since January 2019. The unit's reliance on flexible bank staff had increased from around 300 hours per month to over 500 per month for bank staff. The unit's reliance on agency staff had increased from around 100 hours per month to 200 hours per month. The hospital reported that at times the reliance on agency and bank staff was 33% per shift. Between 29 April 2019 to 29 July 2019, 78 days out of the 92 days the unit had more than 20% reliance on bank and agency staff. In the same

time, for 13 days out of the 92 days there was greater than 20% reliance on agency staff, which was not in line with national guidance. The reason for the increased usage since January was due to vacancies in the unit.

Not all agency staff had a full induction to the unit. We reviewed the checklist that agency staff were required to undertake when working on the unit. The checklist recorded a variety of checks that were required to be undertaken, for example the use of pumps, location of things on the unit and fire drill awareness. However, of the five records we reviewed we found areas of the checklists not completed in all five. This included four out of the five not including whether their photo identification was verified and whether their training was confirmed.

The service had a number of vacancies, at the time of our inspection, there were three reported vacancies which accounted for 10% of the work force. The unit had a turnover rate of 22% this related to six members of the workforce leaving.

Medical staffing

The unit had medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm. Processes were not in place to ensure patients had access to senior medical staff twice daily.

The unit was led by two lead consultant intensivists. They were supported by seven cardiac consultant intensivists and eight general consultant intensivists. Data provided by the hospital showed that a consultant in Intensive Care Medicine (ICM) led the care of the unit every day in the past six months.

The unit had enough medical staff to keep patients safe. In the six months prior to our inspection patients had their treatment plan discussed with a consultant in intensive care medicine on admission 100% of the time.

The unit always had a consultant intensivist on call during evenings and weekends. Staff reported that the consultant intensivists, when on call, were responsive to their needs and were always contactable by phone. When required the on-call intensivist could attend the unit to provide help and support.

There was always a resident medical officer (RMO) assigned to the critical care department in the hospital. These RMOs were all qualified to speciality level four or above. Nursing staff said they had good support from the RMOs. Since our previous inspection, we were informed action had to take resulting in the RMOs being trained in managing airways.

It was not clear if medical staff did review patients twice a day in line with national guidelines. On our previous inspection we found that records did not evidence patients on the critical care unit were reviewed twice a day by their consultant, in line with current national guidance. During this inspection we requested data to determine if action had been taken to improve this. During inspection we were informed that this data was collected, however the hospital reported after the inspection that this data was not collected but was due to be audited. We were therefore not assured whether action had been taken to improve this. We saw evidence in meeting minutes reminding staff of the need to review patients twice a day.

Information between intensivists was shared through the local intensive care group.

Records

Staff kept records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.

Action had been taken since our last inspection. During our last inspection, we identified that critical care patient records did not include the time as well as the date staff made the entry. During this inspection we found that this had been actioned and records we reviewed contained this information.

Patient notes were comprehensive, and all staff could access them easily. All records, apart from imaging records were paper based. We reviewed four sets of records and found them to contain information from different professions. This was in line with National Institute for Care and Health Excellence (NICE) QS15 statement 12: Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.

When patients transferred to a new team, there were limited delays in staff accessing their records. Patients notes were paper based and travelled with the patient during their treatment journey. Patient records could be

tracked within the hospital through an electronic tracking system to determine where the patient's records could be located when needed. Staff reported this system met their needs and records were readily available.

Records were stored securely. We found patient records to be stored at the end of each patient's bed space. Although these were not locked away securely, staff members were constantly present, and records were in line of sight. Also access to the unit was restricted by a swipe access door, meaning that only authorised members of the public could gain access.

Audits of records were undertaken to assess compliance on a quarterly basis. The records audit assessed for compliance in a variety of areas including, NEWs completion, consultant documentation, consent documentation, pain, VTE and falls risk assessment completion. However, this audit only looked at 20 sets of notes and wasn't broken down into department compliance. The provider has since April 2019 increased the audit sample from 20 to 30 to provide a greater oversight.

Medicines

The unit used systems and processes to safely prescribe, administer, record and store medicines.

The unit used the services of a designated Spire Healthcare Limited employed pharmacist. The designated pharmacist had undertaken an additional qualification in critical care. If additional support and advice was required, we were informed the pharmacist could contact a more senior pharmacist at a local NHS trust for advice and support. This was in line with Guidelines for the provision of Intensive Care 2015. Guidance states that there must be a Critical Care pharmacist for every Critical Care who has the minimum competencies and must have access to a more senior specialist Critical Care pharmacist for advice and referrals.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Action had been taken since our last inspection where we found that medicines were not stored securely, and temperature was out of range in the medicine's fridge on the critical care unit. This inspection we found that medicines had been moved to a different fridge, its temperature was monitored regularly, and temperatures were found to be in range.

Audits were undertaken to determine compliance with medicines management. For example, an audit in to controlled drugs was undertaken. An initial audit undertaken in critical care in 1 October to 31 December 2018 showed a 91% compliance with controlled drug recording. Areas of poor compliance included the recording of controlled drugs for administration and poor recording of time and date given. A re-audit was undertaken for the period 1 January to 30 March 2019 which showed an improved compliance rate of 93%.

Staff reviewed patient's medicines regularly. In the medicine charts we reviewed, we found all the required information clearly documented to help ensure the correct medication, dosage and frequency that medicines were given. There was evidence of daily pharmacy reviews of the medicines prescribed and the drug charts.

Allergies were documented in the patients notes and handover documents. We found this to be completed in the four records we reviewed. However, this information was not always transcribed or completed on the staff handover sheet. One patient record we reviewed identified that a patient suffered from specific allergies, this had not been transcribed to the patient handover document. Also, we found the box where allergies were recorded on the handover document did not always contain an answer. It was therefore not clear whether the patient had been assessed and did not have any allergies or whether the information had not been transcribed.

The unit had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We reviewed the hospital recorded medicines incidents between February 2019 to June 2019. During this period 46 incidents were recorded with a clear record of the date, the action and learning taken and the current status of the incident, for example open or closed. Of the 46 medicines incidents reported, none were clearly identifiable as critical care related medicines incidents.

For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

The unit managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team.

Requires improvement

Critical care

All staff knew what incidents to report and how to report them. Staff reported they felt confident in using the incident reporting system and senior staff supported them and actively encouraged them to raise them. Staff felt the reporting system was easy to use and new staff reported that senior staff took the time to sit down with them to help them complete incident reports when needed.

Staff we spoke with reported that they were supported to report incidents and that there was a no blame culture within the department. Staff were aware of the importance of reporting incidents, regardless of their impact, and near misses.

The unit reported no never events in the past 12 months.

The unit reported no serious incidents in the past 12 months.

The number of incidents reported attributable to the critical care unit in the six months prior to our inspection was 10. Of these 10 incidents, four were reported as having low harm and six moderate harm.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three incidents reported using the electronic reporting system. All three showed evidence of a clear history, immediate action taken, lessons learned where appropriate and dissemination to different leads within the hospital. We saw evidence of discussion with the relative of one of the patients involved in the incident.

Staff received feedback from investigation of incidents, both internal and external to the unit, and looked at improvements to patient care. Any learning identified was shared through emails and through team meetings. Hospital-wide learning was also shared with staff through the daily safety huddles. For example, we saw in the clinics, clinical information/key learning folder feedback given to the team to identify learning and share updates following an incident after a patient was transferred home. The unit also displayed the top five reported incidents relating to the hospital to help improve awareness.

There was evidence that changes had been made as a result of feedback. Staff were able to inform us of changes to practice that had occurred following incidents being reported. This included changes to practice following a surgical site infection and the introduction of a critical care monitor for staff to use when transferring patients to the unit.

Staff understood the duty of candour. Duty of candour is a duty whereby, as soon as reasonably practicable after becoming aware a notifiable safety incident has occurred a health service body must notify the relevant person the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. Staff we spoke with had a good understanding of what duty of candour was and meant. Staff reported that training in duty of candour and its application could be accessed through the electronic training platform. However, we only saw a record of duty of candour assessment in two out of the three incident reports we reviewed. The hospital told us that one incident had been wrongly categorised, and therefore duty of candour was not indicated.

Safety Thermometer (or equivalent)

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

Safety thermometer data was displayed on wards for staff and patients to see. Safety thermometer data is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month. The safety thermometers on display had been adapted to highlight those risks that were greatest in the unit. This included hospital acquired infections, medical errors or sampling errors. Data displayed showed that there had been no cases of these incidents in July 2019.

Additional safety thermometer data provided by the organisation, showed the unit achieved over 95% harm free care for the last two months. In March and April 2019, the department reported zero falls, pressure ulcers and urinary tract infections.

Are critical care services effective?

Requires improvement

Critical care

Requires improvement

Our rating of effective stayed the same. We rated it as **requires improvement.**

Evidence-based care and treatment

The unit had access to care and treatment based on national guidance and best practice. However, this was not led locally, but by the organisation and not all staff were aware of updates.

Staff had access to policies to plan and deliver high quality care according to best practice and national guidance via various routes. Policies and pathways were developed centrally within the Spire Healthcare Limited organisation and then cascaded down to the individual hospitals and departments. Staff were alerted to any change of practice through a monthly update and medical staff through email and the medical advisory committee. We reviewed team meeting records for the department and found a record of updated guidelines. Nursing staff were expected to sign to acknowledge when they had read an updated policy. We reviewed the folder containing the record of this and found that not all staff had signed to acknowledge a change in policy. For example, the policy and standard operating procedure relating to adult pre-operative assessments had not been signed by five staff members, even though it was dated 19 June 2019. This did not provide assurance that staff had been updated.

We were not assured that staff were following recently introduced national and local Safety Standards for Invasive Procedures (NatSSIPs), NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). We found dedicated LocSSIPs or local invasive procedure pathways for tracheostomy, NG tube insertion and chest drains. However, at the time of our inspection not all staff were aware of their presence and staff had not received any training in their implementation. This posed a risk that staff would undertake procedures unaware of the actions devised to mitigate the risk of incidents occurring. The hospital stated that staff were following the latest pathways , but this was different to what the staff told us.

Although we found evidence staff were following evidence-based care such as NICE guidelines, when we asked staff about how they were assured they were following best practice, they reported they relied on the overarching Spire Healthcare Limited organisation to implement this.

Not all policies were updated in a timely way. We reviewed four policies for treatment pathways including central venous access devices, chest drain and arterial line management. Three out of the four had been reviewed and were within their review date. However, the policy, relating to chest drains, had a top sheet dated version August 2016 with a review date of August 2019, but the content of the policy was dated version four and five, November 2014. We were therefore not assured that staff would be following the most updated process or policy.

Action had been taken since our last inspection. On our last inspection, we identified that there was no appropriate pathway to follow for neurosurgical patients and that these patients were following spinal surgery pathways. On this inspection we found a specific neurosurgical pathway had been devised for staff to use.

At handover meetings, staff did not routinely refer to the psychological and emotional needs of patients, their relatives and carers. We observed the handover of three patients and the daily handover of all patients on the ward. Only once were the emotional needs of the patients discussed when the surgical ward was handing over to the critical care department. We were therefore not assured that all staff would be aware of the potential the psychological and emotional needs of patients, their relatives and carers.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They relied upon the nutritional screening undertaken at preoperative assessment.

Patients were assessed preoperatively using the nationally recognised malnutrition universal screening tool, however this tool was not used for the reassessment of patients on the critical care unit. Staff informed us they would follow instructions given by the medical staff and if they had concerns about a patient eating, they would refer to a dietician. We were not assured that if a patient was cared for on the unit for an extended period of time, that they would have their nutrition reassessed using the malnutrition universal screening tool.

Specialist support from staff such as dieticians and speech and language therapists were available for patients who needed it although not always on site. Staff were able to refer to an on-site dietician for help and advice in line with guidelines for the provision of intensive care 2015. Guidance states there must be a dietitian as part of the Critical Care multidisciplinary team. However, staff were required to refer to an off-site speech and language therapist if needed.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We reviewed four sets of notes and found them to contain comprehensive assessments. Compliance with the recording of hydration scores was audited quarterly. Data provided by the hospital showed an overall compliance of 85% for the hospital for the period 1 April to 30 June 2019, exceeding the target of 65%.

The unit score for food was better than the England average. We looked at the results of the patient-led assessment of the care environment (PLACE, 2018) and found that the score for food was 100%, which was better than the national average of 98.2%.Patients were offered a range of meals. An audit undertaken by the hospital asked for feedback on the quality of food. The results for April 2019 showed 84% positive feedback from patients.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.

The critical care team had access to a specialist pain team if required. The pain team responded to patients flagged as needing additional support and assessment. Staff also reported if they had concerns about a patient's pain, they could contact the resident medical officer or the on-call consultant. There were also designated pain leads within the hospital. The lead within the critical care unit would attend regular pain meetings with the pain team to discuss any issues, learning or change to practice.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain scores assessment and completion were reported quarterly, for the period 1 January to 30 March 2019 the hospital reported 100% compliance. There were different tools available for staff to assess patients' pain. For example, staff had access to a pain scores that could be determined by asking patients to point at facial expressions rather than a numerical score.

Patients received pain relief soon after it was identified they needed it, or they requested it. We observed staff to monitor patients' pain and offer pain relief if required. The hospital assessed whether patients felt that their pain was well managed as part of the patient satisfaction survey. Information provided by the hospital reported that for the period 1 January to 30 March 2019, 80% of patients responded 'a great deal' to pain being managed. It should be noted that this data is not specific to critical care.

In the most recent pain audit results undertaken in March 2019, 80% of patients reported they were given pain advice pre-operatively, were asked to give a pain score all the time during their stay and that there were no delays in the administration of pain control of more than 5 minutes. It should be noted that this audit only involved the auditing of 20 records and these were not specific to critical care.

Patient outcomes

Staff did not fully monitor the effectiveness of care and treatment. It was unclear how audits outside of the hospital were used to make improvements and achieve good outcomes for patients.

The unit did not participate in all relevant national clinical audits. Information about the outcomes of people's care and treatment about the critical care aspect was not routinely collected and monitored in a way which allowed the unit to compare its outcomes with other units. The Guidelines for the Provision of Intensive Care Services, 2015 recommend that critical care units should collect standardised national data through a recognised national clinical audit, such as the Intensive Care National Audit and Research Centre's (ICNARC) case mix programme to promote local and national quality improvement. These analyses should be reviewed on a regular basis for local action. The organisation's critical care departments did not participate in ICNARC as it is not mandatory for independent hospitals.

We spoke with clinical leads for the department asked how they assessed how they determined whether they were achieving positive outcomes for patients compared to others. They reported they used information such as

returns to theatres, readmissions, and transfers, the unit had a clear audit calendar. However, they were unable to inform us of how they compared or benchmarked against other Spire Healthcare Limited critical care units or other units around the country. Although this information was collected by the organisation. We saw that these rates were presented quarterly via the provider's clinical scorecard which benchmarked all Spire Hospital rates for comparison.

The hospital did compare its cardiac surgery outcomes, these results can be found in the surgery report.

The hospital and department participated in national PLACE audits. These are audits that assess the quality of the patient environment in both NHS and independent health organisations. They look at several different factors such as cleanliness and food.

Managers carried out an internal audit programme. The audit schedule looked at a variety of outcomes including clinic and patient outcomes. For example, bi-monthly audits were undertaken looking at records completion, Venous thromboembolism (VTE) re-assessments and temperature scores. Staff completed annual audits about epidurals, intubation, chest drains and extubation.

Competent staff

The unit made sure staff were competent for their roles although there were limitations to staff exposure to certain clinical competencies. Managers appraised staff's work performance.

New medical staff applications were considered by the medical advisory committee (MAC) with final agreement coming from the hospital director. The senior management team assessed both new staff and current staff (every two years) to determine if they were eligible to be given and maintain practising privileges. This included having an annual appraisal, indemnity, a DBS check and immunity status reviewed as well as a review of any incidents, complaints, adverse outcomes and the use of soft intelligence from staff involved with working with the consultants. Practicing privileges compliance for the hospital was 99% during the period 1 April to 30 June 2019.

Nursing staff were qualified and had the right skills and knowledge to meet the needs of patients. However, due to the nature of the unit, their exposure and thus experience to certain clinical competencies was limited. Seventeen out of the 27 nursing staff had additional qualifications in critical care. This was in line with Guidelines for the provision of Intensive Care 2015. Guidance states that a minimum of 50% of registered nursing staff should be in possession of a post registration award in Critical Care Nursing.

We reviewed the staff competency log and found good compliance with the completion with the competency framework including aspects of care required. Of the 12 staff members, two were new starters and were in the process of undertaking competency assessments. Seven out of the 12 had completed all competency assessments, three required further competency assessments to be fully compliant. However, there were a number of procedures that staff were not exposed too regularly and thus there was a risk that they may not be confident in undertaking the procedure. For example, staff had not been required to wean a patient for approximately two years.

