

# Spire Southampton Hospital

## Quality Report

Chalybeate Close  
Southampton  
Hampshire  
SO12 6UY

Tel: 023 8077 5544







Website: [www.spirehealthcare.com/southampton](http://www.spirehealthcare.com/southampton)

Date of inspection visit: 18 to 19 October 2016 &  
unannounced visit 1 November 2016

Date of publication: 01/06/2017

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 provides elective (planned) surgery, medical care, services for children and young people, and outpatients and diagnostic imaging. The hospital has 84 inpatient beds provided across three inpatient wards, a critical care unit and day care unit. The hospital also provides an oncology suite (The Chalybeate Suite) consisting of 8 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.

We inspected the following core services; surgery, critical care, services for children and young people, medical services (including oncology and endoscopy) and outpatients and diagnostic imaging. We did not inspect physiotherapy services provided at the nearby Spire Perform centre, as this is a separate registration, but we visited the surgical pre-assessment clinic as part of the inspection of surgical services

We inspected the services using our comprehensive inspection methodology. We carried out the announced part of the inspection on 18 and 19 October 2016, followed by an unannounced visit to the hospital on 1 November 2016.

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

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

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

### Services we rate

We rated this hospital as good overall. Safety of surgical and critical care services required improvement but was rated good for medicine, critical care, and children and young people's services. We rated all services good overall for effective, caring, responsive and well led with the exception of surgery which required improvement for well led.

We found good practice in relation to the core services we inspected: surgery, medical services, critical care, children and young people and outpatients and diagnostic imaging:

- The management team provided effective leadership and governance. Actions identified from the previous inspection in October 2014 and November 2014 had been largely addressed. These included improvements to the outpatient department environment and parking areas, establishing safe children's services, improving the segregation of clean and dirty areas in theatres and training staff in dementia awareness.
- There was clear management and support for children's services, which had expanded since the last inspection. As far as possible, the hospital arranged child-only operating lists and provided children and young people with individualised care and treatment.
- There were clearly defined governance arrangements across the hospital and with partner organisations, along with effective risk management processes to support the safety and quality of care and treatment. There was a well established and effective Medical Advisory Committee.
- Staff understood the hospital's vision and values which were focused on quality and safety.

# Summary of findings

- There was a good approach to reporting and learning from incidents. Staff we spoke with demonstrated a good understanding of the duty of candour requirements which were implemented.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Staff delivered care and treatment in line with national guidance and the hospital participated in benchmarking to improve practices.
- Staff met the individual needs of patients and particular focus had been given to improve care for people who might be living with dementia.
- The hospital had good links with the local NHS trust for sharing knowledge and expertise, major incident planning and training.
- Patients were treated with compassion and respect.
- There was good information for patients and the hospital had few complaints. There had been a 30% reduction in complaints since 2015.
- Staff sought patient consent before delivering treatment.
- Staff were positive about the leadership of the hospital and had good access to support, training and development. The provider offered leadership courses and preceptorships.
- There were clear treatment pathways and patient outcomes were monitored in most services. Work was in progress to increase participation in benchmarking groups. The lack of a neurosurgical pathway had been raised to be addressed corporately.
- Patient assessments and monitoring took place, and areas for improvement were identified through the hospital audit programme.

We found areas of practice that require improvement in medicine, surgery, critical care and in outpatients and diagnostic and imaging:

- The environment in some areas posed a potential risk to the wellbeing of patients. There was no dedicated clean clinical room in the critical care unit. This increased the risk of cross contamination and patients acquiring an infection. The management and storage of endoscopes did not meet safe standards.
- Some environmental and equipment risks had not been identified and managed, such as in theatres and endoscopy services.
- Theatres were not always maintained to a clean standard and early interventions following CQC concerns needed to be sustained.
- Theatre log books were not consistently completed but this was actioned immediately when brought to the attention of the senior management team.
- Endoscopy and the cardiac catheter laboratory staff appraisals were not fully completed.
- Equipment was not always managed safely. Staff did not regularly check the temperature of the medicines fridge or take appropriate action when the temperature was out of range. Some equipment in surgery was in need of replacement due to age, duplication or deterioration. The storeroom for theatre and critical care equipment was disorganised and presented a hazard for staff.
- Omissions in the controlled drugs register indicated the management of controlled drugs was not effective.

# Summary of findings

- Staffing levels in surgical theatres and on ward night shifts were not consistently maintained at the hospital's planned levels for safe care. Staff recognised the service was expanding but felt that staffing arrangements were not consistently secure.
- There was no appropriate care and treatment pathway to follow for neurosurgical patients.
- Patients' consent for bedrails was not recorded. This had been identified in the 2014 inspection and not addressed.
- Cleaning materials, covered by the Control of Substances Hazardous to Health Regulations 2002, were not stored securely. This had been identified in the 2014 inspection and not fully addressed.
- Patient records did not consistently include evidence of daily medical reviews.
- Risks to patient's safety were not re-assessed and monitored consistently on each ward, and staff did not update records with sufficient detail to help them reduce those risks effectively.

Following this inspection, we told the provider that it must take some actions to comply with the regulations. The provider should also make other improvements to help the service improve. We issued the provider with five requirement notices that affected Spire Southampton Hospital. Details are at the end of the report.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

## Overall summary

We inspected the following core services:

- Medicine
- Surgery
- Critical care
- Children and young people
- Outpatients and diagnostic screening.