The critical care unit staff were not paediatric trained. This unit was not meeting the expected staffing standards for paediatric critical care. Staff had completed additional competencies to support care of children and young people. These included monitoring vital signs in young people and child safeguarding. The unit treated children for back problems such as scoliosis on average every one to two months and to support a paediatric trained nurse from the children's ward supported the critical care team when paediatric patients were being treated. We were also informed that the hospital did not currently have any pathway for elective surgery that would require post-operative level one or two admission to the critical care unit for paediatric patients. However, the critical care admissions criteria states that the department may also be required to admit acutely ill paediatric patients requiring level three care for stabilisation and short-term critical care support prior to their retrieval by a specialist retrieval team from a paediatric critical care. If this occurred the patient would be under the care of a paediatric consultant anaesthetist and registered nurse children (RN Child). We were told this had not been required in the 12 months prior to our inspection.

Managers gave new staff an induction tailored to their role before they started work. New staff went through both a corporate and local induction. We spoke with staff who had undertaken the induction. They reported they felt that both the corporate induction and the unit induction had

prepared them well for the role. Staff were given supernumerary roles initially until they felt confident and all staff reported they felt comfortable in asking all levels of staff for help and support if it was needed.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection 100% of staff employed by the hospital had received an appraisal in the last 12 months. Managers and human resources staff also provided support for staff going through revalidation. Staff and the unit were alerted when revalidation was needed through human resources staff alerting them during a monthly review.

There were enough clinical educators to support staff learning and development. Since our last inspection, we were informed that there was a designated clinical educator for the clinical care department. This was in line with guidelines set out in Guidelines for the provision of Intensive Care Services.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. We found clear documentation of team meeting minutes stored on the unit. These minutes were clear and informative for those staff that may be unable to attend. There was a log of actions associated with the minutes.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with reported that they were supported to undertake additional courses and development. These were often supported both financially and with allocated time to undertake. For example, we heard of staff who had undertaken the paediatric pain course and had received training to become a trainer in life support training.

Managers made sure staff received specialist training for their role. The unit had an allocated pharmacist who had undertaken additional specialised training in critical care. This is in line with guidelines. If additional help or support was needed, the pharmacist could contact senior support at a local healthcare organisation.

Additional training in certain scenarios were regularly undertaken. Once a month, the hospitals resuscitation officer would undertake a resuscitation training scenario. These scenarios could involve a number of different incidents, for example a paediatric crash call. At the time of our inspection, one of these scenarios was undertaken, staff within the outreach team responded quickly to the call.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff delivered and reviewed care in a coordinated way. Staff felt confident in seeking support from members of the department and hospital. We observed staff members contacting others for additional advice when needed. All staff we spoke with, spoke positively of the relationships they had with all members of the unit and hospital.

There were positive supportive relationships between the unit with the rest of the hospital. We saw staff from all levels and from different departments speak to each other with kindness and respect ensuring the information needed for patient care was shared and disseminated.

At the time of our inspection the hospital was trialling new scrubs for the resuscitation RMO's. These scrubs had their role due to be embroidered on them. The aim of this was to help assist in the identification of their role when they were responding to urgent care needs.

Staff held a daily multidisciplinary (MDT) meeting to discuss patients and improve their care. Additionally, on admission, and daily thereafter, every patient had an individualised MDT discussion with the consultant, nursing staff and intensivist RMO. This approach allowed patient centred care to be delivered based on individual patient needs. All team members were aware of who had overall responsibility for each patient care and who was on call. There was clear identification of the consultant responsible for providing care to the patients on their notes and handover documents.Staff worked across health care disciplines and with other agencies when required to care for patients. Staff knew how to refer patients to appropriate internal services when they required additional support. Staff we spoke with felt confident in referring patients to a variety of services both internally within the hospital and to the local NHS organisation. Staff were able to access services from other organisations through service level agreements.

Seven-day services

Requires improvement

Critical care

Key services were available seven days per week to support timely patient care either through an on call arrangement, or a service level agreement with the nearby NHS trust.

Pharmacy services were available Monday to Friday - 8.30am to 5.30pm and Saturday - 8.30am to 12.30pm. Outside these hours there was a shared 24 hour on-call service provided by Spire Southampton and another local Spire Healthcare Limited hospital across the two sites.

Access to pathology services was provided 24 hours a day seven days a week, with on-site services Monday to Sunday during the day shifts, and an on-call service available outside of these hours.

Most imaging services were available seven days a week. Staff had access to X-ray and computerised tomography services seven days a week. These were located within close proximity of the critical care unit. Magnetic resonance imaging was available five days a week. Staff reported if an urgent MRI was required outside of these hours, the patient would be transferred to the local NHS organisation.

Staff on wards could call for support from the critical care outreach team seven days a week. The lead nurse for the outreach team was a critical care nurse. This service was available seven days a week.

Consultants provided a 24 hour, seven days a week, on call (off site) service for their patients. Staff reported these consultants could all return to the hospital within 30 minutes.

Health promotion

Staff relied on the wards to give patients practical support and advice to lead healthier lives.

There were limited opportunities for staff to undertake health promotion, due to the nature of the care provided by the unit. However, the service supported staff to promote healthy lifestyles including smoking cessation at relevant opportunities.

The unit did not have relevant information promoting healthy lifestyles and support. We found no leaflets or information on the unit to help advise and support patients or their relatives to make healthy life choices or to advise them of support services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patient's consent. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There were consent forms for staff to use when gaining a patient or relatives consent. Staff were aware of the need to gain consent for procedures. We observed staff obtaining verbal consent from patients for general care such as observations or manual handling.

Staff clearly recorded consent in the patients' records. During our previous inspection we raised concerns about patients consent to the use of bedrails as we found no evidence of the involvement of patients in the decision to use bed rails. During this inspection we found consent had been gained for the patients where bed rails were being used.

Staff understood the use of do not attempt resuscitation forms. However, they were rarely required in the unit due to the type of patients seen and treated with only one required in the past year.

Staff understood how to assess whether a patient had the capacity to make decisions about their care. Staff had access to support guidance to help determine if a patient was suffering from delirium which may impact a patient's ability to consent. There was clear step by step guidance for this assessment. Staff reported if they had any concerns about a patient's capacity or consent they would contact the resident medical officer or on call consultant. However, it was not clear whether there was any specific guidance or pathway for the assessment of a patient's capacity. When we requested to see this, staff informed us they were not aware of any document and would assume this would be recorded in the patients records.

Are critical care services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

Requires improvement

Critical care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed all staff introduce themselves and explain who they were and their role. The tone of voice used was one of respect and care which extended to both the patients and their relatives.

Patients said staff treated them well and with kindness. Due to the nature of the conditions of the patients and the limited number of patients being cared for during our inspection we were only able to speak to one patient. However, we were also able to review several cards given to the wards by patients. All comments we reviewed were positive about the care patients received, comments included, 'joyful dedication touched my heart and soul', 'I felt really safe throughout the whole process and in good hands' and 'thank you so much for being so kind and gentle'.

Staff did not always follow policy to keep patient care and treatment confidential. Staff did not always ensure that curtains were pulled when undertaking care. We observed curtains being drawn however, gaps were left between the curtains meaning that discussions could be overheard, and care given observed by both staff and visitors.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff recognised the importance of adapting their care when caring for patients between the ages of 16-18. Staff recognised the importance of respecting patient's wishes on whether they wanted to be treated as an adult or child, whilst adapting their tone and assuring patient needs were met.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff caring for both the patient and their relatives and recognising when additional emotional support might be needed. Staff took the time to assist relatives when needed and extended care to them as well as the patients. For example, we observed two staff members supporting both a patient and their relative with a hot drink.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Thank you, cards, given to the unit demonstrated this level of support. Comments written included, 'thank you for the kindness and understanding you afforded my family' and from a patient relative, 'thank you for the support and company you provided me during those times'.

Staff recognised the need to try, where possible to make the unit a friendlier place. For example, we were informed that the television on the unit had been used to show significant events to patients. This included sporting events such as football matches.

Understanding and involvement of patients and those close to them. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. A relative that we spoke with reported their relative was in the unit and that they felt reassured by the care their relative was being given.

Staff extended care to patients' relatives. We observed staff taking the time to support a patient relative to the unit. They recognised the relatives need for support and how this might need to be extended when the patient was discharged. Staff spoke in a kind, compassionate and respectful way when discussing the patients and relative's needs. We also heard nurses explain the purpose of certain equipment to relatives to involve them in the care.

It was unclear how patients and their families could give feedback on the unit and their treatment and how staff supported them to do this. There were no formal mechanisms for patients or families to give feedback about the unit outside of the hospital's friends and family survey. Staff were unaware of any other mechanism and how to support patients in doing so.

A high proportion of patients gave positive feedback about the unit in the Friends and Family Test survey. The friends and family test are a survey which asks patients whether

they would recommend the service to friends and family. The results for the hospital showed a score of 92% and above from November 2018 to April 2019, however, these results were hospital wide and did not give an indication of patients' satisfaction with their experience on the critical care unit.

Are critical care services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The unit planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. There was a clear admission criterion for elective services. Safe admissions were planned via the pre-assessment appointments. These were appointments with the patient to plan their surgery and identify any additional support requirements. Cardiac surgeries were planned for Mondays, Wednesdays and Fridays. Weight loss surgery for obese (bariatric) patients was planned for Tuesdays and Thursdays to allow time for their recovery and flow within the unit. There was a contract with the NHS to complete the surgeries for 50 short stay patients per month, meeting the needs of the population in Southampton, Portsmouth and Dorset and the nearby surrounding areas.

There were a sufficient number of beds for the services being delivered. We saw the unit had seven bed spaces, with five in use during our inspection. One unused bed space was allocated for emergencies in case of a transfer back to critical care from the wards. One bed space was designed as an isolation room but was used as a storage room during the inspection.

There had been a lack of development since our last inspection in 2017 and there were aspects of the guidance that the unit could comply with. For example, high backed chairs were not available in the bed space, instead high-backed chairs without the required foot elevation were stored in the isolation room. There were no clocks with elapsed time control or pendants above the beds to provide syringe pumps or vacuum equipment required in critical care.

Staff were unable to access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia. There was no mental health lead within the hospital, however critical care staff told us that they rarely provided care to patients with dementia or mental health problems as most patients were elective admissions. We were told that although there was no formal arrangement in place to access emergency mental health support the hospital had a good relationship with the nearby NHS trust and safeguarding teams to access this help when needed. This had not been required in the 12 months prior to our inspection.

Patients attended pre-assessment clinics to develop a suitable care pathway prior to their surgery and admission to critical care and the wards. We were told that additional needs would be identified and managed and were given examples of when this had happened.

The unit had systems to help care for patients in need of additional support or specialist intervention. We heard how staff would refer to the bariatric specialist team for support with obese patients. Staff advised us that they could borrow dementia resources from the ward, should they be caring for a patient with dementia. There was a system for booking face-to-face interpreters. This had been used to good effect for a client with no understanding of the English language. During pre-assessment the interpreter was booked for the anticipated ward transfer hours, prior to the patient's admission to hospital. However, telephone interpreters were rarely used despite a portable telephone being stored in critical care.

Relatives of patients below the age of 18, with dementia or learning disabilities could stay overnight in the patient's ward bed, while the patient was on critical care. Relatives could use the relative's room and get food and drink from the on-site restaurant.

The unit relieved pressure on other departments when they could treat patients in a day. We saw written feedback from the hospital management team thanking the critical care team for supporting the wards. Patients well enough for transfer to wards stayed on critical care to 'reduce pressure

on the wards and prevent cancellations. Staff described times when they supported the wards by releasing a nurse to work on the ward. This was possible when there were fewer patients in critical care. However, although this helped relieve pressure on the wards, it meant that the length of stay for patients on the critical care was longer. This can impact on the patients rehabilitation in a negative way.

Meeting people's individual needs

The unit was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet most of their needs. We were given examples of additional support given to patients who had learning disabilities and were non-English speaking. The need for support was assessed and then put in place following the pre-operative assessment appointment and this support continued on the critical care unit. We were made aware of pre-operative assessments being conducted over many appointments to ensure patient understanding and level of support required.

A patient's individual care needs were documented from the point of pre-operative assessment in the patient records. A best interests meeting would be held as required and planning would be discussed in the morning safety huddles, plus the weekly planning meeting. All staff had received training in caring for patients living with dementia although they did not use the 'This is me' documents and patient passports. Staff reported that they rarely cared for patients living with dementia. However, if they were caring for a patient, or were caring for a confused patient following the removal of airway support they would comfort and reassure them. If additional support was needed staff could refer to the dementia lead within the hospital, and could make reasonable adjustments to the environment as required.

The unit was not designed to meet the needs of patients living with dementia. The hospital achieved below the England average score for the patient-led assessment of the care environment (PLACE, 2018) with a score for dementia of 47.76%, which was worse than the national average of 78.9%. The score for how well the needs of patients with a disability were met was 63.63% which was worse than the England average of 84.2%.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. To comply with the Accessible Information Standard, the hospital could provide information to patients in different formats to ensure patients of all abilities have access to important clinical information. However, although a hearing loop was not available in the critical care unit there were mobile hearing loops around the hospital including in outpatients and at reception areas. If a patient required one they could be borrowed from one from these areas.

The unit had information leaflets available in languages spoken by the patients and local community. Staff described how information would be provided at the pre-operative assessment appointment, rather than in the critical care unit. The limited space and thorough pre-operative assessment process were given as the reason for not providing leaflets in critical care.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation services for patients where English was not their first language. This service was provided via the ward contacting reception to book a face-to-face interpreter.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff were able to request face-to-face interpreters for patients and had access to telephone interpreting, although we were informed that this was rarely used or needed. Staff talked about how they would access the 'dementia box' on the ward to use tools like the dementia friendly digital clock, coloured plates, doll and special cutlery.

Access and flow

People could access the unit when they needed it and received the right care promptly. The unit admitted, treated and discharged patients in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed. Data provided by the hospital showed that from May 2018 to April 2019 the

number of bed days used was a lot lower than the number of bed days available. For example, in April 2019, of the 120 level three bed days available, only 26 bed days were used, and of the 90 level two bed days available, only 32 bed days were used. During our inspection five out seven beds were in use.

Guidelines state that admissions to intensive care must occur within four hours of making the decision to admit. Data provided by the hospital showed 100% compliance in the six months prior to our inspection for admitted patients being seen and reviewed within four hours.

Managers worked to keep the number of cancelled operations to a minimum. The surgery list was planned to promote flow within the critical care department and wards. Hospital feedback and staff on the critical care unit described times when they would keep patients ready for transfer to the wards on the critical care unit to ease the pressure on the ward to avoid cancellations. As the unit was rarely full, this mean the critical care had the capacity to support the wider hospital.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients would typically stay on the critical care unit for 24-48 hours. Staff told us that patients who were obese or had received weight loss surgery were often transferred to the ward to stay in the double bay instead of the critical care unit, where critical care staff would care for the patient. This was to encourage the patients to mobilise and to provide an environment that was most suitable for the patients' recovery.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff spoke highly of the pre-operative assessment and described how it was important in planning for the admission, treatment and discharge of vulnerable patients.

Managers and staff worked to make sure that they started discharge planning as early as possible. Guidelines state, discharge from critical care units to a general ward must occur within four hours of the decision. Data provided by the hospital showed that only 3.7% of patients had their discharges delayed by more than four hours.

Readmission rates were low. Unplanned readmission rates to critical care units within 48 hours of discharge, to a ward, must be minimal (less than 1.8%). Data provided by the hospital showed one unplanned readmission to the unit in the previous six months within 24 hours and one within 48 hours. This amounted to 1.85%.

The unit moved patients only when there was a clear medical reason or in their best interest. Managers monitored patient transfers and followed national standards. Transfers to the ward were completed within four hours from decision to discharge. Transfers to the NHS hospital would usually be completed within four hours, but staff spoke of how it was dependent on the NHS hospital bed availability. In the previous six months to our inspection, the unit reported one patient level three to level three transfer.

Staff supported patients when they were referred or transferred between services. Staff had access to a transfer documents to ensure relevant information was shared with the ward. At the time of our inspection, this document was in the process of being adapted as staff recognised that the need for different information to be highlighted for cardiac and general patients. This was in line with Guidelines for the provision of Intensive Care 2015. Guidance states there must be a standardised handover procedure for medical nursing and staff for patients discharged from critical care units.

Staff spoke of their supportive relationships with clients and their families, describing the family's needs as 'part of the patient's care' needs. Thank you, cards, seen on inspection detailed appreciation for the support received by patients and their visitors. Relatives we spoke to commented on how they were kept informed by staff and knew when their loved one would be transferring to the ward. Staff were thankful for the administrative support assisting the referral and transfer process, with a diary being completed to record the patient movement. This data was reported electronically.

A study day was due to be held on the critical care unit in September 2019. The study day was named 'transferring the critically ill patient' and was planned for a Sunday when patient numbers would be at the lowest for the week and staff availability would be higher. The aim of this study day was to improve transfers and team working.

Staff did not move patients at night. Guidelines state that discharges from Critical Care must occur between 7 am and 9.59pm. Staff informed us that patient transfers were

completed with assistance from the porters who worked until 10pm at night. Staff said it was very rare for a patient to be transferred after 8pm as it was disruptive for the patient. The reason for overnight transfers was due to clinical need and emergencies. We reviewed data provided by the hospital and found 1% of patients were discharged out of hours in the previous 12 months to our inspection.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The unit treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. Staff advised us that this information was provided in the pre-operative assessment process.

The unit did not clearly display information about how to raise a concern in patient areas. Staff spoke of the lack of space in critical care, restricting their ability to display the complaints information. Complaints posters were located on the ward which was attended before and after a patient was admitted to critical care. However, it was unclear if relatives would be aware about how to raise a concern about the critical care unit straight away prior to attending the ward.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. We reviewed complaints received in the last six months. There was a record of the complaint, the area the complaint related to and the action and learning taken. Of the 61 complaints received none were specific to the critical care department.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff described how complaints would be responded to by those working in the hospital management suite. Managers shared feedback from complaints with staff and learning was used to improve the unit. Staff explained how lessons learnt were stored in a blue folder on critical care. Lessons learnt were discussed at the monthly team meetings and suggestions were made by the team, to improve the unit.

Are critical care services well-led?

Requires improvement

Our rating of well-led went down. We rated it as **requires improvement.**

Leadership

Leaders had the skills, knowledge, experience and integrity to manage the clinical aspects of the critical care services.

Consultants were supported by a general intensivist and a cardiac intensivist.

At the time of the inspection there was an interim critical care unit lead in position who was providing leadership and managerial support at the time of the inspection. A new hospital director and a new critical care unit lead had been appointed at the time of the inspection and were waiting to start. There was additional support provided from the Spire group's central team and the interim senior management team.

Leaders understood challenges to quality and sustainability. Leaders within the unit helped to maintain relationships with the local NHS organisations through maintaining close working relationships. The decision to make changes to the environment was made locally to maintain quality and a business case for funding had been submitted and approved at the provider level.

Leaders were visible and approachable. Staff told us the leadership were supportive, compassionate and caring of the staff and the patients they treated. They felt the senior team were available when they needed support or guidance. Staff knew who their senior managers were.

Staff felt supported by leaders. Staff felt confident in raising concerns with members of the leadership team. They felt they would be listened to and action taken where possible. Staff we spoke with from all levels of the organisation spoke of a supportive and collaborative relationship with leaders. We found that nurses appreciated the gestures of thanks from their managers. One staff member informed us that leaders were, positive, consistent but not too authoritative.

There was a leadership development programme. A leadership programme had recently been introduced and was being rolled out to include nurses of varying levels.

Requires improvement

Critical care

Vision and strategy

There was a vision for the unit, the newly recruited leader would be responsible for driving and delivering change within the service.

There was a designated Spire Healthcare Limited vision and hospital vision. Spire Healthcare Limited's vision was 'to be recognised as a world class healthcare business" and their mission was "to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care. The hospital vision was to be a regional centre of excellence in private healthcare provision which is underpinned by the hospital's way of working.

Leaders within the department reported their vision was to maintain exemplary standards and oversee a physical rebuild of the unit. This was aligned with the hospitals vision, which included the redeveloping of the critical care unit to meet building regulations.

Leaders had an awareness of the current health and social care economy and the future impact on the unit. Medical leaders were aware of the importance in maintaining being able to support the care of both NHS and private healthcare patients. They recognised that to maintain the skills and level of care they provided and wanted to provide that strong relationships with the local healthcare organisation were important. This work was supported by clinicians working in both organisations.

Culture

There was a positive culture amongst the unit and the staff that worked there. The culture was supportive.

The department did not have its own set of values but used the hospital wide values. These values were caring is our passion, succeeding and celebrating together, driving clinical excellence, doing the right thing, delivering on our promises and keeping it simple. We also saw evidence of a critical care aim, which was to strive to look after patients as staff would wish to be cared for themselves. Although it was unclear when this aim had been devised, and with who's involvement, we saw this value displayed by staff in the care that they undertook.

Staff we spoke with felt supported, respected and valued. Staff spoke of a culture where staff felt free to speak up. Staff felt able to challenge colleagues in a safe and supported way. Patient care was perceived as the top priority. Staff we spoke with reported that good patient care was their top priority, and this was supported by the department.

There was evidence of team working and cooperative, supportive and appreciative relationships among staff. During our inspection, we observed staff supporting each other and supporting learning for more junior staff. Staff told us they had support from both the internal team, but also from throughout the wider hospital staff when the department was under pressure from high demand. Staff spoke of collaborative working relationships amongst nursing staff, therapy staff and medical staff. Staff discussed changes that had occurred following concerns being raised, for example, the introduction of a log of nurse's responsibilities in relation to cleaning which had reduced confusion between nursing and cleaning staff. Also, the introduction of laminated cards to act as a reminder for consultants to document within the notes and to record certain details e.g. date, time, signature. These were kept at the end of each patients' bed with the patients records.

The organisation celebrated success and rewarded staff. Staff could be nominated for Spire Healthcare Limited's inspiring people awards. Also staffs' good work was discussed daily during the multidisciplinary huddle as part of the inspiring people agenda item. This information discussed those staff members who may have undertaken a good piece of work or had an exceptionally positive impact on a patient. This information was then shared with those staff members discussed being given cards with phrases such as, 'you went the extra mile', 'thank you' and 'well done'.

Staff development was encouraged. Staff we spoke with reported they were supported to develop their skills and qualifications. They reported this had been a recent area of improvement for the organisation, although they still felt that development was heavily reliant on individuals finding courses and gaining permission to attend rather than driven from within the organisation.

Data was collected and submitted to comply with Workforce Race Equality Standards (WRES). All Spire Healthcare Limited hospitals fed this information to head office as data submitted to NHS England came from provider level and not location level. All independent healthcare organisations with NHS contracts are contractually obliged to take part in the Workforce Race

Equality Standard (WRES). Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality. The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in "Freedom to Speak Up" in 2015. At the time of the inspection there was a Freedom to Speak Up Guardian who linked into the overarching Spire Healthcare Limited's national guardian.

Governance

The unit did not have a clear systematic approach to continually improve the quality of its services and safeguard high standards of care. The systems needed further development.

Information from ward to the governance committee were shared. Staff received feedback from governance work, Information and actions from governance meetings and other meetings were fed back to staff in a variety of ways. There were monthly team meetings, daily safety huddles and quarterly leadership meetings. This was supported using emails and newsletters to help ensure those staff that were unable to attend had access to the information required.

Staff were clear about their roles and understood what they were accountable for, and to whom. They were clear and knowledgeable about who to raise concerns with and who to contact for guidance and support. They felt confident in doing this.

Most meeting minutes were informative and clear, however not all information was reviewed. We requested the last six months of critical care governance meeting minutes. We were informed that these were held quarterly, and February's meeting had to be abandoned as it was not quorate. We were provided with June 2019 meeting minutes. We found the meeting was reasonably well attended and a review of the governance report, infection prevention and control and recruitment. However, we found no record of discussion surrounding key learning or alerts. The only reference to the risk register was that, the hospital wide and departmental risk hierarchy was attached for reference and that the risk ratings would be shared with staff. There was no reference to any action taken to reduce the risks identified. The provider stated that alerts were shared daily via safety huddles and email and summarised and shared monthly via the national safety bulletin.

There was a programme of clinical and internal audits to monitor quality and operational processes. We were told this information was collected by the organisation. We saw that these rates were presented quarterly via the provider's clinical scorecard which benchmarked all Spire Hospital rates for comparison. However, when we spoke with clinical leads for the department they were unable to inform us of how they compared or benchmarked against other Spire Healthcare Limited critical care units or other units around the country

There was a lack of assurance all learning was identified. Regular mortality and morbidity meetings were held for cardiac patients. This was in line with Guidelines for the provision of Intensive Care 2015. Guidance states units must hold multi-professional clinical governance meetings, including analysis of mortality and morbidity. However, it was not clear if these were held for general intensive care patients, of the minutes we reviewed, we found them to be well attended by nursing staff, surgical staff and anaesthetists and held quarterly. They were clear and informative. They contained a breakdown of performance and complications. Complications were discussed, and learning identified. Staff reported that if learning was identified, this would be shared through emails and added to the agenda for the next business meetings.

There was a service level agreement in the event of a deteriorating patient requiring treatment or referral to an NHS organisation. In the event of an emergency the unit would transfer patients to the local NHS organisation.

In the event of a death in the critical care unit we were told that Spire Healthcare had adopted the national Learning From Deaths Framework, which meant every unexpected patient death was subject to a full review by an expert from the central team independent of the hospital.

Managing risks, issues and performance

The management of risk, issues and performance was inconsistent.

There was a hospital wide risk register discussed by the senior management team at monthly formal meetings. On

a monthly basis, local risk was discussed by the senior management team with progress on actions expected to be presented. We were told that information was then cascaded to the critical care manager.

The hospital risk register contained two risks relating to critical care, this included:

- Clinical competencies or training for Critical Care and Theatre staff to deal with a cardiac surgical emergency
- There is a risk of failing to attract, hire and retain trained, qualified and competent staff across a number of key clinical areas including wards, diagnostic imaging, oncology, critical care and cardiac catheter room.

However, in the governance and quality report for the period 1 April to 30 June 2019 the fourth top risk was that the critical care layout did not meet national standards and the unit was designed prior to national regulations and had a lack of space and storage. We saw this risk reported on the departmental risk register with a score of 12 which was greater than the rating assigned to the concerns surrounding staff competencies to deal with cardiac surgical emergencies. It was not clear why this was not reflected in the hospital risk register.

The organisation had systems for identifying risks, however action to reduce or eliminate them was not always carried out in a timely manner. For example, the unit had been given a set of Local Safety Standards for Invasive Procedures using the national Safety Standards for Invasive Procedures. However, staff were unaware of them and had not been given any training in how to use them. We were therefore not assured that although the risk with undertaking these procedures had been identified, staff were aware of the actions to reduce them. Most of the staff we spoke with reported that they felt staffing was the biggest risk facing the unit.

There was limited benchmarking against other organisations to drive improvement. We asked staff how they benchmarked their critical care and unit outcomes against organisations both internally and externally. Staff reported that, apart from cardiac surgical outcomes which are reported on in our surgery report there was little other participation in national audits. Leaders were also unaware of how the unit compared with other Spire Healthcare Limited critical care units.

Poor performance was managed. Staff we spoke with reported that if concerns were raised about a staff members performance, investigations were undertaken, and action taken. We were given examples of when this had occurred, and staff felt confident in the systems.

Measures were taken to monitor professionals. The hospital director ensured consultants holding practising privileges had a level of valid professional indemnity insurance. This was in line with the Health Care and Associated Professions (Indemnity Arrangements) Order 2014. The hospital medical advisory committee (MAC) monitored consultant's practice to ensure staff had the required qualifications, competencies and insurance to continue to provide care at the organisation.

Managing information

Arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were maintained.

Records were stored on site for a period of time and could be tracked through an electronic tracking system when needed. After a set period of time, records were then stored securely off site.

Staff knew where to locate policies and contact information if they needed additional help or information. Policies were stored both electrically and in paper format and staff were able to access them quickly when needed.

Engagement

The unit engaged well with staff, however there were limited mechanisms to engage with the public. The department collaborated with partner organisations effectively.

The views of patients and their relatives were not formally sought however verbal feedback, we were told, was received along with friends and family tests to gain patient and relatives views. However, these were not broken down to departmental level, so staff could not identify patient's views about their care and treatment on the critical care unit. We asked staff if there were any other formal mechanisms to gain patient or relative views and were informed there was not.

Engagement with patients and members of the public had not led to improvements within the department. The

organisation reported that they displayed 'You Said, We Did' actions throughout the hospital to evidence learning and action to patients and staff. However, there were no such displays within the critical care unit.

Staff were not actively engaged so that their views were reflected in the planning and delivery of unit. During our previous inspection, staff highlighted the need for both a redesigned critical care unit as well as the need to submit data to the Intensive Care National Audit and Research Centre. However, we found both needs had not been acted on. When we raised this with leaders of the unit, we were informed that these decisions had been made at a provider level, and they were not aware of future plans.

Staff views were obtained. Staff members had the opportunity to complete an annual staff survey. All staff we spoke to reported that they felt confident in raising concerns or issues with more senior members of staff if needed.

The department engaged well with stakeholders and the wider healthcare system. There were good working relationships between the department and the local NHS organisations supported by service level agreements. These relationships were enhanced by the fact that most medical staff worked across both organisations and were able to support the sharing of learning, clinical practice and information.

Learning, continuous improvement and innovation

Innovative approaches had been introduced to improve the unit.

The unit, along with a local NHS organisation, were the only organisations in the country to offer chemo saturation for patients with liver metastases. This treatment enabled patients living with liver metastases to have chemotherapy focused on the liver. This had been shown to not only reduce the side effects on patients, but also increase the patient's life expectancy. The unit had treated patients from all over the world.

The unit reported that the outcomes for cardiac patients was one of the best in the country.

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Good

Services for children & young people

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

Are services for children & young people safe?

Good

We spoke with five children and young people and five parents. We spoke with two out patients' staff, two children's nurses and the Children and Young person's service lead. We observed an interaction with a consultant in the outpatient's department and followed one child through the operating department. We reviewed information provided to us in advance, during and after the inspection. We also reviewed five sets of records.

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

Our rating of safe stayed the same. We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

There were ten mandatory training core modules for all staff for 2019. These included antibribery; compassion in practice; equality and diversity; fire safety; health and safety; infection control; manual handling; safeguarding adults and safeguarding children. Information governance was updated as a core module in June 2019 for this module compliance was at 87% for all other modules it was above the providers target of 95% compliance.

There were role specific mandatory training modules which included European Paediatric Life Support (EPLS) paediatric immediate life support (PILS) and paediatric basic life support for those staff who interacted with children. Information provided showed 83% of staff required to compete the PILS training had done so. One member of the registered children nurses' team did not have a current EPLS training, however there were plans for them to attend a course.

Safeguarding

Staff understood how to protect children and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The safeguarding children and young people lead was the children and young people (CYP) service lead who was trained to level 4. They were part of the Hampshire Local Safeguarding Children's Board, with the board's lead nurse providing them with supervision for matters relating to safeguarding. The lead nurse told us this was to help ensure the service kept up to date with safeguarding strategies.

In-house face to face training was provided by the CYP lead nurse. The provider told us all registered nurse children (RN Child) had completed level 3 Safeguarding Children training along with all registered nurses (RN) and support staff directly involved in the care of children. All other hospital staff completed level 2 safeguarding children training. This was in line with the intercollegiate document Safeguarding Children and Young People: Roles and competencies for Health Care Staff published in March 2019.Information provided indicated 534 staff directly

employed were involved in the care of patients aged under 18. All staff have completed safeguarding children training. Five hundred and eleven had completed level 2 safeguarding children training and 59 level 3.

Any consultants registered with the hospital's paediatric register to see or treat children under 18 were required to provide evidence of level 3 safe guarding children training. Appointments could only be made for consultants who were compliant with the hospital's paediatric register. A review of practicing privilege documents confirmed consultants had provided this information.

Staff were clear about their responsibilities to safeguard children and the action to take if they had any concerns. Additional information was on display including information about who the safeguarding lead for children was and the pathway to follow if they had any concerns.

The names of those adults who were the primary carers for the child or young person were recorded in their records. This helped staff ensure only those known to the individual and with the right to visit were allowed to do so. There was also a section for families to inform the team if support was being provided by social services.

Section 11 audits were completed annually, and this was sent to the safeguarding children's board and the Clinical Commissioning Group. This is where all local agencies and organisations who provide services to children and young people are asked to self-assess the extent to which they meet the safeguarding requirements and standards as set out in Section 11 of the Children Act 2004.

Three safeguarding alerts had been made for children in the last year. Actions were taken in all cases through the correct channels.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect children and young people, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were visibly clean and odour free.

There was an established process for the cleaning of toys which staff were able to describe and we saw this was documented and monitored.

All staff were observed to be bare below the elbow, to help reduce the risk of the spread of infection and staff washed their hands or used hand sanitation gel between patient contact in line with World Health Organisation's "five moments of hand hygiene" standards.

Equipment was cleaned between use and labelled with 'I am clean stickers' to indicate it was clean and ready for use.

Personal protective equipment such as gloves and aprons were available and we saw staff using these when carrying out procedures and personal care activities.

While the patient rooms and clinical area were fitted with hard flooring which could be easily cleaned, the main corridor remained carpeted. To manage the potential infection risk these were deep cleaned monthly.

For the first three months of 2019 there had been no surgical site infections with 31 days of surgery for children and young people.

See information under this sub-heading in the surgical section.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept children and young people and their families safe. Staff managed clinical waste well.

The children and young people were looked after in a designated, secure ward-based environment. The area comprised five private rooms and a play room. Folding beds were provided so a relative could stay with a child or young person.

Access to the children's ward was secure and needed swipe card access, the exit button was out of reach of children.

Outpatient services were provided within the wider outpatient's department environment. This meant children would be waiting in an environment with adults. The potential risk was being managed by the requirement for children and young people to be accompanied and with the provision of child friendly waiting area. Parents and young people we spoke with in the outpatients' department felt this was not an issue as they did not have to wait long in the department.