We undertook an announced inspection 18 and 19 October 2016, with an unannounced visit on 1 November 2016. We visited all departments, theatres and wards at different times of the day and evenings.

We reviewed a wide range of documents and data we requested from the provider. These included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital prior to the inspection, which enabled staff and patients to provide us with their views. We received ninety three comments from patients and relatives, of which 96% contained positive comments.

We spoke with 56 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We

spoke with 19 patients and relatives. We also received ninety three tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 33 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 had last been inspected in October 2014 and we found areas needing improvement. We found breaches of four regulations. These were regulations relating to cleanliness and infection control, safety and suitability of premises, supporting staff with training and assessment and ensuring there were enough suitably trained staff when treating children. We reviewed improvements in these areas specifically.

There were 326 consultant surgeons and anaesthetists who worked at the hospital under practising privileges across anaesthetics, orthopaedic surgery, plastic surgery, ophthalmology, gastroenterology, rheumatology and oncology.

# Summary of findings

The hospital employed seven resident medical officers (RMO), who worked on a 'one in five' 24 hour shift pattern Monday to Friday and one in five weekend rota.

There were 124 contracted staff which equated to 106 full time equivalent (FTE) nurses and operating department practitioners and 27 contracted healthcare assistants which equated to 23 FTEs. The accountable officer for controlled drugs (CDs) was the registered manager.

## Activity (July 2015 to June 2016)

- In the reporting period July 2015 to June 2016 there were 10,842 inpatient and day case episodes of care recorded at the hospital; of these 28% were NHS-funded and 72% other funded.
- There were 8,554 visits to theatre in the reporting period July 2015 to June 2016.
- 45% of all NHS-funded patients and 58% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 70,740 outpatient total attendances in the reporting period; of these 82% were other funded and 18% were NHS-funded.

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

- 1 Never event in surgery
- 1157 clinical incidents – higher rate than in other independent acute hospitals: 1 serious injury (patient fall); 15 deaths of which 9 were unexpected

- 0 incidence of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- 0 incidence of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- 1 incidence of hospital acquired Clostridium difficile (c.diff)
- 1 incidence of hospital acquired E-Coli
- 10 complaints received by CQC

## Services accredited by a national body:

- Macmillan Quality Environmental Mark
- Pathology ISO accreditation
- Sterile Services Department CE accreditation with SGS Yardsley
- VTE Exemplar Status.

## Services provided at the hospital under service level agreement:

- Critical Care transfer agreement
- Multidisciplinary Team for oncology
- Gynaecology CNS
- Sterile Services

# Summary of findings

## Our judgements about each of the main services

### Service

### Rating

### Summary of each main service

#### Medical care

Good



Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in surgery section. We rated this service as good because it was safe, effective, caring and responsive and well led. We rated safe, effective, caring, responsive and well led as good.

- Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents. When something went wrong, thorough investigation took place involving all relevant staff. Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected.
- Staffing levels and skill mix for the endoscopy, oncology and cardiology services were planned, implemented and reviewed to keep people safe at all times. There were effective handovers and shift changes, to ensure staff could manage risks to people who used services.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Weekly endoscopy rinse water checks and annual microbiological tests were being undertaken, and sent to Public Health England.
- Hospital-wide mandatory training compliance was 81% at October 2016.
- Staff were appropriately qualified, had the skills to carry out their roles effectively, and took account of best practice. The learning needs of staff were identified and training put in place to meet their learning needs. Staff were supported to maintain and further develop their professional skills and experience.

# Summary of findings

- The services were taking action to meet current evidence based guidance. The endoscopy lead had an action plan in place to drive towards achieving joint advisory guidance (JAG) accreditation in gastrointestinal endoscopy.
- Staff were supported in their role through appraisals, and there was 100% compliance in oncology. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care Staff obtained appropriate consent from patients.
- During the inspection, we saw that staff were caring, compassionate and sensitive to the needs of patients. Patients commented positively about the care provided from all of the endoscopy, oncology, cardiac catheter laboratory and ward staff. Patients felt well informed and involved in their procedures and care.
- The service was responsive to patients in the inclusion criteria, with waiting times of one to four weeks. Care and treatment was coordinated with other providers. The needs of different people were taken into account when planning and delivering services.
- Staff were clear about the vision and strategy for their areas, that were driven by quality and safety. The staff we spoke with described an open culture and leaders were visible and approachable. There was a governance structure for senior staff to report concerns/ issues to be discussed.

However

- Ventilation in the theatre used for endoscopies did not meet national guidance. This was being monitored, and there were plans to upgrade the system.
- Some health and safety and environmental risk assessments in the medical service were overdue for review.
- A system was not in place to monitor outcomes following gastrointestinal endoscopy, but was under development.

# Summary of findings

## Surgery

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.

Ward staffing was managed jointly with medical care.

We rated the service provided by Spire Southampton Hospital over the whole hospital as good. We rated effective, caring, responsive and well led as good. However, we rated safe as requires improvement.

We rated surgery as requires improvement because safety and well led required improvement. However, we rated effective, caring and responsive as good.