Environmental checks were completed weekly and fuller risk assessments were completed monthly to ensure risks

to children and young person were considered, in the areas were children were routinely seen. We reviewed the records in two areas which confirmed this process was followed and action taken where required.

Following an anaesthetic staff recovered children and young people in the main operating department recovery area. National guidance is clear children should not be recovered alongside adults, to manage this a section of the recovery area had been screened off and decorated to make it more suitable for the younger age group.

There were facilities for the segregation and safe disposal of clinical waste and we observed staff segregated waste as required.

Age appropriate equipment was available in all departments where children were seen. We checked a sample of equipment and there were labels to indicate when the last service and safety checks had been completed and all of these were current.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each children and young people and removed or minimised risks. Staff identified and quickly acted when children or young person was at risk of deterioration.

There was always someone on duty trained to provide advanced life support in an emergency. All resident medical officers (RMO's) were required to have up to date European Paediatric Life Support (EPLS) or equivalent. All employed registered nurse children (RN Child) had also completed EPLS training or paediatric immediate life support (PILS) training. In addition to these five staff in recovery, three theatre staff had also completed the training. This provided the required level of cover as per the Guidelines for the Provision of Paediatric Anaesthesia Services 2019. One member of staff in the critical care unit had completed EPLS training.

There were arrangements to facilitate a safe and managed resuscitation attempt if an emergency occurred. A daily hospital wide safety resuscitation huddle took place where the resuscitation roles for the next 24 hours were agreed, and who was holding the resuscitation bleeps.

The resuscitation training officer and lead nurse for CYP provided PILS training for staff in clinical areas of the hospital where children were seen, including those where interventional procedures took place.

Staff on the ward adjacent to the children's ward were also required to complete PILS training as they would be the first to respond in an emergency. Training records confirmed this training had been completed or there were planned dates for training. In some areas of the hospital, such as the radiography department staff undertook paediatric basic life support training, as the risk in the department was assessed as low. When the level of risk increased, for example a scan requiring the injection of a contrast, a RN Child would attend the department and support the child. This ensured a member of staff with a higher level of resuscitation training was present.

There were plans for a child resuscitation training scenario to take place monthly to assist in providing staff with the confidence and skill to manage in an unexpected situation. Information we were provided with included an asthma based scenario under taken in April 2019 and a sepsis based one in May 2019. The information showed the management of the scenarios were reviewed, staff identified any learning and took follow-up actions. For example, provision of an 'app' for the RMO containing the hospital's emergency procedures and the paediatric resuscitation equipment bag being taken to all resuscitation calls.

Resuscitation equipment suitable for children was available close to where children were treated and cared for. It was available on the children's ward on the top floor and the recovery area in the operating department on the second floor; this equipment also covered the outpatient department and radiography department. There was clear information about where this equipment was located by the resuscitation equipment in the outpatient's department. This had been risk assessed and equipment to provide oxygen therapy was available on the adult resuscitation trolleys.

A RN Child completed a preadmission assessment for all planned admissions or invasive procedures. The pathway for the duration of the child's stay would be initiated at this first point of contact. A review of records confirmed risk

assessments relevant to the care of the child or young person were commenced at this stage and reviewed throughout their stay. These included for example paediatric nutritional assessment.

A review of observation charts confirmed the paediatric early warning system (PEWS)was being used. This tool is used to aid in the early recognition and escalation of emerging risk as indicated by clinical indicators. This included the consideration of the risk of sepsis. Staff understood the need for early escalation of any emerging risks.

There was a formal transfer agreement with the local paediatric retrieval team. This was required in case a child or young person required an unplanned transfer because of deterioration which the hospital was not equipped to manage.

Nurse staffing

The service had enough staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

A registered nurse children (RN Child) was the service lead and they were supported by a team of RN Child including RN Child bank nurses. A review of staffing rosters and discussion with staff demonstrated staffing was planned to consider the planned activity for the service. Staff worked flexibly to ensure cover was provided with at least one RN Child on duty when children were admitted, in line with current guidance.

The lead nurse also had responsibility for supporting children and young people attending clinic's in the out patient's department. We were informed and a review of booking information confirmed, most children and young people were seen in the outpatient department on a Tuesday and Wednesday. Most of the time a RN Child would work in the department on these days to support these clinics or there was a dual qualified (adult and children) nurse who would cover in their absence. To support this patient group at other times nursing staff, within the department, undertook additional training and assessment to care for children. Support was also available from the lead CYP nurse or a member of the children's nursing team.

The service responded to potential risk linked with staffing level and skill mix. There, had until recently been a scoliosis (spinal surgery) service, which included the young people having an extended period of recovery in the critical care unit. This was planned and an RN Child who had completed additional training and competency assessment cared for them in the critical care unit. Due to staff sickness, and in recognition of the potential risk of continuing with a service which they could not consistently staff with staff the right competency, this service had been suspended.

When a child or young person attended the radiography department for a magnetic resonance imaging (MRI) or computerized tomography (CT) scan which, required a level of intervention a RN Child would accompany the individual and support them through the scan until discharge.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children and young people safe from avoidable harm and to provide the right care and treatment.

All children and young people were always cared for by a named consultant. All consultants caring for children and young people in either a surgical or anaesthetic context provided evidence they undertook clinical paediatric activity within their scope of practice in the NHS This was confirmed by a review of the practicing privileges records.

Standards for Children's Surgery Children's Surgical Forum, The Royal College of Surgeons, 2013 recommend there is a consultant paediatrician available during time of peak activity. There was no consultant paediatrician with practicing privileges at the hospital who could be available to provide advice and support in the surgical environment. To manage this consultant paediatric support was available 24 hrs a day through agreement with a local NHS trust hospital. In addition to this there was a national medical paediatrician advisor who could provide advice.

There was a resident medical officer present in the hospital twenty-four hours a day.

Good

Services for children & young people

See information under this sub-heading in the surgical section.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

The Spire Healthcare Limited's standardised pathways were used for all children. This was audited and reported quarterly as part of the CYP quality dashboard. Results for the first three months of the year showed a high level of compliance.

In preparation for admission staff ensured records were available and prepared in advance. This included ensuing all pre admission information was present.

Records were securely stored in a locked cabinet in a locked room.

A review of records showed them to be contemporaneous and legible, with entries dated and signed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

All children were weighed and had their height measured. This was recorded in the medicines chart along with any known allergies. This was to assist in the calculation of the correct medicine dose.

Medicines were stored securely in cupboards in a locked room in the department. Medicines that required refrigeration were stored in a dedicated refrigerator where the temperature was checked daily to check it was within the correct limits. Nursing staff knew the actions to take if the fridge temperatures were not within an acceptable range. Room temperatures where medicines were stored were checked and recorded daily. A random check of stock medicines found them to be in date.

Controlled drugs were in date with records maintained of stock levels and their use.

There was a system in pace for the safe management of the keys which gave access to the medicines, with them either being held by a nurse or securely stored elsewhere in the hospital.

See information under this sub-heading in the surgical section.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff were clear about their responsibility to report incidents, the type of incident to report and how to report the incidents. A review of reported incidents supported this. We reviewed a selection of incidents and saw they included action taken to prevent reoccurrence. This included a change in process for the requesting of postoperative x-rays, following an incident where someone was called for an x-ray a day too early.

Staff were clear about the need to be open and honest if something went wrong. From the incidents we reviewed it was clear staff spoke with parents or guardians, for example when a procedure had to be cancelled to ensure they were aware of why.

See information under this sub-heading in the surgical section.

Are services for children & young people effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The provider had a central system for the monitoring of policies to ensure they were kept current. The governance team at the location and centrally were responsible for

carrying out gap analysis related to professional guidance. Bulletins arising from central office listed any changes to guidance, medicine alerts, medical device matters and policy updates.

There was a provider wide Children and Young People's Steering Group and lead nurse for CYP. This group took on responsibility for ensuring the service provided for children and young people was in line with current guidance.

The corporate policy procedure for the care of children and young people in Spire Healthcare Limited's clinical policy 11 was issued in April 2019 with a review date of April 2020. The policy included references of the literature and guidance which had been used to inform the policy.

Pathways of care for the CYP service were introduced provider wide in 2017. The CYP pathway was created by Spire Southampton hospital then cascaded across the whole Spire Healthcare Limited's group to standardise the pathway for children's services. The pathways put the child or young person at the centre and were based on current guidance.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The hospital followed National guidance by the Royal College of Anaesthetists (RCA) and the Royal College of Nursing (RCN) that patients should receive clear fluids up to two hours and food up to six hours of surgery.

Locally, work had been undertaken to ensure children and young people were not fasting for long periods of time and that they were following national guidance. This work was undertaken following an audit which showed there was only a 60% compliance rate. The steps taken included working with the anaesthetists and the production of a simple card given to each child indicting the time to start fasting and the time for their last drink. A further audit showed 100% compliance.

Nutrition and hydration

Staff gave children and young people enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Children were offered a varied diet and the menu choices included a selection reflective of the age group served. Staff told us special diets could also be catered for, and this would be captured a part of the pre-admission process.

To help prevent children and young people fasting for long periods of time everyone was provided with information about when to stop eating and when to stop drinking. This information, where possible was provided on an information card with the dates and times clearly stated. At other times this information would be discussed with the parent or guardian over the phone.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Pain assessment was discussed at the pre operative assessment clinic. This included a review of the tools available and the one to be used for the child or young person recorded in their notes.

There were a variety of pain assessment tools available considering the child's or young person age, development and level of understanding. These included pictorial faces and number scales.

A review of records confirmed pain was assessed. When children or young people were in pain, staff acted and the effectiveness of these actions were monitored.

Staff had received training to care for a child with an epidural and patient controlled analgesia. Discussion and a review of records confirmed the use of these devices was discussed at pre-admission and protocols for the monitoring of their use and their effectiveness were followed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Spire Healthcare Limited published a group wide quarterly CYP dashboard which included a variety of measures to benchmark performance and outcomes across the group.

Good

Services for children & young people

The dashboard included hospital activity and was presented under the domains of safe, effective, caring, responsive and well led. This was easy to read, and we saw how these were displayed on the ward so staff could see their performance at a glance.

Consultant activity was monitored and information included unplanned returns to theatre, readmission and unplanned transfers. For the first three months of 2019 there had been no unplanned returns to theatre, no readmissions and no unplanned patients transfers in the service.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff spoke positively about the support they received. Monthly one to one meetings had recently been introduced and staff told us these were an opportunity to touch base and made them feel valued.

Managers undertook annual appraisals and staff spoke about these as being a chance to discuss direction and development. One member of staff spoke positively about how they had been enabled to undertake additional training, which had provided them with the knowledge and skills required to care for the young people having spinal surgery.

Nursing staff who had not completed a recognised qualification in care for children, but who worked in areas where children were seen, under took additional training and assessment in key areas such as safety and child observations to try and ensure staff had a basic level of knowledge to help them care for children. Records reviewed confirmed these had been completed.

All consultants were required to provide evidence of their annual whole practice appraisal and their revalidation. A review of consultant information confirmed this process was followed.

For additional information see information under this sub-heading in the surgical section.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff in all areas of the hospital we visited where children were seen spoke positively about the joint working with the children's team.

Seven-day services

Key services were available seven days a week to support timely patient care.

The children's service was a flexible service providing a service on a planned basis. The children's ward was open according to planned activity and staff worked flexibly to provide a service which could meet the planned activity.

The out patients department was open 6 days a week. The children's team worked with the outpatient's department to provide staff in the department at their busiest times for children. This was possible because consultants tended to have set clinic days.

Consultants responsible for patients were always required to be contactable when their patients were at the hospital. Resident medical officers (RMOs) provided 24-hour care seven days a week.

See information under this sub-heading in the surgical section.

Health promotion

Staff gave children and young people practical support and advice to lead healthier lives.

Information leaflets about coping with childhood stress were available on the children's ward. There was also information about healthy eating and the benefits of exercise for this age group.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards. Staff supported children, young people and their families to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Our review of consent forms confirmed children, where they were able to demonstrate a level of understanding, were invited to sign the form along with their parent or guardian.

Good

Services for children & young people

Young people over the age of 16 who were able to demonstrate an assessed level of competency and understanding were able to sign their own consent form. This was in line with the Gillick competency guidelines which help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe.

We found consent forms included information about risk and benefits of treatment. For one young person, where there was a lot of detail this had also been covered in a letter to them and their family. This helped ensure children and their families made informed decisions about their care.

We observed consent being taken in an efficient and effective way involving the child and young person with clear explanation of the procedure, the benefits and the risks.

Are services for children & young people caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

All staff we spoke with were passionate about providing care focused around the child or young person. We observed interactions where the child was clearly the centre of discussions and interaction.

Children, young people and their families were treated with kindness and compassion. Staff knocked before entering the room and staff introduced themselves. Staff confirmed how people wanted to be addressed and this was respected.

Feedback from parents and guardians for June 2019 indicated 92% were likely to recommend the service; 94% said "staff understood my needs."

Emotional support

Staff provided emotional support to children, young people, families and carers to minimise their distress.

Children, young people and their families were invited to attend a pre operative assessment clinic. During the time play therapist would spend time with the child using play to help prepare them for their operation.

Staff worked in partnership with families to ensure their needs were met. Parents or guardians were invited to stay with the child or young person and to support them throughout their stay.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Families we spoke with in all areas of the hospital were complimentary about the time taken to explain things and to ensure they understood, this included speaking directly with the child or young person.

For those undergoing spinal surgeries, a specialist nurse was involved in preparing them for the surgery. A parent told us this was thorough and informative with time to ask questions.

In the critical care unit, we observed a children's nurse was involved in preparing a young person for a procedure. Time was taken to ensure they understood the next steps and the nurse supported them throughout the procedure and ensured they were comfortable afterwards.

Parents were encouraged to be present, where suitable, in the anaesthetic room recovery area and were supported by an RN Child throughout this time.

Pre-operative information was available to children young people and their families in a digital and/or booklet format. An 'app' was available for parents to download called 'Little Journey'. This was an interactive virtual reality app for children and families to help them prepare for their admission.

In feedback dated June 2019, 88% of respondents said, "I felt fully informed".

Good

Services for children & young people

Are services for children & young people responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local children and young people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The provider described the Children's and Young Peoples Service as a developing one. In the outpatient department, they saw children of all ages from birth to 18 years across a range of specialities including orthopaedics, ear, nose and throat, plastic surgery, urology and general surgery. Inpatient and day case surgery was offered to children aged three years and above.

The service had until recently provided a scoliosis (spinal surgery) service. This was planned and provided in consultation with the specialist surgeon and clinical nurse specialist, to ensure they provide a service which met the needs of this group of young people. The service had been temporarily suspended, however there were plans to re start the service once the provider was assured they were able to provide a consistent quality service with the right staff.

All admissions were planned following an admission criteria which ensured the service would be able to meet the needs of the child or young person. Those individuals with complex needs, which would have an impact on the surgical risk, would not be accepted for admission.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families individual needs and preferences.

Young people aged 16 to 18 could be cared for on the adult ward if this was something they wanted and an assessment showed the environment would be suitable for them. Discussion took place as part of the pre-admission process.

Staff had worked together across the children and adult wards to ensure a patient's wish to be cared for on the adult ward was met but retaining the option of a relative staying.

The rooms were all en-suite and designed for adult patients. To make the environment more suitable for the age of the child or young person, there was a selection of age appropriate duvet covers, toys and DVD's. For the older young people there were electronic devices available. When a child or young person attended the preadmission clinic they were given the opportunity to choose their duvet cover and any items they would also like to be placed in their room such as books and toys. This was then recorded so the person caring for them on the day of their admission could prepare their room in advance. We saw this worked well and a child was delighted to have the cover they had chosen.

Families were catered for and provided with refreshments and they could also use the hospital restaurant.

Rooms were equipped with fold-out beds so a nominated individual could stay.

See information under this sub-heading in the surgical section.

Access and flow

People could access the service when they needed it and received the right care promptly.

The service provided care on a planned basis. Surgical admissions were planned to ensure the right staff were available to meet the needs of the child or young persons. If a child required to be readmitted this was managed in a controlled way, and only if the service could safely meet their needs.

Out patients' appointments were managed on a consultant by consultant basis. There was a process for following up on non-attendance. Information provided showed there had been no non-attendance in the outpatient's department for children and young people since January 2019.

Cancellation of surgical procedures was monitored. Since April 2019 three cases were rescheduled when paediatric anaesthetic cover was not confirmed; three were cancelled due to the child or young person being unwell on day of surgery and had not followed pre-operative advice; one

was cancelled due to preoperative infection screening not being completed and one scoliosis procedure was cancelled due to operational issues in the operating department.

See information under this sub-heading in the surgical section.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The provider treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

There were no complaints relating to children from November 2018 to April 2019.Staff made changes as a result of feedback. Staff discussed an informal complaint and how this had led them to reflect on the pathway of care. As a result, a nurse from the children's ward now also attended the preadmission clinic along with the specialist nurse for those young people undergoing spinal surgery.