### Requires improvement



- There were not consistent completion of theatre logs, cleaning of theatre environment and equipment, and disposal of dirty instruments within theatres.
- There was not always sufficient staffing in theatres to allow time for staff break relief and theatre overruns.
- Ward staffing levels at night did not always comply with requirements of planned hospital ratios.
- Ward nurses did not always reassess patient risks following surgery.
- There was not a consistent daily record of medical reviews of patients seen within inpatient records which were inspected.

However,

- The processes for reporting, investigating and learning from incidents were well established and implemented.
- Staff had a good understanding about hospital safeguarding procedures. Surgical safety checks were adhered to.
- Medicines were stored safely and there were processes to audit procedures
- Staff worked especially hard to make the patient experience as pleasant as possible. They were caring and compassionate.
- Staff recognised and responded to the holistic needs of their patients. Staff knew how to support people with complex or additional



# Summary of findings

needs and made adjustments wherever possible. We saw good responses to referrals, pre-operative risk assessment before admission, and then planning for their patient's discharge from the hospital.

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. There was a local and corporate annual audit programme, which measured the hospital's compliance against policies and national guidance.
- The service participated in national audits where applicable and outcomes were good, particularly for cardiac surgery. The hospital was fully engaged in the Private Healthcare Information Network (PHIN) work to develop outcome measures for private patients.
- Staff were well trained and competency assessed, all had received annual appraisal.
- The complaints process was available to patients and their carers. Staff reviewed complaints and implemented learning.
- Staff were aware of the mission, vision, values of the hospital and wider organisation, and demonstrated commitment to them in their care practices and personal development plans within their appraisals.
- The services were generally well led and staff spoke passionately about the service they provided and the care they offered to patients.

## Critical care

Good



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 critical care unit has seven beds for patients who require level 2 or level 3 care.

We rated critical care services as good because it was effective, caring, responsive and well-led although it required improvement for being safe.

- There was a culture of reporting and learning from incidents and staff had a good understanding about safeguarding procedures.

# Summary of findings

- There were sufficient numbers of nursing, medical and allied health professional staff to deliver care and treatment over a seven day period.
- Staff followed established processes for the management of deteriorating patients.
- Care pathways, nurse competency assessments, policies and procedures supported staff to deliver care and treatment according to current national guidelines.
- Staff completed mandatory training.
- The critical care unit was visibly clean. Staff followed infection control and prevention procedures. Equipment, including emergency resuscitation equipment, was available and in working order.
- All staff demonstrated a caring and compassionate approach in their care and treatment of patients.
- Staff felt the unit manager provided good support and leadership. There was a cardiothoracic and a general intensivist consultant lead for the service.
- The governance structure of the hospital and critical care service meant all staff had an overview and an understanding of their role in issues affecting the hospital and the development of the hospital services.

However,

- There was a risk that people could access the medicines fridge, which was not locked.
- Records did not fully evidence care and treatment was consistently provided in line with national recommendations and guidance.
- Staff did not always follow best practices in their recording in patient records.
- Staff did not act to lessen all identified risks. The medicine fridge was unlocked and its temperature was recorded as outside the recommended range. Storage facilities were cluttered, and posed a risk to the safety of staff. There was no assessment of risks relating to the availability of the critical care outreach team.

# Summary of findings

## Services for children and 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, responsive and well led.

- Children were protected from avoidable harm and the service had a good safety record.
- The hospital safeguarded children and young people appropriately. Although there were no children-only waiting rooms or consulting rooms, staff accompanied children through the process, limiting the risk.
- The children's nurses had specialist training and the lead nurse promoted skills in nursing children, training non-specialist nurses in paediatric lifesaving skills. A range of risk assessments were in place.
- Care and treatment was planned and delivered with current evidence based guidance and standards with a holistic approach to care.
- Relevant audits were used to assess compliance with best practice.
- Staff were qualified and had the relevant skills for their role and were encouraged to undertake specialist training in their field of expertise.
- Parents said their children had received compassionate care and they were fully informed and involved in decisions about their child's treatment and care.
- Children's and young people's services provided access at times to suit children, young people and their parents.
- The service supported child inpatients by introducing them to the environment through a visit and a pre-assessment appointment, so that everything would be familiar.
- The service had developed a vision for the expansion of children's services and facilities and this was shared with staff. The appointment of a lead children's nurse had improved the services.

**However**

# Summary of findings

## Outpatients and diagnostic imaging

Good



- Staff and managers understood they needed to strengthen quality and performance monitoring and introduce learning from audits and benchmarking.

Outpatients and 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 because it was safe, caring and responsive and well led. We inspected but did not rate 'effective' as we do not currently collate sufficient evidence to rate this.

- There was an open and transparent safety culture in the outpatients and diagnostic imaging departments. Staff understood their responsibilities to raise concerns and report incidents.
- Staffing levels and skill mix were planned and reviewed to ensure the safety of patients.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Staff were appropriately qualified, had the skills to carry out their roles effectively, and took account of best practice. The learning needs of staff were identified and training put in place to meet their learning needs. Staff were supported to maintain and further develop their professional skills and experience.
- Staff were supported in their roles through the appraisals process, there was 100% compliance in OPD and Diagnostic Imaging. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care.
- Staff always sought consent from patients.
- Staff in the outpatients department (OPD) and diagnostic and imaging service were caring, compassionate and sensitive to the needs of patients. Patients commented positively about the care provided from department staff.
- The service had improved its reporting times for CT and MRI scans.