See information under this sub-heading in the surgical section.

Are services for children & young people well-led?

Good

Our rating of well-led stayed the same. We rated it as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They were visible and approachable in the service for patients and staff.

The lead registered nurse children (RN Child) for the children and young people's (CYP) service reported to the deputy matron who reported to head of clinical services who, in turn, reported to the hospital director.

Staff confirmed the deputy matron was visible in the clinical areas and they would be happy to approach them.

The CYP lead was highly visible in areas of the hospital where children and young people were seen. Staff were positive about the supportive relationship they had with the lead nurse.

Additional support was available for the CYP lead from the providers national lead for children services and the MAC representative for children's' surgery and the lead children anaesthetist.

See information under this sub-heading in the surgical section.

Vision and strategy

The service had a vision for what it wanted to achieve although an underpinning strategy had not been developed. The vision was were focused on the sustainability of the services.

There was a strong desire to grow the children's service; however, at the time of our inspection the leadership team had put these plans on hold. Further discussions were taking place about the management and oversight of the service while the lead under took a period of planned absence. There was an expectation the current service would continue with support from the providers national lead for children.

See information under this sub-heading in the surgical section.

Culture

Staff felt respected, supported and valued. They were focused on the needs of the children young people and their families receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The staff we spoke with were positive about working for the CYP service and in the hospital. They spoke of an unrushed service where they were able to spend time with children, young people and their families. They also commented on the time invested in them as individuals and the support they received.

See information under this sub-heading in the surgical section.

Governance

Good

Services for children & young people

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The CYP lead attended the hospital clinical effectiveness and the clinical governance meeting.

A quarterly children's service report was produced and shared at these meetings and directly with the matron.

Quarterly audit documentation included the PEWS chart, pain scores and documentation for CYP. Other reviews and audits included a CYP health and safety and infection control audit.

See information under this sub-heading in the surgical section.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. There was a process for capturing identified risks and when identified action were taken to reduce the risk. There was also an escalation process of risk for consideration for inclusion on the hospital wide risk register. However, this was not consistently utilised to capture all risks.

There were no specific risks, on the hospital risk register relating to the children. Some hospital wide risks recorded on the risk register, such as challenges with staff recruitment, were generic and would apply across the hospital.

Local risk assessments had been completed for identified risks relating to the safe provision of the service. These were awaiting review by the risk manager. Any assessed risk with a high score would be escalated for consideration for inclusion on the hospital wide risk register.

There was a system for risk to be escalated and considered for inclusion on the hospital wide risk register. The governance team also told us they provided training and support to department manager to help them in recognising the risks in their department to ensure they were assessed and captured.

We were told if a risk needed to be escalated, the service completed a risk assessment which was reviewed by the clinical governance team. While the staffing challenges in CYP were currently being managed and we were told discussions were taking place on how the service would be managed moving forward, the long-term impact had not been considered and documented as a risk. There was no evidence this had been assessed and recorded and formal escalation considered. Post inspection the provider told us they would only provide a service they could safely staff and therefore staffing did not propose a risk to the service.

We reviewed the CYP clinical dashboard for the first three months of 2019. A system of red, amber and green (RAG) was used to identify the level compliance with the providers expected scores. The CYP service at this hospital was rated green (good) for all the indicators were a RAG rating was allocated, except one. This related to fasting preoperatively and staff had acted and the monitoring in place was showing an improvement.

See information under this sub-heading in the surgical section.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The CYP service had access to the information they required to manage their staffing to ensure they could meet the needs of the service in all areas where children were seen.

The service collected and collated patient feedback information and had access to safety information, complaints and incidents to inform assessment of the quality and the management of risks in their service.

See information under this sub-heading in the surgical section.

Engagement

Leaders and staff actively and openly engaged with patients, staff, to plan and manage services.

The fifteen steps process, a toolkit which helps explore the child's or young person's experience by involving them and

their families in quality assurance processes, had recently been introduced. There was information on the wall inviting children and young people to take part in this process.

We reviewed a detailed summary provided by one young person and saw changes had been made in response to the feedback they had provided. This had included staff being more aware conversations could be overheard in the room adjacent to the nurse's desk, and a play room being provided in response to an increased understanding of the distraction and disturbance caused by the noise of children playing in the corridor.

Children, young people and their families were invited to complete an on line survey. The questions were designed with the age of the person completing the survey in mind. The early results were positive. For May 2019 children in the four to 11 year old age group said 100% of people who looked after then were nice; 100% said there was enough toys to play with; 100% reported the doctors and nurses explained everything. Areas scoring lower where "did you like your food" (50%) and "did you like your room" (63%).Further results were being gathered and reviewed to identify themes so consideration could be given to any action required.

Children were also asked to provide immediate feedback which was recorded on a washing line with tops being good and pants being those things which were not so good. Positives included "my nice nurse" and "have the duvet cover I asked for", the not so good included "the food".

Staff spoke positively about being involved in discussion about the service and being encouraged to take responsibility for different aspects of the service, for example the 15 steps challenge. However, there were some concerns about the long-term sustainability of the service, with the CYP lead about to have a planned period of absence.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

The service was proactive in developing resources which had been adapted by the provider and shared across the hospital group: for example, the fasting instruction cards.

The latest innovation had been the 'app' to help children and young people prepare for their hospital stay.

One member of the CYP staff team had been supported and encouraged to implement the 15 steps process to help them see the quality of the service from a patient's perspective.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated it as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Mandatory training for staff covered topics including manual handling, fire safety and information governance. We saw that outpatient staff compliance across 10 topics ranged between 94% and 98% meeting the providers target of 95% compliance.All staff had access to an online system for training. The system was able to give the outpatient manager an overview of performance and gave prompts when staff were due to re-take or refresh their training. The hospital matron could also see mandatory training performance and would send emails to department managers reminding them if any staff were approaching their due dates.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

All members of outpatient staff had received safeguarding adults training and safeguarding children training level two. Those that had regular contact with children were required to complete level 3. The service recorded that eight members of staff were eligible for safeguarding children level three training, and all members of staff had completed this.

The outpatient safety board displayed who the safeguarding lead and champions were for the hospital.

Staff told us they had received training on safeguarding and would feel confident in how to report an incident should it arise.

Up to date policies on safeguarding for both adults and children were available to all staff on the hospital's intranet.

There were also posters and flowcharts for the PREVENT strategy which was part of anti-terrorism training, and what to do if female genital mutilation (FGM) was suspected.

For further information please see information under this sub-heading in the surgery section.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.

All staff we saw in the outpatient's department were bare below the elbows to help prevent the spread of infections in accordance with national guidance. We also observed them using personal protective equipment (PPE) when required. PPE, such as gloves and aprons were available in all clinical areas visited.

Hand sanitiser gel was available at the main entrance of the hospital and throughout the outpatient's department. We spoke to patients who told us they saw staff clean their hands before their consultation.

The outpatient's department staff completed observational hand hygiene audits. The audit was completed with a minimum of ten staff members each month. The audit included measures such as whether staff were using the correct hand cleaning technique, and whether they were bare below the elbow. The result of the most recent audit completed in June 2019 showed more than 90% of staff observed were compliant with good practice. Staff who had not been compliant were reminded again of the correct techniques and policy.

Outpatient staff received infection prevention and control training as part of their mandatory training package. We saw that 97% respectively had completed this training.

There were established processes to ensure the department was kept clean. The outpatient department was cleaned in the morning before clinics started and, in the evening, to minimise disruption to patients and staff during the day when clinics were being held. All medical equipment was the responsibility of the nursing and healthcare assistants to clean after each use, and everything else was the responsibility of the housekeeping team.

Equipment used in the outpatient's department was clean. Staff used 'I am clean stickers' to indicate an item of equipment had been cleaned and decontaminated. We saw there was a checklist for cleaning each piece of equipment and all equipment was cleaned as scheduled. Patient privacy curtains in the treatment rooms and other clinic areas were clean and labelled with the date they were last changed.

There were cleaning checklists on the back of clinic room doors within the outpatient's department and we saw these had daily checks documented for July 2019.

We reviewed three consulting rooms in the outpatient's department and found no concerns. In all these rooms "I am clean" stickers were used to indicate equipment that was ready to use, and hand sinks were available for hand washing. Personal protective equipment such as gloves and aprons were available, and consumable items were checked and found to be within their expiry dates.

The hospital matron was the director of infection prevention and control and there was an Infection prevention lead nurse for the hospital. The outpatient department also had an infection prevention link nurse.

We saw flowcharts displayed on the outpatient safety board for what to do in the event of a sharps or splash injury.

For further information see information under this sub-heading in the surgery section.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment generally kept people safe.

The outpatient's department was tidy and suitable for the services offered. The reception area was spacious and had adequate seating arrangements. Most areas were carpeted except the clinic rooms. This meant the clinic rooms could be cleaned effectively. There was a risk assessment and standard operating procedure available to mitigate the risks of carpeted areas, for example steam cleaning.

We saw housekeeping staff used the correct colour of waste bags for clinical and domestic waste. Waste was disposed in a secure area in all locations and there was a separate area for disposing of clinical waste.

All the sharps bins inspected were properly assembled, labelled and signed and dated in line with best practice and filled below the line indicated on the bin.

All equipment checks in the outpatient's department were up to date. Staff maintained a reliable and documented programme of checks including electrical safety testing. All the equipment we inspected had maintenance stickers showing they had been serviced in the last year. For example, overhead lights in the minor procedures room and laser equipment.

The minor procedures room had a surgical trolley, overhead lighting, clean and dirty areas, stock cupboards and a trolley for nursing staff to lay out equipment that would be needed. The space was suitable for minor procedures with separate doors allowing privacy, and a post treatment area for patient's well-being to be checked post procedure.

A resuscitation trolley was available containing emergency equipment to be used in the event of an adult

having a cardiac arrest. There were also separate medical bags for children. The equipment on the resuscitation trolley had been checked daily and daily check logs were signed and up to date. The trolley was sealed, with clearly labelled drawers for airways; breathing; circulation and medicines, alongside a list of what was in each. The attached sharps box was signed and dated in line with best practice.

Clean and dirty utility rooms were locked and there were warning signs alerting people to the fact liquid nitrogen was stored in the dirty utility room. We saw the rooms were tidy and well-arranged.

All store rooms were tidy. Hazardous substances were locked in a COSHH (Control of Substances Hazardous to Health) Cupboard and handled in line with the control of substances hazardous to health regulations 2002.

Assessing and responding to patient risk

There were systems and processes to assess, monitor and manage risks to patients.

Minor procedures were carried out in the outpatient's department. Staff carried out a checklist of safety standards for invasive procedures prior to each procedure. We observed two procedures during the inspection. The lead nurse undertook the assessment for safety and ensured all staff in the room understood their role in it. The patient was involved, and their understanding was checked.

Acutely unwell patients did not generally visit the outpatient department. However, if a patient deteriorated whilst in the department, there were always two resident medical officers (RMOs) on site. Staff told us RMOs were responsive when called, dependant on urgency and need of patients on the wards.

All staff at the hospital including outpatient staff received training to enable them to deal with emergency where resuscitation may be required. Senior staff nurses completed immediate life support training and basic life support training, all other staff completed basic life support training. Training compliance data showed that 100% of outpatient staff had completed basic life support training and immediate life support training. Outpatient staff also completed paediatric basic life support training, and training compliance data showed that 100% of staff had completed this.

The hospital had a 'resuscitation lead' who ran training scenarios twice a month, one adult focused and one child and young person focused On the Monday before the inspection, a scenario had been carried out in outpatients for an adult emergency. On the second day of the inspection a second scenario was run in the children and young person's ward. We were invited to observe the staff as they responded to an emergency bleep. Afterwards feedback was given, and staff were able to discuss how they would address their actions.

At the hospital wide morning safety huddle, staff were allocated roles for any emergency situations. Staff found that was a good way of planning for any event and meant staff immediately undertook their assigned roles. We observed this worked well when we observed the emergency scenario.

There were no emergency buzzers in the consultation rooms. Senior staff told us this was always under review however and recorded as a risk.

An audit of five procedure checklists in the outpatient's department in April 2019 showed that all the correct checks had been completed for the procedures reviewed.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Managers regularly reviewed and adjusted staffing levels and skill mix. The hospital had bank staff, many of whom had worked or still worked, at the hospital. If needed the department requested additional staff from the bank and requested the same staff who were familiar with the department.

The outpatient's manager would be aware of the planned clinics in advance and the manager then staffed accordingly. The rotas were available for staff to see and the manager and nurse in charge managed any absences.

There was a nurse in charge and a nurse for each consultant who had clinics and an extra nurse, who could step in and assist when needed. The nurses and consultants were supported by health care staff and administration staff on the reception desk.

The nurse in charge managed the rotas and the rotas and notice board clearly indicated where staff were working and which consultant they were assisting.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The outpatient department had access to a range of medical staff who could provide appointments across a range of specialities. Resident medical officers were available to provide medical cover to the outpatient department should there be an emergency.

For further information regarding medical staffing see information under this sub-heading in the surgery report.

Records

Staff kept detailed records of patients' care and treatment.

Records were clear, stored securely and easily available to all staff providing care. However, they were not always up-to-date, as in half of the notes we looked at the consultants had not signed and dated the paper copies. This meant the secretary could not be certain of the date or who had written the notes they were transferring to the electronic system.

Prior to the inspection the service advised us that in the three months before the inspection many notes had not been available for appointments in outpatients. The action they had taken meant notes were made available for follow up appointments and minor operations. Consultants had their own notes and were available on request.

If a patient attended and there were no notes available, the nurse would assess the situation, contact the ward if they were an inpatient or contact the secretary for the consultant's notes. If no notes could be made available, the nurse would contact the consultant directly for instructions and advice on how to proceed.

Patients notes were written by hand then added to an electronic record. We looked at a random sample of eight patient notes. However, four sets out of eight outpatient hand written and typed notes looked at on the first day of our inspection had not been signed and dated by the consultant. This was not in line with best practice. We fed this back to the outpatient's department manager who undertook to speak with the consultant responsible.

The records included all patient information. We saw the records had details of all tests carried out, medicines, medical order history, all assessments and reports. The allergy status of all patients was recorded. Pain scores were recorded where relevant and a treatment plan was recorded. Consent was obtained for all procedures in the records reviewed. In addition, staff recorded pre-procedure vital signs and the start and finish time.

We observed that the electronic record system was secure, and staff logged in to access the records. In addition, we observed staff logging out when they finished accessing the electronic system.

There was a safe system for the transportation and management of records. Paper notes were transferred from records in zipped bags to protect privacy. They were not left on desks and were handed to the nurse who was assisting the consultant for safety. They were removed from the consulting rooms as soon as the consultant had completed their appointments.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Prescriptions used for prescribing medicines was stored securely and managed appropriately. There was a signing in/out process with medical staff having to sign for a prescription, this was checked by a nurse.

There was a pharmacy on site where the prescribed medicines could be collected.

Medicines were stored securely in cupboards in a locked room in the department.

Medicines that required refrigeration were stored in a dedicated refrigerator where the temperature was checked daily to check it was within the correct limits. Nursing staff knew the actions to take if the fridge temperatures were not within an acceptable range. Room temperatures where medicines were stored were

checked and recorded daily. These measures helped ensure the medicines remained safe to use. The outpatient's department did not keep controlled drugs in the department.

Registered nurses held the keys to the medicines cupboard which was in line with best practice.

Random samples of medicines and IV fluids were checked and found to be in date, and boxes that were close to their expiry date were pulled to the front of the cupboard. Flammable medicines were kept in a lockable, fireproof cabinet. Weekly checks were completed for contents of the cupboard.

Emergency cardiac arrest and anaphylaxis medicines were kept on the resuscitation trolley and were checked daily. Anaphylaxis is a life-threatening allergic reaction that requires immediate treatment.

For further information please see information under this sub-heading in the surgery section.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

There were no never events reported relating to the outpatient department. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Information provided to us, in advance of the inspection, indicated for outpatients and diagnostic imaging between April 2018 and March 2019 there had been 210 clinical incidents and 29 non-clinical incidents. It was not possible from the information provider to break this down further between the two departments.

Staff were aware of how to report an incident using the hospitals electronic reporting system. They were also clear about what constituted an incident and would require reporting. They told us they received feedback on trends within the hospital. Senior staff shared information about incidents and learning at handovers, on the staff notice board and at meetings. We attended a meeting where information was shared with the senior management team and department managers. Senior staff attended meetings every day and discussed trends at the meetings that had occurred across all provider sites.

Staff were familiar with the duty of candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. 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.

Are outpatients services effective?

At present we do not rate effectiveness for outpatient in acute independent hospitals but during our inspection we noted the following good practice:

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Current National Institute for Health and Care Excellence (NICE) guidance was a standing agenda item on the clinical governance meeting that was held monthly. This highlighted new or updated guidance that would be relevant to the departments.

Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies, such as the Royal College of Nursing, National Institute for Health and Care Excellence (NICE). All the guidelines we reviewed were easily accessible on the hospital's intranet and were up to date.