# Summary of findings

- The needs of different people were taken into consideration when services were planned and delivered.
- Staff were clear about the vision and strategy for their areas, that were driven by quality and safety. The staff we spoke with described an open culture where leadership was visible and approachable. There was an appropriate governance structure for staff to report concerns or issues to be discussed.

However,

- The service did not always meet the target response times for treating NHS patients, due to changes in commissioning pathways.

# Summary of findings

## Contents

### Summary of this inspection

	Page
Background to Spire Southampton Hospital	16
Our inspection team	16
Information about Spire Southampton Hospital	16
The five questions we ask about services and what we found	17

### Detailed findings from this inspection

Overview of ratings	21
Outstanding practice	94
Areas for improvement	94
Action we have told the provider to take	96

Good 

# Spire Southampton Hospital

**Services we looked at**

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

# Summary of this inspection

## Background to Spire Southampton Hospital

Spire Southampton Hospital is operated by Spire Healthcare Limited and is a private hospital in Southampton, Hampshire. The hospital primarily serves the communities of southern England for both private and NHS surgical care. It also accepts patient referrals from outside this area.

The hospital registered with the CQC in 2010. It provides a wide range of services which include day care, and inpatient and out-patient services. The main activity is elective (planned) surgery, and more complex procedures such as cardiac and spinal surgery are supported by the onsite critical care facilities. The hospital works in partnership with local NHS acute hospital trusts for example in recent provision of robotic surgery. Medical services include oncology, endoscopy and a limited number of medical inpatients. The children and young people inpatient service has recently expanded. There is

a large refurbished outpatient department along with extensive diagnostic imaging services.). The hospital treats both adults and children (three years of age and above

The hospital's registered manager has been in post since October 2010.

The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Surgical procedures
- Treatment of disease, disorder, or injury.

## Our inspection team

The team that inspected the service comprised a CQC lead inspectors, assistant inspector and specialist

advisors with expertise in surgery, medicine, critical care, paediatric care, radiography and out patients. The inspection team was overseen by a CQC Inspection Manager.

## Information about Spire Southampton Hospital

The hospital has 84 beds and these are provided across three inpatient wards, a day care unit, the oncology suite (The Chalybeate Suite) and a seven-bedded critical care unit. Ward one is predominantly for cardiothoracic patients and ward two for orthopaedic and spinal neuro surgical patients. Ward three is predominantly general surgery with two high dependency beds and occasional admission of medical or oncology patients. The day care

unit is expanding from 12 rooms to 18 bays to become an admissions ward. 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.



# 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?

We rated safe as requires improvement because:

- Environmental risks had not been fully identified, managed or mitigated. Theatre equipment was not risk assessed adequately and there was unsuitable storage of endoscopes and critical care equipment.
- Staff had not managed the cold storage of medicines safely, by ensuring fridges were locked and the temperature of fridges was measured and safely controlled.
- Staff did not follow the hospital policy when checking controlled drugs.
- The theatre log books were not consistently completed but this was actioned immediately when brought to the attention of the senior management team.
- There was not always sufficient staffing in theatres to allow time for staff break relief and theatre overruns. Ward staffing levels at night did not always comply with the requirements of planned hospital ratios.
- The critical care outreach service did not meet the recommendation of the Guidelines for the Provision of Intensive Care Services 2015, to provide a service day and night.
- There was no neurosurgical care pathway.

However,

- Staff reported incidents and there were systems for investigating and learning from incidents.
- There were low infection rates and infection control procedures were in place and followed.
- Staff understood the duty of candour.
- There was suitable medical cover from the resident medical officer and consultants.
- Staff understood safeguarding and followed agreed procedures for reporting concerns.
- There were emergency procedures and transfer arrangements in place, with links to the local NHS acute hospital.
- Staff completed their mandatory training.

Requires improvement



### Are services effective?

We rated effective as good because:

Good



# Summary of this inspection

- Staff provided care that took account of guidance from national bodies, such as the National Institute for Health and Care Excellence (NICE), and care and treatment followed best practice.
- Staff managed patients' pain effectively and the hospital had introduced an end of life care plan since the last inspection
- Staff worked in multidisciplinary teams to coordinate patient care both within the hospital and across other hospital sites and the NHS.
- Patient outcomes were good when benchmarked against national standards. The provider engaged in the Private Healthcare Information Network to support benchmarking and shared learning across the sector.
- Doctors and nurses and allied healthcare professionals had relevant competencies and skills for their roles. Consultants provided evidence of assurance of their skills to maintain their practicing privileges agreements.
- The hospital ensured new staff completed induction training and offered preceptorships to newly qualified registered nurses.
- Systems for obtaining consent were compliant with legislation and national guidance.

However,

- The provider had not implemented a neurosurgical pathway, and this had been noted in the 2014 inspection.
- There were no outcome measures for endoscopy procedures, but this omission was being addressed.

## Are services caring?

We rated caring as good because:

- Staff treated patients with dignity and respect and offered emotional support. Patients said staff respected their privacy and we observed staff in theatres being mindful of patients' dignity when they were in a vulnerable condition.
- Patients and their relatives said they were treated well and staff spoke with patients in a caring and reassuring manner.
- The hospital had employed customer service coordinators to meet and greet patients and support them with any practical issues needing addressing.
- The hospital has introduced roles such as patient pamper nurses and customer services liaison to ensure patients receive quality time with staff to relax and talk to them about fears or concerns. The patients spoke highly of the care and relaxation treatments attention the 'pamper nurses' gave them.