The department adhered with guidelines for example, we saw evidence of the use of clinical response to national early warning scores (NEWS2) triggers, with a pathway for admissions from the outpatient's department to the main hospital wards.

The department undertook clinical and non-clinical audits. These included infection prevention and control, medicines management, procedure checklists and documentation audits.

The service also had a local audit programme that included a chaperone audit, waiting times and hand hygiene audits.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Hot drinks and water were available to all patients in the outpatients waiting area. Following a procedure staff offered snacks and drinks to patients. Staff also offered patients biscuits when they were waiting for long periods of time.

For information on advice given to patients at pre-assessment such as fasting prior to a minor operation or procedure, see information under this sub-heading in the surgery section.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Appropriate pain relief was available to patients in the outpatient's department. However, staff told us they provided medication only on prescription from a consultant or resident medical officer (RMO).

As part of the risk assessment staff asked patients how much pain they were in before the procedure, during and afterwards and ensured relief was given.

When carrying out a procedure staff ensured patients were pain free by asking them to ensure local anaesthetics had worked before carrying out the procedures. We observed two minor procedures during the inspection, both nursing and medical staff spoke with patients throughout, ensuring they understood what was happening, reassuring them and checking whether they were comfortable and not experiencing any pain. The staff did this by asking the patient during the procedure. Afterwards a nurse would confirm the advice from the consultant about wound care and pain relief when they went home.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Whilst the outpatient department did not specifically monitor patient outcomes, test results could be viewed on the electronic systems by staff.

For further information please see information under this sub-heading in the surgery section.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Appraisal rates for nurses and health care assistants in the outpatient department were 95% for nurses and 100% for health care assistants. Appraisals and continuous professional development (CPD) were tracked on an online system and we saw examples of staff clinical and business objectives, CPD and any development they would like to undertake over the coming year.

New staff were given an induction pack and wore a badge to show they were new. The pack included, departmental structure, opening times, parking arrangements, wellbeing, uniform, and a four, eight- and 12-week review was completed with their line manager. New members of staff told us it was useful and gave them enough information to help them during their first weeks of work.

The outpatient's manager kept an electronic staff training 'tracker'. The overview demonstrated what training staff was in date and those who were approaching needing a refresher.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Good

Outpatients

Regular daily and monthly multidisciplinary meetings were held to ensure the hospital staff worked together for the benefit of all patients.

Nursing staff confirmed they had good working relationships with consultants and could easily ask for help. They also had good relationships with the imaging team. They had quick access to diagnostic test results, which were saved on the electronic system and accessible to all staff in the outpatient's department.

There was a bariatric clinic where dietitians, consultants and specialist nurses worked together to benefit the patient during their weight loss treatment.

Seven-day services

Key services were available seven days a week to support timely patient care.

The outpatient's department was open six days a week to support patient care.

The department operated between 8am to 9pm, Monday to Friday. On Saturdays the department was open 8am to 1pm. The type of clinic available depended on the consultant liaising with the outpatient's manager to confirm when they would hold clinics.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support in the outpatient's department.

The outpatient's department offered practical support in the form of clinics to enable patients to be healthy, for example, smoking cessation clinics and healthy eating.

Leaflets were available and offered to patients at their appointments, such as how to stop smoking, eating healthy and what to do if you suspect you have diabetes.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff were aware of their responsibilities under the Mental Capacity Act (2005). They were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. Staff told us they had not come across a patient who lacked capacity. Staff could demonstrate an understanding of the hospital's policy but told us they had not had to put this into practice.

Staff were clear about their responsibilities in relation to gaining consent from people, including those people who lacked capacity, to consent to their care and treatment. Our review of eight medical records showed well documented consent forms were completed. Staff could tell us how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff had access to best practice guidance and local mental capacity policies in the department. Overall, 95% of outpatients staff had completed the Mental Act Capacity and Deprivation of Liberty Safeguarding training.

Are outpatients services caring?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated it as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patient, family and friends' feedback was positive. For example; "Thank you so much for all your care and attention. You have been amazing", "Just to say thank you for everything. I could not have got through the last few weeks without your care and kindness." "Thank you for your professional, courteous, friendly helpful and reassuring nursing whilst I was being examined."

We saw staff treat patients and visitors with warmth and care. We observed staff interactions with patients; they were courteous, professional and demonstrated compassion to all patients. We saw staff stopping to speak with patients and visitors and directing them to the right locations.

Good

Outpatients

Staff introduced themselves to patients and all staff wore name labels on their uniform which enabled patients and visitors to easily identify which staff member was providing their care/support.

Patients said they were happy with the care provided and that they were treated with dignity and respect. Patients who went through minor operations said the operation went smoothly and was arranged to their convenience. Patients described the care provided as "exceptional".

Clinic rooms had 'busy/free' signs on the doors and we observed staff knocking and waiting before entering clinic rooms. Patients told us that they felt their privacy was always respected during their appointment.

However, we saw that the area for measuring height and weight was in the corridor, which meant that privacy during measurements may not always have been maintained.

Emotional support

Staff provided emotional support to patients.

Staff provided emotional support to patients, families and carers to minimise their distress. Chaperones were available if requested. There were posters displayed in the waiting areas advising patients they could request a chaperone.

Staff told us upsetting or unexpected news was delivered sensitively and in appropriate private surroundings. They had nurse specialists who provided emotional support for example at breast clinics.

Reception staff told us they sometimes saw patients who appeared anxious due to the nature of their visits. They told us they approached them and directed them to staff who could help. We saw staff routinely spoke with patients in the reception area to help with any concerns they had.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Patients and their relatives said they were involved in their care and were given explanations about their treatment. They said staff explained procedures and obtained their consent before any treatment. Patients told us the consultants were thorough, they spent time explaining procedures to them and they felt comfortable and reassured. They felt they were given clear and adequate information. We saw staff introducing themselves to patients before assisting them.

Senior staff showed us a new form they had begun using as they had had feedback from patients about the payment of some tests during a consultation. Staff said the form had helped them to explain the cost of items, so patients had a full understanding about the cost of their consultation and treatment.

Are outpatients services responsive?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people.

Staff told us that patients were usually seen promptly following their referral. Patients were given the next available appointment with their chosen consultant. Patients confirmed they had not waited long for their appointment.

We observed a relaxed atmosphere in the outpatient area. The waiting areas were not overcrowded, and clinics were running on time. Clinics ran in the outpatient department between 8am and 9pm Monday to Friday, and on Saturdays until 1pm. This allowed patients who worked office hours during the week to attend at a time that suited them, and we spoke with patients who told us they were able to get appointment times that suited their needs.

Meeting people's individual needs

The service took account of patients' individual needs. Staff made reasonable adjustments to help patients access services.

Good

Outpatients

The main waiting area in the outpatient's department had a hot and cold drinks machine, television and a range of newspapers, magazine and information leaflets to read. There was also an area for children who were waiting containing toys and activities to help whilst they were waiting for their appointment.

The hospital provided translation services if needed. There were information posters in multiple languages, advising patients what was available for them.

The hospital had a dementia policy in place. Staff had undertaken training in dementia awareness however, staff informed us they rarely had instances of patients attending with dementia or learning disabilities in the outpatient's department.

There was disabled access, toilet facilities and guidance available in the car park to assist patients with parking.

Access and flow

People could access the service when they needed it and received the right care promptly.

Reception staff welcomed visitors to the hospital and directed them to the right department. All staff assisted if they thought someone had lost their way.

Patients were referred to the outpatient's department by their GPs, or they could self-refer. Patients could book an appointment by submitting a form online or by making a telephone call. Patients were offered the most convenient appointment with their preferred consultant.

All eight patients we spoke with said it was easy to make an appointment and were seen quite quickly on their arrival at the department. Information provided by the service prior to the inspection showed waiting times for the period January to April 2019. Patients were seen on time up to 78% of the time.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

There had been one complaint made regarding the outpatient's department outpatients between July 2018 and July 2019, this had been responded to as per Spire Healthcare Limited's complaints policy which was initial contact within 48 hours then a full response in 28 days.

Feedback leaflets and comment cards were available in the department to encourage patients to give their feedback and report concerns.

Staff said they tried to resolve complaints informally. However, if patients wanted to raise it further, they escalated complaints to the patient experience manager. We saw evidence that learnings from complaints were used to improve the service.

These were displayed on the noticeboard under 'you said, 'we did'. For example, staff explained costs to patients using a form which included blood tests and asked them to sign it to show they understood which test they were paying for. This was in response to several complaints about the cost of treatments. Another example showed they had acted to revise the reception area after patients had complained they had been queuing on or near the stairs. The reception desk has been made bigger, with an extra member of staff and a rope barrier to keep people away from the stairs, this also offers more space and privacy. The hot drinks machine was also moved to improve safety.

For further information please see information under this sub-heading in the surgery section.

Are outpatients services well-led?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings.

We rated it as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the

priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

There was a good level of visibility and engagement of the department's senior teams, Staff we spoke with understood the departmental structure and knew who their line manager was. They reported feeling able to discuss issues with their line manager and felt they could contribute to the running of the department.

We found the morning operations meeting, attended by the hospital's senior management team and heads of department, provided opportunities to discuss operational issues, incidents and other issues of relevance to the hospital each day leading to a healthy reporting culture.

For further information please see information under this sub-heading in the surgery section.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital had a clear vision and strategy, which incorporated all service areas including the outpatient's department. The hospital vision was to be a regional centre of excellence in private healthcare provision which was underpinned by the hospital's way of working – "We will deliver clinical excellence and a personalised patient experience and work in a way that demonstrates a collaborative approach, a purposeful attitude and innovative thinking".

All staff we spoke to were aware of the hospital's vision, they were passionate about the care provided to patients and the opportunities they had working in the hospital.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us there was a freedom to speak up guardian and there was a whistle blowing policy.

Staff said the leadership team was visible and approachable and there was an open culture for raising matters and shared learning. Staff spoke highly of their managers and the support they provided to staff.

There was a culture of enhanced training and development opportunities for staff. Staff said they were supported in their role and found opportunities for development motivated them in their work.

Our observations and discussions with staff confirmed to us there was an open culture where staff were confident to share ideas and to highlight any concerns, incidents, or errors and learn from the subsequent investigations.

Staff at all levels reported a positive culture within the department. Staff said they had not experienced any discrimination and they had been supported to maintain a work /life balance. The hospital had an anti-bullying policy in place and staff said they worked in a healthy environment. Staff said it was a nice place to work and there was a friendly atmosphere in the department.

Staff said they were motivated to go the extra mile to make sure patients receive the best care and are safe.

Staff confirmed the department was open and transparent and they could raise any concerns with senior staff. Staff understood their responsibility under the duty of candour and we noted that information about the duty of candour regulations was available on the staff notice board in all locations visited.

The requirements related to duty of candour were met through the processes for investigating incidents and reviewing and responding to complaints. Staff were able to tell us how important it was to be open and honest with people when things went wrong. They were also aware of the policy and had undertaken training.

For further information please see information under this sub-heading in the surgery section.

Governance

Good

Outpatients

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The governance framework included a network of meetings and working parties. Senior staff told us this ensured safe delivery and effective oversight of the clinical and non-clinical services in the hospital with a clear flow of information. The manager in the outpatient's department was able to describe the governance framework and how the information flowed two ways from staff to the senior management team and back.

The senior managers attended a daily '10 at 10' meeting where a staff representative from each area had the opportunity to update the hospital manager and colleagues with respect to their department. We attended one of these, and witnessed the communication of information, such as activity, equipment matters, and risks and innovative practice being shared. The outpatient's manager reported to the '10 at 10' for their department and took information back to their department afterwards and shared this with staff.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There a systematic programme of clinical and internal audit to monitor quality, operational and financial processes, and systems to identify where action should be taken which was overseen by the senior management team, for example medicine errors.

There were robust arrangements for identifying, recording and managing risks, issues and mitigating actions. The worries staff had were recorded on the risk assessment had received a risk value.

The hospital had a risk register and managers updated this accordingly. The managers in the outpatient department was aware of their department's risks, and these had been correctly recorded on the departments risk assessment documents. At the time of the inspection there was one risk regarding the outpatient's department on the register.

We were invited to attend a risk management meeting, where the hospital director alongside the risk manager asked each head of department about the risks they had recorded and the action that had been taken.

A formalised daily meeting provided opportunities for staff to update colleagues with respect to their department, and to be informed of other service related developments.

Quarterly health and safety monitoring audits took place to review risks and ensure mitigation was in place. If any actions were required a plan was put in place to track and monitor action taken. We discussed the most recent action plan for the period of February 2019 to May 2019 with the outpatient's manager. We could see where action had been taken, was pending and action that had completion dates later in the year. For example, 'fire action signs by alarm call points', had a completion day of May which was not recorded as completed. The manager told us the signs had been delivered on 16 July 2019 and it would take a further two weeks to fit them. However, the action log had not be up dated to reflect this. We discussed the with the manager who was aware of everything that had taken place and agreed they would update the action plan accordingly.

The risk regarding a lack of emergency buzzers in the consultation rooms was recorded. This was rated as a low risk. The rationale was the treatment rooms where the risk was higher had emergency buzzers, for other areas staff were always around.

There were procedures for ensuring only consultants with approved practicing privileges worked at the hospital. These included checks on fitness to practice, professional indemnity and registration. Appraisals and re-validation were monitored and requested where renewal was required.

Staff said they received regular support and were made aware promptly of concerns as well as being given praise.

Managing information

Good

Outpatients

Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were joined up and secure.

Patient notes were kept in both paper format and electronically. However in four of the eight patient files we looked at consultants had not signed and dated their updated the notes by hand and then their secretary updated the electronic records. These records were available for staff if needed.

Consultants and staff had access to information they needed in a timely way for example blood tests and x ray results.

Outpatients staff received information governance training as part of their mandatory training package. We saw that 97% of staff had completed this training.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients for example the local NHS hospital to assist with critical care of young people.

Patients were invited to compete a feedback card. These were analysed, and a report published by an independent company. The report was discussed with staff every month at their team meetings, which included individualised feedback for positive comments. Negative feedback was given anonymously. For example, the waiting area had been changed due to concerns regarding safety.

The results of the patient survey were on display in public areas in the department. This consisted of the number of replies the department had received and changes were listed in the 'you said we did' part of the poster.

Staff said they received regular newsletters, and there were forums and daily communications which kept them informed of key messages and performance updates. The hospital manager told us they ensured they walked the floor and spoke with staff, asking about the challenges they had, and communicating with them about the staff changes that were to take place.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The outpatient's manager said they were going to trial a new endoscope in the outpatient's department, in August 2019 which specifically looked at the throat and voice box. They did not currently offer this examination and hoped it would prove useful to their patients.

Good

Diagnostic imaging

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

Are diagnostic imaging services safe?

Requires improvement

We previously inspected outpatients jointly with outpatients so we cannot compare our new ratings directly with previous ratings. An inspection of the diagnostic imaging service was carried out in April 2019, following which a number of requirement notices were made.

We rated it as **requires improvement.**

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training cycle for Spire Healthcare Limited ran from January to December each year. Modules included information governance, health and safety, fire safety and infection control.

Mandatory training was delivered using a mixture of face-to-face training and e-learning.

The department had a target of 100% compliance with mandatory training, which was above the hospital target of 95%.At the time of the inspection this figure was 97%.Staff said they had easy access to mandatory training, they were notified when they needed to renew their mandatory training.

Staff working with radiation were trained in the regulations, risks and use of radiation and had signed the local rules relating to the appropriate areas in which they worked.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The safeguarding vulnerable adult's policy, the safeguarding children and young people policy and chaperone policy, were all in date. Since the inspection of diagnostic imaging services in April 2019, the local policy had been revised to include local safeguarding contacts.

Mandatory training included safeguarding training at the levels that staff needed for their job role, as described in the safeguarding children and young people: roles and competences for health care staff intercollegiate document 2019. There was 97% compliance with safeguarding training. The training included awareness of female genital mutilation, child sexual exploitation and prevention of radicalisation.

When children were brought into the department for diagnostic scans they were accompanied by their parents and a registered nurse children (RN Child).

Staff we spoke with were aware of their roles and responsibilities in safeguarding and knew how to raise matters of concern appropriately. Staff told us they could contact the hospital leads for safeguarding adults and children for advice.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The waiting areas, corridors, examination areas and changing rooms were visibly clean and well organised.

There were rotas for cleaning the areas and rooms. We saw completed cleaning schedules for June and July 2019 and provisions were in place for patients with an infection.

Radiographers cleaned scanning equipment after each patient use with sanitising wipes. Paper covers were used on the scanning couch. They were disposed and replaced after each patient.

Staff adhered to the hospital's hand hygiene and bare below the elbow policy. Personal protective equipment such as gloves and aprons were available to wear during care and treatment. There were instructions for washing hands above the sinks. There were wall-mounted hand gel sanitisers readily available in all areas. Staff used sanitising hand gels before providing patient care.

All staff completed hand hygiene competency assessments annually, which included observation of their hand washing practices. We reviewed competency assessment documents for five member of staff which identified these five staff were fully compliant with the hospital's hand hygiene policy.