**Good**



# Summary of this inspection

- Results of patient surveys were better when compared with other hospitals, for example for patient satisfaction and the NHS Friends and Family test.

However,

- Results of the patient led assessment of the care environment (PLACE) were lower compared with other hospitals in privacy, dignity and wellbeing.

## Are services responsive?

We rated responsive as good because:

- Services were planned to support self funded, insured and NHS patients, through liaison with commissioners and NHS providers.
- Some clinics were planned to offer patients appointments outside normal working hours.
- The environment met patients' specific needs. For example, the oncology unit had been awarded the MacMillan Quality Environment Mark in 2014 and the hospital had improved the capacity of the day surgery service. The car parking for outpatients had improved since the last inspection.
- Staff pre-assessed patients to determine their specific needs, and supported patients living with dementia. Services for children were planned to accommodate practical considerations such as school holidays and the school day.
- Information for patients was provided in different formats, and staff could call upon interpreters when necessary.
- The hospital actively encouraged patient feedback on a daily basis with the patient liaison service to listen to patients and to respond to any concerns.
- The complaints process was available to patients and their carers. Staff reviewed complaints and implemented learning.
- The hospital held planning meetings to schedule care appropriately. Although the hospital had not met the target referral to treatment times for NHS patients in the year to June 2016, it was working with commissioners to improve the pathways.

However,

- Staff in critical care said their service was under increased pressure following the increased surgical capacity

Good



## Are services well-led?

We rated well-led as good because:

Good



# Summary of this inspection

- Staff were aware of the vision, values of the hospital and wider organisation, and demonstrated commitment to them in their care practices and personal development plans.
- There was an effective governance system and managers shared learning from incidents, complaints and patient feedback.
- The medical advisory committee was effective in advising the senior management team. It monitored the quality and safety of services and the consultant group and granted and reviewed practicing privileges.
- There were strong links with the local NHS to develop innovative practices and services.

However,

- The hospital risk register did not capture all the key service level risks, such as those relating to the environment, equipment or management arrangements.
- Critical Care staffing did not fully meet the Guidelines for the Provision of Intensive Care Services 2015, as there was no dedicated supernumerary nurse on duty each shift.






# Detailed findings from this inspection

## Overview of ratings

Our ratings for this location are:

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

# Medical care

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

## Are medical care services safe?

Requires improvement 

We rated safe as requires improvement.

### Incidents

- The hospital had reported 1237 clinical incidents, and 138 non-clinical incidents, from July 2015 to June 2016. The overall rate of incidents reported during that period was higher than the rate reported by other independent hospitals that CQC holds data for. This may indicate a positive culture of reporting incidents so learning can occur.
- Staff in endoscopy, oncology and catheter laboratory services were aware of their responsibility to report incidents. Between July 2015 and June 2016, staff in endoscopy had reported five incidents. Those in oncology 13 and staff in the cardiac catheter laboratory had reported one incident. Staff we spoke with were confident to report incidents and challenged poor behaviour by staff at any level, medical or nursing, if they were concerned about poor practice.
- Within the endoscopy service, oncology units and cardiac catheter laboratory, there were no serious incidents from July 2015 to June 2016.
- The hospital reported four expected deaths in oncology from July 2015 to June 2016. The hospital carried out mortality reviews. For example, in May 2016 they reviewed the death of a patient with advanced disease, who was on active chemotherapy treatment. The oncologist contacted the coroner who did not want a post mortem or inquest undertaken.

- The oncology team undertook a root cause analysis (RCA). The consultant, deputy matron, risk manager, oncology sister and oncology nurse specialist attended a meeting following the incident. There was no learning identified from this incident, but a recommendation that all oncology patients have telephone assessment contact at around 10 days, following their first dose of chemotherapy. This would enable oncology staff to assess a patient for any toxicity to their chemotherapy.
- Senior staff understood the importance of learning from incidents. The lead in endoscopy had reported an incident where a chemical used for disinfecting endoscopes had leaked from a machine. The endoscopy lead ensured staff education was carried out with regard to what to do in the event of a leak.
- Staff in endoscopy, oncology and the cardiac catheter laboratory services were aware of the duty of candour legislation. 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.
- If any incident occurred in oncology, endoscopy or the cardiac catheter laboratory service, nursing staff, were open and honest in talking with patients following incidents. The matron was aware of the need to write to patients providing them with an opportunity or a meeting to discuss serious incidents and any learning. There was a process in place and we saw evidence of the implementation of duty of candour.
- No never events had been reported in the endoscopy, oncology or cardiac catheter laboratory service. Never events are serious incidents that are wholly preventable

# Medical care

as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

- An oncology consultant advised us that the service was linking with the local NHS trust following a patient death in oncology. If a patient died within 30 days of oncology treatment, the case would be need to be discussed at the bimonthly mortality and morbidity meeting at a local NHS Trust.