Infection control was included in mandatory training for staff. There was 97% compliance with infection control training.

Environment and equipment

The age of imaging equipment presented a risk of breakdown of equipment and reduced image quality. However, the design of the premises kept people safe. Staff were trained to use the equipment and they managed clinical waste well.

Most of the imaging equipment was more than ten years old. National and international reports detail that equipment over the age of ten years is at higher risk of breakdown, increased operational costs and may have reduced image quality. This meant there was a risk of delayed diagnosis and treatment due to delayed imaging and reduced image quality. In a report by the Royal College of radiologists published in 2015, they reference that the European Society of radiology recommends the replacement of radiology equipment over the age of ten years. The service had acted to lessen risks to patients.

Regular checks of the performance and safety of the MRI, CT and x-ray devices was undertaken yearly by the RPA service. Records showed the MRI, mammography scanner and CT scanner were tested within the past 12 months and had met the quality assurance and performance criteria. This indicated there were no concerns with the performance and image quality of the imaging machines at the time of the testing of the machines. An advisory note was made requiring the service to update their local rules in order they were consistent with the updated IR(ME)R 2017 regulations. Review of the local rules showed the service had completed this action.

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The service had a maintenance contract to attend to faulty equipment. Staff reported there was a prompt response to any defect identified in the equipment.

The risk register detailed the service could use mobile scanning units or arrange to borrow or lease ultrasound equipment from other organisations. The business continuity plan detailed the hospital had a service level agreement with a local independent hospital to carry out urgent CT and MRI scans. The business continuity plan also detailed that mobile CT and MRI scanners could be used if equipment was out of action for a period time and referenced that some imaging equipment could be loaned from manufacturers or equipment suppliers. The service had submitted business cases to the provider for the replacement of magnetic resonance imaging (MRI), computed tomography (CT), ultrasound and fluoroscopy equipment. In conversation with staff, they were only aware that the MRI scanner would be replaced but did not have any timescale for this.

Records showed, that during the twelve months preceding the inspection, there had been 45 cases where MRI or CT scans had been cancelled or delayed due to technical problems with the equipment. This equated to 0.85% of all patients attending the service for a CT or MRI

scan. The service said that staff assessed the risk to all patients at the point of cancellation which identified none of the scans cancelled required urgent scanning. The hospital said that all patients had their appointments rebooked and their imaging carried out within three days of the original appointment.

The service had three radiation protection supervisors (RPS) who had responsibilities for specific areas of the diagnostic imaging service. The service had a radiation protection advisor (RPA) from an external company, who was also the medical physics expert.

We saw that all relevant MRI equipment was labelled in line with Medicines and Healthcare products Regulatory Agency to identify whether it was safe to use in the MRI scanning room or not.

Local rules for radiation were held in each treatment area for each modality of radiation and were signed by appropriate members of staff, except for agency staff. However, discussion with agency staff showed they knew about the local rules and were complying with them.

The Radiation Protection Advisory service had undertaken a review of the diagnostic imaging service on 20 February 2019. The findings of the report concluded "Good compliance with the regulations and associated guidance was found. Except where indicated recommended actions from the previous review January 2018 have been completed." Discussions with the RPA confirmed they had reviewed and assessed that the service had addressed these points.

Risk assessments were completed for all the modalities of radiation and the risk assessments addressed occupational safety to radiographers and to patients.There were signs and warning lights outside controlled areas where radiation was used to make it clear when it was safe to enter.

Specialist personal protective equipment was available and used by staff and carers when needed. This included lead aprons, skirts and thyroid protection shields. The service followed an audit programme to check the effectiveness of all specialist protective equipment in the diagnostic imaging department and theatres where imaging equipment was used. This included yearly scanning to identify holes in the lead equipment. There was a clear process staff followed if any defects were identified in the equipment.

Following the inspection in April 2019, to reduce the risk of damage, the service had acted to improve the storage of specialist personal protective equipment in the treatment rooms. This included providing enough numbers of hangers to store the equipment on.

The service monitored staff for radiation exposure with the use of dosimeters. The report of the inspection carried out in April 2019, raised concerns that staff carrying out fluoroscopy did not wear thyroid dosimeters. Following that inspection, the RPA confirmed that the fluoroscopy equipment used by the service and the method used for carrying out these examinations meant this was not a risk to staff or patients.

The service used several electronic systems for storage and transfer of images. This included the picture archiving and communications systems (PACS). There was 24 hour, seven days a week, PACS support available. There was IT support that could be contacted in the event of IT failure.

Adult resuscitation equipment was in the department. Records showed staff carried out daily checks that the trolley had not been tampered with and monthly checks of all equipment in the trolley. Paediatric resuscitation equipment was available in the hospital, and there was clear signage by the resuscitation trolley about where to locate that equipment.Cleaning chemicals and were stored in locked cupboards, which met the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

There were arrangements in place for ensuring clinical and domestic waste was appropriately segregated and disposed of in accordance with statutory requirements. There were colour coded bins throughout the department. Sharps bins were not overfilled, were securely fastened to walls, or out of reach of young children.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff required patients to complete MRI patient safety questionnaires before scanning took place. Radiographers checked the completed forms to ensure

there were no safety contraindications for MRI scans before the patients could enter the MRI/CT suite. Other people, such as carers, parents, children and nurses accompanying children who also required entry to the MR suite were also screened to ensure they were not at risk of harm caused by the strong MR magnet.

Following set protocols, radiography staff checked the pregnancy status of women for certain diagnostic imaging. Staff were clear about the action they needed to take if a woman declared she might be pregnant. This included the action they would take if a young person under the age of 18 said they may be pregnant. This was in line with IR(ME)R guidance and an improvement from the inspection carried out in April 2019.

Staff followed process to escalate patients to the resident medical officer (RMO) if a patient became unwell during their examination or procedure. Resuscitation scenarios were carried out and reviewed by the resuscitation officer. We looked at the review of a resuscitation scenario carried out in July 2019. This identified areas of good and excellent practice as well as some areas for learning and improvement.

Staff followed processes to escalate unexpected or significant findings, both at examination and upon reporting. Local rules dictated who could request diagnostic imaging examinations and tests.

Nurse and allied health professional staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service included radiographers of different gradings, health-care assistants and non-clinical administration staff. The service sometimes used agency staff to meet the demands of the service. The service used regular agency staff, to ensure they knew the departments, systems and processes.

A generic staffing risk assessment tool was in place, and staffing was mapped and planned against planned activity to meet the needs of the service. The MRI and CT suite were always both supported by two radiographers to each modality. Staffing of the x-ray and fluoroscopy modalities was flexible depending on service demand.

A registered nurse children (RN Child) in advanced paediatric life support attended when a child was scanned.

A noticeboard, in the waiting area, displayed photos of staff uniforms for the service so patients understood different staff roles.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

At the time of the inspection, 31 consultant radiologists had practising privileges at Spire Southampton Hospital. The provider reported that during the preceding 12 months, there had been no instances in which a radiologist had their practicing privileges revoked or suspended.

Spire Healthcare Limited had a buddy system across local Spire Healthcare Limited hospitals to provide access to radiologists for advice and support when needed.

Records

Inaccuracies of times displayed on some imaging equipment meant there was a risk that patient records were inaccurate. Records were stored securely and easily available to all staff providing care.

There was a disconnect between the time recorded on MRI and CT scanning equipment and the actual time which resulted in a risk that it was not clear at what time the patient had their scan carried out. The MRI scanner and its integrated control computer screen located in the MRI and CT control room both displayed the time. As these were integrated systems, the time displayed on both pieces of equipment should read the same and should read the real time. However, both displayed different times that were both inaccurate. The CT scanner and its integrated control computer screen located in the same control room both displayed the time. As these were integrated systems, the time displayed on both

pieces of equipment should read the same and should read the real time. However, the same as the MRI scanning equipment, both displayed different times that were both inaccurate. The real time was displayed on a clock located in the control room. The greatest time difference displayed on the scanning equipment was ten minutes outside the real time.

There was no assessment about the impact or risk this might present to patients. Staff did not identify this as a concern or risk to the accuracy of patient records. Staff recorded patient scan times in patient records according to the real time as displayed on the clock in the MRI and CT control room. However, the imaging produced by the MRI and CT scanners, displayed a different and inaccurate time. Staff told us they were aware of the inaccuracy of the times on the scanning equipment but had not considered it as a risk to the accuracy of patient records or whether it presented a risk to patient treatment. Once we raised this to them as a concern, they contacted the service engineers to attend and address the problem. Following the inspection, the hospital has notified CQC that this issues has been resolved.

Patient records were easily available to all staff providing care. These were mainly electronic, although referral forms were paper. Referral forms were audited to check they were appropriate for the imaging and that any risks to patients were identified.Following an incident, where images were identified as having not been reported, the service introduced a daily record log to evidence reporting of images including review and escalation where there was a delay in the reporting. This had been successful in making sure no images were left unreported.

The service provided electronic access to diagnostic results. The service could send images to other hospital sites.

The service had a target of five days for reporting of results to GPs with the reporting carried out electronically. Staff monitored and audited the reporting process. The corporate score card showed between April and June 2019 Spire Southampton hospital performed like other Spire Healthcare Limited diagnostic imaging services, with 99% of images being reported on within five working days.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Medicines were stored in locked cupboards. Room temperatures and fridges in which medicines were stored were checked daily. Review of temperature checks showed these were within the recommended ranges. There were clear directions about the actions staff needed to take if the temperature was outside the recommended range.

Radiographers used patient group direction (PGDs) to enable them to administer a range of medicines including contrast studies, during CT and MRI scans. A PGD is a written instruction for the supply or administration of a licensed medicine (or medicines) in an identified clinical situation, where the patient may, or may not, be individually identified before presenting for treatment. Copies of PGDs were stored locally. We reviewed a range of PGDs and noted they were signed by practitioners, the authorising manager, pharmacist and a radiologist consultant. All PGDs were in date and valid for use.

Staff completed competency assessments to demonstrate they had the skills and knowledge to administer the medicines as specified by the PGDs.

For our detailed findings on medicines please see the Safe section in the surgery report.

Incidents

There was an improving oversight and management of incidents with the change in the leadership of the service. Managers investigated reported incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff we spoke with knew how to report incidents using the hospital electronic reporting system. However, staff had not considered whether the inaccuracies of the times displayed on the MRI and CT imaging equipment presented as a potential safety incident for patients. In

the 12 months preceding the inspection staff reported a total of 80 incidents, 14 of which resulted in low harm to the patient and the remaining 66 were either near misses or resulted in no harm to the patient.

There had been one never event reported in the 12 months preceding our inspection. This related to an ultrasound guided injection being carried out on the wrong part of the body. Never events are serious incidents that are wholly preventable. Detail about this was included in the report of the inspection carried out in April 2019. At this inspection, staff described and showed the changes made to practices reducing the risk of a similar occurrence. This included changes to the referral document, introduction of a consultant radiologist induction programme, work to ensure staff understood the national safety standards for invasive procedures and auditing of the surgical safety checklist that had been adapted for use in the diagnostic radiology setting.

Alerts from the central alerting system were passed on to staff during routine briefings.Hospitals are required to report any unnecessary exposure of radiation to patients under the Ionising Radiation (Medical Exposure) Regulations (2000). The service had procedures in place to report incidents to the appropriate regulators, for example the CQC. In the twelve months preceding the inspection, they had reported three such incidents.

Staff followed processes to ensure the right person received the right radiological scan at the right time. Staff checked each patient's identity, medical history and pregnancy risk, applying a six-point check. The risk assessment process included checking the imaging was required and appropriate.

All staff we spoke with within the department knew their responsibility and the process relating to Duty of Candour. The Duty of Candour is a legal duty that relates to openness and transparency and requires providers of health and social care services to inform patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.

Are diagnostic imaging services effective?

At present we do not rate effectiveness for diagnostic imaging.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

The service used guidance from the National Institute of Health and Care Excellence, the Royal College of Radiologists and the Royal College of Radiographers.

The service used national diagnostic reference levels (DRLs) for each piece of scanning equipment that produced radiation. DRLs are used as a guide to help promote improvements in radiation protection practice. They can help to identify issues relating to equipment or practice by highlighting unusually high radiation doses.

Staff followed a process to ensure all magnetic resonance imaging (MRI) and computed tomography scans (CT) were "protocoled" by a consultant radiologist. Protocols are a pre-defined set of imaging sequences designed to optimally assess a specific region or regions of the body. This ensured that patients received an appropriate sequence of scans available, whilst also minimising their total exposure of ionising radiation.For other diagnostic imaging procedures, the service used pathways and protocols that were evidence based and available on the hospital intranet.

Staff supervision, appraisals and competency assessments gave the service assurance that staff followed national and local guidance.

Nutrition and hydration

Staff gave patients enough drink to meet their needs.

Hot and cold drinks were available for patients in the main reception area of the hospital and cold water was available in the diagnostic imaging department.

As patients were only in the department for short periods of time, there was no need for the department to provide meals for patients. However, if patients wanted a meal they could purchase a meal in the hospital canteen.

Pain relief

Staff gave pain relief and advice about pain relief in a timely way.

Good

Diagnostic imaging

Patients attending for interventional radiological procedures including joint injections were offered oral pain relief on an individual basis. Patients were provided with self-care advice and contact information for the hospital in the event they experienced pain which could not be controlled with regular analgesia.

At the inspection in April 2019, there was no local audit activity to demonstrate how well the service managed patient's pain post-procedure. At this inspection, although there was no formal local audit activity, calls received by patients following procedures were reviewed to identify if any calls were about pain experienced by patients. Staff said patients rarely called the department about pain, as the guidance directed them to contact their own GP if they experienced pain that was not relieved by their normal pain management medicines.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Managers and staff monitored the effectiveness of the diagnostic services and had started to compare outcomes of their services within the Spire Healthcare Limited group.

Since the inspection in April 2019, the service had introduced a programme of audits that was being embedded into practice. These included safety checklists, referral audits, consent audits, and Ionising Radiation (Medical Exposure) Regulations audits.

At the inspection in April 2019, the service did not carry out any formalised discrepancy reporting process within the service. The Royal College of Radiologists recognises discrepancy reporting processes as a means by which services can learn collectively from radiology discrepancies and errors and therefore improve patient safety. At this inspection, a process for discrepancy reporting had been introduced, but was not yet embedded.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Radiologist induction included equipment competencies and scope of practice. This was an improvement from the inspection of April 2019 when the radiologist induction had not included assessment of their competency to use the diagnostic imaging equipment.

Consultant radiologists worked under a practising privileges agreement, which gave them the authority to undertake private practice within the hospital. Practising privileges were formally reviewed every two years. This review considered compliance with the consultant's agreed scope of practice, satisfactory participation in annual appraisal and processes required for revalidation, and compliance with the Consultants' Handbook.

There was an induction process for agency staff. An agency member of staff told us they had completed an induction programme prior to working in the department.

All staff completed competency assessments each year. This included subjects specific to radiology and core subjects such as safeguarding and moving and handling. Staff confirmed they received regular supervision and appraisal from their managers. Data provided by the service showed 100% of staff, including administration staff, had a completed appraisal in the twelve months preceding this inspection.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Radiologists attended multidisciplinary team meetings held at the local NHS acute trust for patients undergoing surgical or medical treatment for cancer.

Radiography staff attended the daily multi-disciplinary safety huddle, which considered any issues that might affect the delivery of the service across the hospital. This meant staff had relevant information to support each other across the hospital.

Good

Diagnostic imaging

The radiation protection adviser told us that the diagnostic imaging department worked well with him and responded promptly to any advice and guidance to ensure patients received effective care and treatment.

There were good links with the hospital's children and young people's service. The diagnostic imaging staff and RN (Child) staff worked together to support children undergoing CT and MRI scans.

Seven-day services

Key services were available seven days a week to support timely patient care.

The main diagnostic imaging department opened Monday to Saturday 8am to 10pm. Radiographers were on-call out of hours to support urgent requests for imaging within the in-patient setting.

The MRI service ran from 7am to 10pm Monday to Friday; CT ran from 8am to 4pm Monday to Friday. Where demand required it, the CT and MRI service operated at the weekends.

Ward-based mobile x-ray services were available. These could be provided 24 hours a day with radiographers supporting an on-call rota. This meant patients who were too sick or those who were restricted to bed, such as those in the critical care unit, could still have x-rays at any time of day or night.

There was no formalised radiologist on-call rota to support the service. The service used a "buddy system" across different Spire Healthcare Limited hospital sites to ensure urgent imaging was reported on. Staff said, this system worked well and there had been no incidents where urgent imaging had not been reported on in a timely manner.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

There were various health promotion leaflets available for patients in the department. This included information provided by Spire Healthcare Limited and information provided by external organisations.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

All staff competed training and competency assessments about consent, the Mental Capacity Act and associated Deprivation of Liberty safeguards. 97% of all diagnostic imaging staff had completed this training. The one member of staff who had not completed this training for 2019, was two weeks into post and was completing mandatory training, including Mental Capacity Act and associated Deprivation of Liberty safeguards training and competency assessments, during their induction programme.