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

- Safety information was displayed in two areas of the hospital; by the restaurant and in the outpatient department (OPD). From April 2016 to June 2016, the hospital infection rate overall was low at 0.5%.
- The Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE), or blood clots in veins. The hospital recorded and reported the results of the NHS Safety thermometer to commissioners for the NHS patients using the service and displayed results in the hospital. The hospital data showed 100% compliance with VTE screening assessment.
- The oncology service reported five incidents of deep vein thrombosis (DVT) and one pulmonary embolism (PE) from July 2016 to September 2016. The hospital investigated these incidences using root cause analysis (RCA).The hospital had two investigations that were not complete at the time of our inspection in October 2016. The learning from one incident included the need to ensure that if a patient had experienced a DVT in the past, staff should record this on their VTE risk assessment.
- The hospital reported 100% compliance with the completion of venous thromboembolism risk assessments from April 2016 to August 2016.

## Cleanliness, infection control and hygiene

- Endoscopy staff decontaminated the endoscopes on site. Due to the building layout and environment, it was not possible to have physical separation of clean and

dirty areas. The endoscopy lead nurse had risk assessed the decontamination process and clear operating instructions were in place to minimise the risk of cross contamination.

- The estates staff undertook weekly quality checks of the rinse water used to clean the endoscopes. The endoscopy lead and estates department ensured that when the results were of concern, appropriate action was taken. In October 2016, the hospital estates department had decided to arrange a deep clean of one of the automated endoscope washers.
- The hospital commissioned a review by the Authorising Engineer (Decontamination) to assess the hospital's readiness to apply for Joint Advisory Group (JAG) accreditation for gastrointestinal endoscopy. The review was undertaken on 7 April 2016. The report noted that annual test reports were not compliant with British Standard 15883. The hospital actioned this finding immediately by moving over to a corporate testing contract and subsequent testing has been compliant.
- Disposable aprons and gloves were readily available. Staff used them when delivering care and treatment to patients, to reduce the risk of cross infection. Staff also wore disposable gloves and aprons as personal protective equipment when undertaking endoscopy examinations and administering chemotherapy. Staff wore a visor to protect their eyes during the cleaning of the endoscopes.
- Staff followed a cleaning schedule and maintained a record of cleaning tasks. Cleaning checklists we reviewed in endoscopy showed full compliance on days when the endoscopy department was open. The deputy theatre manager had records of 'end of the day' cleaning audits and weekly cleaning audits carried out in endoscopy from April 2016 to June 2016. The oncology department had documented evidence of weekly cleaning. The deputy matron was planning to ensure 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. The hospital considered the national hand gel audit was limited in providing assurance of effective hand hygiene and supplemented this with feedback from patients regarding hand sanitiser staff usage, regular

# Medical care

observational audits and with the use of a glo-box for extra reassurance that hand washing techniques were effective. The provider's corporate audit was updated in July 2016 to benchmark observational audit results nationally and Spire Southampton were 100% compliant with this measure. The hospital scored 99% for cleanliness, compared to the national average of 98%, for the patient-led assessment of the care environment (PLACE) audit carried out from February 2016 to June 2016.

- The medical service had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA) or meticillin-sensitive staphylococcus aureus (MSSA) from June 2015 to July 2016.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff were able to access the relevant policies and procedures. We saw policies and processes for the management of waste and decontamination.

## Environment and equipment

- Environmental risks in the endoscopy suite were not managed appropriately to ensure patient and staff safety was maintained. For example, there were trailing wires in the endoscopy treatment room, which we raised to the endoscopy lead during our planned inspection in October 2016.
- On the unannounced inspection on 1 November 2016, we noted there was a rubber cable tidy around the trailing wires, to manage the hazard. The endoscopy lead explained there was a plan for the endoscopy department to have wireless electronic equipment stack from main theatres in December 2016.
- The 'management of endoscopes' risk assessment was not up to date. The risk assessment had not been reviewed since a change of use of the endoscope dryer. The endoscopy staff used this dryer for endoscope storage, and the disinfectors had been modified to dry the endoscopes.
- There was no suitable cupboard in which to store dried endoscopes. Staff were storing the endoscopes coiled, which is against manufacturer's instructions. We were told the team were unable to hang the endoscopes straight to prevent any water collecting in the channels and maintain them in good working condition. Another staff member told us the endoscopes were brushed and further disinfected before use to minimise the risks from

retained water. The team informed us they were working with the estates department to develop plan for decontaminating endoscopes in the sterile supplies department.

- Staff passed 'used' endoscopes through a hatch to an allocated team member who manually cleaned and disinfected the endoscopes. This hatch did not have a door, so there was a risk that splashes of cleaning solution could pass through the opening. We raised this with the endoscopy lead nurse who planned to discuss management of this risk with the estates department.
- The endoscope decontamination area had a single sink for washing and rinsing endoscopes. A double sink is recommended in department of health guidance. The endoscope lead had work instructions in place to ensure effective washing and rinsing of endoscopes, with the single sink that was in place.
- The endoscopy lead advised there was a problem with the ventilation in the theatre where procedures took place. The Institute of Healthcare Engineering and Estate Management (IHEEM) described the issue with ventilation as a medium risk in April 2016, when they undertook an annual review of the flexible endoscope decontamination facilities at the hospital. The IHEEM recommended upgrading of the ventilation system to provide satisfactory airflows; they did not specify a timescale for implementation. The hospital told us that there were no requirements to check air quality where there was no mechanical ventilation installed.
- The hospital had submitted refurbishment plans, which included addressing these ventilation concerns. The hospital management provided written information following the inspection that work was likely to be carried out in three to six months from 1 November 2016. The lead advised the hospital manager they were providing annual health checks for staff to ensure this was not affecting staff health. All staff health checks had been satisfactory in 2016.
- There were sufficient numbers of endoscopes of different sizes for scheduled endoscopy lists to proceed uninterrupted. This met the standards set by the Joint Advisory Group (JAG) on gastrointestinal endoscopy.
- There was a monitor, camera and printer linked to the endoscopy process. However, the endoscopy lead nurse explained the printer had developed a temporary fault and had been sent for repair. They said consultants



# Medical care

drew their findings in the patients' records, as a temporary measure. At our unannounced inspection on 1 November 2016, the endoscopy lead nurse advised us that the printer was expected back that week.

- Maintenance and repair contracts were in place for endoscopes, the washer disinfectant, the drying cabinet and the machine that processed the water for rinsing. We saw maintenance records were up to date during our inspection. The endoscopy lead nurse explained the service had set up 'annual health checks' for the endoscopes for routine, planned maintenance.
- Staff told us that if the endoscope washer broke down, the suppliers were responsive. The suppliers gave advice over the telephone or repaired the equipment that day or the next. The endoscopy lead explained if both disinfectors broke down, the service would be suspended.
- In the cardiac catheter laboratory there were 24 risk assessments in place. These included ensuring the floor did not become a slip hazard in the scrub area.
- Patients in the oncology unit had access to scalp coolers, and staff were trained to use this equipment. The oncology lead commented the department had some new scalp coolers that were better tolerated by patients, as they started cooling more gently. Scalp cooling can reduce hair loss caused by chemotherapy.
- There were resuscitation trolleys outside endoscopy, in the cardiac catheter laboratory, and in the day admission ward. Records showed 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 sufficient equipment in the cardiac catheter suite, and items had labels on saying when they were last safety tested. The theatre manager explained that larger specialist equipment in the cardiac catheter laboratory was serviced under contract..
- The sister in the day care ward told us there were two hoists available at the hospital if needed, and a range of different size slings. There were also disposable slings available if needed. The hospital had a 'hover jack', to assist people from the floor if they should fall.

## Medicines

- Patients attending the oncology day unit received intravenous chemotherapy, for which safe systems were

in place. There were always two registered nurses on duty when chemotherapy was administered. Staff used a specific chemotherapy medications chart for the prescribing and recording administration of medication.

- We reviewed the storage of controlled drugs (prescription medicines that are controlled under Misuse of Drugs legislation). Controlled drugs were transported and stored securely, and were administered with records kept according to legislative requirements.
- There was a patient group direction (PGD) for endoscopy staff to administer lignocaine throat spray to numb the back of the throat prior to gastroscopy. The PGD used in endoscopy had been approved and signed off by senior staff. The endoscopy lead explained a consultant had trained one of the endoscopy staff who was now training and assessing the other three staff to ensure competence.
- 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 to medicines or treatment, were available on the day care unit and were accessible to both endoscopy and oncology staff. 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

# Medical care

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.

## Records

- We reviewed 15 patient records; five in endoscopy, five for patients who had had a procedure in the cardiac catheter 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 90% to 100% from April 2016 to June 2016. There were three sets of records out of 20 where staff had not documented patient's observations on admission.
- On our unannounced inspection on 1 November 2016, we reviewed three sets of records and found that patients' admission observations were documented.
- Endoscopy staff kept manual tracking and traceability records of the endoscopes. We checked these records and found there were three patient identification numbers omitted on three records checked. The endoscopy lead explained that these scopes had been stored and were out of use.
- On our unannounced inspection on 1 November 2016, we checked five entries, and the endoscopy staff had started recording when endoscopes were out of use. The endoscopy lead commented there was an issue with the endoscopy department not always having the patient identification number when an endoscopy was carried out in the operating theatre. The endoscopy lead had followed up this issue with the theatre manager, to ensure endoscopy staff were given these patients identification numbers.

## Safeguarding

- Staff working in the medical service confirmed there had been no safeguarding incidents from July 2015 to June 2016.
- Staff could explain how they would respond if they witnessed or suspected any abuse of a vulnerable person, and would report it to the matron who was the lead for safeguarding of children and adults.

- Policies and procedures for safeguarding were available to staff to refer to and inform their practice. Staff could access the hospital's safeguarding policies and procedures via the intranet. The safeguarding policy was last reviewed in July 2015.
- Compliance with level 2 safeguarding training for the hospital was 79.1% for adults, and 77.9% for children at October 2016. This was on track for the hospital's target for all staff to have completed the training by 31 December 2016.
- Staff directly employed or working under practising privileges had DBS checks

## Mandatory training

- Staff were required to complete mandatory training, that included resuscitation, health and safety, equality and diversity, moving and handling, and compassion in practice.
- The overall compliance with mandatory training was 81% at October 2016 against a year end hospital target of 100% at 31 December 2016. Mandatory training compliance for the hospital was on track to meet this target.
- Medical consultants were 100% compliant with mandatory training

## Assessing and responding to patient risk

- Patients attending for an endoscopy or a procedure in the cardiac catheter laboratory were asked to complete pre-assessment health check questionnaires. A registered nurse checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for the planned procedure. The pre-operative 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 day care sister told us if a patient had diabetes, this was highlighted for nurses to manage the risk of low blood sugar in the pre-operative fasting period. The sister advised that diabetic patients would be first on the list to reduce this risk. Staff assessed and managed a patient's individual needs, if there was more than one patient on the list with diabetes.
- 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,

# Medical care

designed to prevent avoidable harm and mistakes during surgical procedures. We observed staff performing the checklist correctly during our visit. Hospital observational audits undertaken in endoscopy showed 100% compliance with safer surgery checklist from January 2016 to June 2016.