Radiographers screened and approved MRI and CT contrast questionnaires prior to any scan being undertaken. These forms also served as a consent form and detailed the procedure and any likely risks associated with the intended scan.

Following a never event that occurred in 2018, the service had acted to ensure consultants documented consent gained from patients undergoing interventional procedures. Radiography staff carried out monthly audits to monitor that written consent was obtained.

Audits for May and June 2019 showed that consent forms were fully completed for all patients undergoing interventional radiological procedures.

Discussion with staff showed they had a good understanding of their accountability towards the Mental Capacity Act and associated Deprivation of Liberty safeguards.Staff had an understanding about Gillick competence and its relevance for children consenting to their care and treatment.

Are diagnostic imaging services caring?

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.

We rated it as **good.**

Good

Diagnostic imaging

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We saw staff introduce themselves to patients prior to their scan. Staff wore name badges which were visible and clear.

The environment had been adapted to ensure patients privacy and dignity was maintained; this included individual changing rooms for patients attending the department.

All 15 patients and relatives we spoke with told us they found the staff to be caring and kind. Each patient said they would recommend the service and they would use it again.

We observed signs prompting patients to request a chaperone if they would like one present when examined. Staff had received training about chaperoning patients.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff said that some patients attended the hospital regularly and so welcomed them by name into the department.

We saw the radiographers kept in touch with patients through the intercom system during their magnetic resonance imaging and computerised tomography scans to reassure them.

Patients were able to choose music to listen to, whilst having their scan, to help with relaxation and reduction of anxiety.

Radiographers tried to see the same patients when they attended for multiple scans to give continuity of care.

Radiographers were compassionate and caring and were observed reassuring patients upon their arrival to the department.

Staff described examples where they worked with patients and their relatives to reduce anxiety. This included, if there was no clinical impact, rescheduling scans after patients had received bad news to give the patient and relatives time to process the news.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Specialist health professionals were available to support patients who had received a diagnosis of cancer or other serious health condition.

Patients we spoke with each said they felt they had been well informed about their imaging procedure and what to expect when they had their procedure.

We saw health professionals explaining the process and what to expect when patients entered the MRI or CT scanning suite.

Staff involved parents and carers to help when children were having a diagnostic procedure.

Carers could stay with relatives or children when they were having a magnetic resonance imaging scan if they completed the safety questionnaire.

Leaflets about the imaging processes and radiation levels were available in both the main diagnostic waiting area and the CT/MRI waiting area.

Staff advised patients about how to contact the service if they had any concerns after leaving the hospital. Information about how to contact the service was on the hospital website and business cards detailing how to contact the service were given to patients.

Are diagnostic imaging services responsive?

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.

Good

Diagnostic imaging

We rated it as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served.

There were a range of diagnostic services available to support NHS and self-funding patients who required treatment.

The environment was appropriate and comfortable for patients. There was enough car parking for patients and a car parking attendant supported patients to find a place to park.

The diagnostic suite was located on the first floor of the hospital and was accessible by a lift. There were two waiting areas, one for the MRI and CT scan and the main waiting and reception area for all other diagnostic imaging services.

There was small children's waiting and play area, with toys and books, in the main reception and waiting area.

There was clear signage to support people find their way to the diagnostic imaging department. When patients were unsure about finding the departure, hospital reception staff accompanied the patient to the department.

All patients we spoke with said their appointments were on time and they did not have to wait long in the department. The service monitored patient wait times. Information provided by the service showed that between January 2019 and June 2019, an average of 74% of patients had their imaging carried out at the appointment time, an average of 18% had their imaging carried out up to 15 minutes after their appointment time, and less than 5% had their imaging carried out over 30 minutes after their appointment time.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service could arrange appointments to suit the specific needs of patients, for example taking into consideration their work commitments or travel constraints.

Translation services were available, and staff knew how to contact them.

Single sex toilets were located throughout the department. There was an accessible toilet with equipment to help people with reduced mobility.

The service made reasonable adjustments that included extended appointment times and allowing family members or carers to accompany and support patients with conditions such as dementia or a learning disability in the treatment and x-ray rooms.

Children who attended for scanning were accompanied by a paediatric nurse who used play techniques and distraction techniques to relax children during scanning.

Although there were changing rooms, with lockable facilities for patients' personal possessions in both the main and CT/MRI reception areas, these were all small and there was no large changing room for patients with mobility problems. Disabled patients, or patients requiring more room to change were able to change in the scanning room.

It was not possible for the hospital to scan obese patients as the machine was not a wide bore MRI scanner. This was despite the hospital providing a specialist bariatric (weight loss) surgery service. The patient pathway for bariatric surgery did not include the need to have an MRI scan, but if these patients' conditions during their treatment necessitated an MRI scan, this would have to be carried out at an alternative health care provider. A business case had been submitted for the replacement of the MRI scanner with a scanner that was able to be used by obese patients.

Access and flow

People could access the service when they needed it and received the right care promptly.

General plain x-ray services ran both a booked appointment system and general walk-in service to allow for patients attending outpatient appointments to also have plain x-rays on the same day.

Good

Diagnostic imaging

The service was able to offer additional scanning sessions on the CT/MRI modalities at weekends if demand called for this.

The service monitored the report turnaround times, the time it took for reports to be sent to patients' GPs. The hospital target was for reports to be sent within five days of the radiological examination or procedure. Data provided by the service showed that between 1 April 2019 and 30 June 2019, 99% of imaging reports met this target.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

There was information in the department, at the main reception and on the hospital website about how to complain or raise concerns.

Staff described changes made to the service in response to patient's concerns and complaints. One of these included the introduction of scrubs for patients to wear rather than the less dignified hospital gowns.

See the surgery section for main findings.

Are diagnostic imaging services well-led?

Good

We previously inspected diagnostic imaging jointly with outpatients so we cannot compare our new ratings directly with previous ratings.

We rated it as **good.**

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills.

The diagnostic imaging department was run by a diagnostic imaging manager. Since the inspection in April 2019 a new manager had started employment. At the time of our inspection they had been in post for two weeks. Spire Healthcare Limited's lead radiographer was supporting the new manager during their induction process, as well as supporting the department to make the improvements required following the inspection in April 2019.

The manager reported to the outpatient service manager. Discussion with the outpatient service manager showed they had reflected on the challenges with the previous management arrangements in the diagnostic imaging services. They described the action they had taken to reduce the risk of a similar occurrence of poor management occurring. This included making themselves more visible and accessible to the diagnostic imaging staff, reassuring staff they could raise concerns and attending clinical effectiveness meetings.

At the previous inspection, there had been no representation from the consultant radiologist team at the medical advisory committee, which had resulted in delays with authorisation of policies and procedures. Since that inspection, a radiologist had accepted the role as a medical advisory committee representative.

Vision and strategy

The service used the hospital vision for what it wanted to achieve and followed the hospital's three year strategy to turn it into action.

There was a hospital wide vision which was 'To be recognised as a centre of excellence in private healthcare'. To deliver the vision, the strategy suggested two required outcomes: (1) Clinical excellence. Outstanding quality clinical treatment every time. (2) A more personal patient experience. Recognising the person behind the patient: deep understanding of patient's wider needs, not just clinical.

All staff in the department had personal objectives as to how they would support delivery of the vision in the department. Staff appraisals considered objectives linked to the hospital strategy, hospital targets, departmental improvements and targets. Staff were also measured against how well they demonstrated the hospital values and behaviours.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving

care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

At the previous inspection in April 2019, morale was reported to be low across the department. At this inspection, we found staff morale had improved. Staff felt listened to and well supported. For example, staff rotas were published at least one month in advance which allowed staff to manage any personal commitments they had.

Staff were proud of the department and were keen to share the changes and improvements they had made to the running of the department. It was clear, during our conversations with staff, that changes to the service to bring about improvements had been developed with input from staff delivering the service.

It was clear that staff had been unsettled by changes in management of the service, including changes happening at hospital level. However, they felt positive about the support provided by the new diagnostic imaging manager, the corporate manager and the outpatients and diagnostic imaging service manager.

The service acknowledged that, due to its size, there was limited scope for career progression and promotion within the department. However, support was given to staff to develop their clinical skills and development to enable them to meet the requirements of their professional registration. Examples included additions to the mandatory training and competency assessments of National Institute for Health and Care Excellence (NICE) and staff being supported to become skilled in the different modalities of diagnostic imaging.

Following the inspection in April 2019, the outpatient and diagnostic imaging service manager identified that not all staff working in the diagnostic imaging service had felt able to raise concerns to either herself or to the hospital's freedom to speak up guardian. Since that time, they had worked with staff to assure them that concerns raised would be treated seriously and would be managed with sensitivity as well as working to raise the profile of the freedom to speak up guardian. Staff we had conversations with said they could raise concerns with the new diagnostic imaging manager, the outpatient and diagnostic imaging manager or the freedom to speak up guardian. They felt confident that any concerns they raised would be taken seriously and that their personal wellbeing would be considered during the investigation of any concerns.

Governance

Leaders of the diagnostic service operated governance processes that they were developing and embedding into practice. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The report for the inspection carried out in April 2019 described the diagnostic imaging governance process as at an "an embryonic stage". Since that inspection the service had acted to improve the governance of the service.

The service had continued to develop its quality dashboard. This monitored performance against targets such as mandatory training, attendance at team meetings, reporting turnaround times, quality assurance, completion of request forms, WHO checklists and consent forms. This meant the service had easy access to information about how they were performing so they could identify areas for improvement.

The effect of the quality dashboard to provide assurance and bring about improvements had not yet been tested. Several of the metrics had only started being collected since May or June 2019, with most others being collected since January 2019. This meant there was insufficient data to identify trends of performance. However, the data did provide monthly assurance about how the service was performing.

Areas on the dashboard where the service did not meet their set targets included six-point patient identification confirmation, incomplete request forms and completion of pregnancy checks." However, the data also showed that there was an improving trajectory for six-point patient identification confirmation and completion of pregnancy checks. Data also showed the service met the hospital's 100% target for WHO documentation and WHO observational audit in June 2019, emergency equipment trolley checks between January and June 2019, x-ray medicine expiry checks between April and June 2019 and imaging cassette quality assurance checks between

January and June 2019. Discussions with staff showed they knew the areas for improvements and they showed the quality checks and audits they now carried out to promote improvement in performance.

The diagnostic imaging manager generated a diagnostic imaging report which was considered at the hospital governance meeting on a quarterly basis. At the inspection in April 2019, we found the content of the report was limited and was insufficient to provide assurance to the hospital's senior leadership team. At this inspection, we found the content of this report had been reviewed and changed to include more detail about the running of the service, including information about complaints, incidents, trends and learning from audits key risks, staffing and staff training.

The service held staff meetings, during which staff said they discussed performance, identified areas for improvements and planned the actions to take to bring about improvements. Our review of records of these meetings showed staff reviewed risks, incidents, complaints and compliments, audits and the actions taken in response to these.

Regulation and radiation protection meetings were held yearly and learning from incidents and risks identified nationally.

Managing risks, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were standardised processes across the hospital for the management of risks. The department carried out risk assessments for all aspects of the delivery of the diagnostic imaging service. Following set criteria, risks of a pre-determined level were escalated to the risk manager for consideration to be added to the hospital wide risk register. This meant high level risks were monitored by the hospital management team, but lower level risks were managed by the staff delivering the service. Staff reviewed risks during departmental meetings.

Following the inspection in April 2019, all risk assessments for the diagnostic imaging service were reviewed and discussed with the risk manager who confirmed no additional risks needed to be added to the hospital wide risk register. This was because the risk manager assessed staff were managing the risk effectively within the department.

Staff were aware of most of the risks relating to the delivery of the service. The top three assessed risks for the service were displayed in staff areas of the department, these matched staff views about the risks to the service. The risks included the risk associated with the age of some of the equipment, risks of patients receiving incorrect radiation exposure and risks associated with a previous lack of discrepancy auditing. The hospital wide risk register included detail about two of these risks (age of equipment and risk of patients receiving incorrect radiation exposure). However, staff had not considered whether there was any risk associated with the inaccuracy of time recordings for MRI and CT images.

Our review of the hospital wide risk register showed that the age of equipment was identified as a risk and that the service was taking some actions to lessen the risk this posed to patients. The business continuity plan gave further detail about how staff would access replacement imaging equipment in the event of equipment failure.

The risk registered detailed that business cases had been submitted for replacement of imaging equipment, however staff that we spoke with were only aware that there were plans to replace the MRI scanner.

The service used the developing quality dashboard to monitor performance and identify areas for improvement.

A formalised hospital wide daily meeting provided opportunities for staff to update colleagues about any current risks and performance issues about their department, and to be informed of other service related developments.

The service had emergency generators in case of failure of essential services.

Managing information

Good

Diagnostic imaging

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Patient information was held on electronic records. Access to the electronic records was pass word protected. Staff transferred any paper documents onto electronic files and then shredded all hard copy versions.

The department used a range of computer systems to manage the diagnostic imaging service, including the reporting information system (RIS) which is a nationally recognised imaging system in use by several providers, both independent and NHS. The service also used a recognised, secure radiology picture archiving communication system to improve access to images, manipulations of the view and sharing of images with referrers.

At the inspection in April 2019, we found general housekeeping of information technology systems was poorly audited with staff only being able to provide verbal assurances that systems were checked weekly to ensure no images remained unreported. At this current inspection we saw staff followed a set process to ensure no images remained unreported, which included daily checking and recoding of images taken, and reported on.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

The service used several methods to engage with and seek feedback from patients. This included comment cards and the use of a dedicated outpatients department and imaging service survey which had been introduced for 2019 across all of Spire Healthcare Limited hospitals.

The service took note of comments patients provided. The waiting area displayed a “you said, we did” board, which described the actions the service had taken in response to patient’s comments. This included later opening hours and opening at weekends, so patients could fit appointments in around their working hours, improving signage so patients found it easier to find the department and providing grey scrubs for patients having CT and MRI scans to wear so their privacy and dignity was protected.

Staff were encouraged to provide feedback and were listened to. Staff said they had confidence their managers listened to their views and used their views and opinions to make improvements to the service.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Following the inspection in April 2019, changes in the monitoring and auditing of performance showed the service was committed to improving the service provided for patients. Staff had confidence that the new management of the service would support ongoing improvements.

Staff gave examples where their views and opinions had been considered in making improvements to the service.

Outstanding practice and areas for improvement

Outstanding practice

Children and Young People

- The service was proactive in developing resources which had been adapted by the provider and shared across the hospital group: for example, the fasting instruction cards.
- The latest innovation had been the 'app' to help children and young people prepare for their hospital stay.
- One member of the Children and Young People's staff team had been supported and encouraged to implement the 15 Steps process.

Surgery

- The hospitals bariatric Tier three weight management service won a UK Association for the Study of Obesity best practice award in 2018.

Areas for improvement

Action the provider MUST take to improve

Critical Care Services

- The provider must improve governance processes so there is assurance that the service is managing risk and delivering evidence-based care and treatment.
- The provider must ensure that staff are trained and aware of the local invasive procedure pathways.

Action the provider SHOULD take to improve

Surgical services

- The provider should be clear to staff what parts of the new medicine chart needed to be completed or not, such as for venous thromboembolism (VTE) risk assessments
- The provider should give clear guidance and or training for new procedures such as for the use of the Controlled Drug register.
- The provider should improve flooring in the autoclave area to improve compliance with infection preventions and control.
- The provider should lessen the risk of injury to staff from the uneven flooring in the autoclave area on a permanent basis.
- The provider should consider removal of all carpets in the hospital corridors to improve compliance with infection preventions and control.

Critical Care

- The service should review the use of the isolation room as a storage room.
- The service should improve compliance for the safe disposal of sharps.
- The service should reduce reliance on bank and agency staff to meet guidance which states that there should not be more than 20% reliance on bank and agency staff per shift.
- The service should complete all aspects of the agency induction checklist.
- The service should monitor and improve compliance with consultant intensivists undertaking twice daily reviews of patients.
- The service should complete a duty of candour assessment for all incidents.
- The service should close patient curtains fully to protect patient's privacy and dignity.
- The service should provide patients, relatives and visitors with information about how to raise a concern or a complaint. The service should provide a platform to engage with patients and their relatives to gain their views and opinions.
- The provider should have clear pathways for staff to be conversant with the requirements of the Mental Capacity Act (2005).

Children and Young People

Outstanding practice and areas for improvement

- The service should consider the risk staffing may have on the delivery of the Children and young people's service and how this will be mitigated. They should ensure the risk is fully assessed and documented and mitigating actions communicated to staff.

Diagnostic Imaging

- The service should improve risk management processes so there is assurance that all risks to patients and the service are identified and managed effectively and safely. This includes acting to reduce risks to patient because of breakdown or poor image quality of imaging equipment over ten years of age.
- The service should continue to embed the use of audits to monitor and improve performance.
- The service should continue to implement discrepancy reporting processes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The critical care service did not have effective processes to give assurance that the service was managing risks, providing evidence-based care and treatment and measuring performance for all care and treatment provided by the service.