- The national early warning system (NEWS) is a scoring system that identifies patients at risk of deterioration, or needing urgent review. This includes observations of vital signs and the patient's wellbeing to identify whether they were at risk of deteriorating. This system was used correctly by hospital staff. Medical and nursing staff were aware of the appropriate escalation action to take if a score indicated a patient's deterioration.
- Emergency call systems were in place to summon assistance if staff in the endoscopy operating theatre, the cardiac catheter laboratory, or oncology department required extra assistance urgently.
- 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 nursing staff used a tool called the United Kingdom Oncology Nursing Society (UKONS) triage tool to help identify the urgency of a particular problem. A senior nurse in oncology carried out monthly audits of the use of the UKONS tool by ward staff. The audit showed calls from oncology patients had ranged from two to 10 a month between April 2016 and September 2016. The ward staff had responded appropriately to concerns, which included contacting the oncology consultant when needed.
- Oncology nurses provided patients with information on discharge, should they have any concerns. The oncology lead had recently designed a wallet sized card with contact telephone numbers. The card also gave clear advice for patients about information helpful to have ready when making a telephone call to the hospital, and about symptoms of concern in relation to their treatment.
- The hospital had a transfer agreement with a nearby trust and a policy in place for a patient that became unwell. One patient had been transferred to the local NHS trust in the period July 2015 to June 2016, where the procedure had not gone to plan. The hospital reported there had only been one other transfer for this speciality in the last four years.

- The resident medical officers (RMO) working at the hospital had advanced life support training. The hospital had a resuscitation team in place that could respond if there was a clinical emergency.
- The hospital undertook four adult and three paediatric emergency scenarios annually, where different mock situations were managed. Scenarios had included cardiac arrest and bleeding. Learning points from the scenarios were identified, and recommendations taken forward. These had included ensuring staff aware of where emergency call bells were in refurbished rooms. The lead had ensured this information was cascaded via meetings and in the department 'first sight' folders.

## Nursing staffing

- The endoscopy lead confirmed there were no vacancies, and scheduled endoscopy lists went ahead as planned. There had been no gastrointestinal endoscopy lists cancelled due to not having sufficient appropriately skilled staff. There were four registered nursing staff, which included the endoscopy senior nurse, and one healthcare assistant specifically allocated to supporting gastrointestinal endoscopy procedures.
- Three registered nurses formed the oncology team. Two chemotherapy-trained nurses were always on a duty when a patient was booked for a chemotherapy treatment. A senior nurse in oncology confirmed the skill mix and competencies of staff enabled the needs of patients attending the unit to be effectively met. A bank nurse was used when required. At our unannounced inspection 1 November 2016, we spoke with a bank nurse who demonstrated they had the competence and skills to support oncology patients.
- Two cardiac nurses and a cardiac radiographer formed the permanent team in the cardiac catheter laboratory. The cardiac nurses said if additional staff were needed for a cardiac catheter laboratory procedure, staffing would be planned according to the procedure.
- We observed a hand over between the nurses on ward three, on a day when there were two medical patients. The handover was centred on the patient, and included the patients' specific needs and discharge plans.
- For detailed findings on nurse staffing on the wards, please see the surgical report.

## Medical staffing

# Medical care

- Senior staff in endoscopy, the cardiac catheter laboratory, and oncology advised us that all the consultants also carried out work in the NHS. The hospital had 10 consultants specialising in gastroenterology, 24 in cardiology and 18 in oncology. Clinical care was booked according to consultant availability, which ensured there was always adequate medical cover.
- At the radiological procedure we observed a consultant interventional radiologist, anaesthetist and a cardiovascular perfusionist (a specialised healthcare professional who uses the heart lung machine) were part of the team.
- Resident medical officers (RMO) provided 24 hour, seven day a week medical cover at the hospital. There were seven RMOs that worked on a rota to ensure that medical advice and emergency support was always available. The RMOs were provided through an external agency that could provide additional cover for sickness or other unscheduled leave as required.
- The consultants maintained overall responsibility for the patients' care throughout their admission to the hospital. The RMO had immediate access to the responsible consultant if needed. Consultants also attended at short notice in case of an emergency, as the hospital required they were within 45 minutes' drive from the hospital. Two consultants explained the medical on call rota and holiday cover. Staff told us that they had always been able to contact a consultant if needed.

## Are medical care services effective?

Good 

We rated effective as good.

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

- 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 (NEWS) to assess and respond to any changes in a patient's

condition, in line with NICE guidance CG50. The RCA's completed by the hospital, showed that VTE risk assessments were completed and NICE guidelines for preventative measures were followed.

- The endoscopy service were actively working towards Joint Advisory Group (JAG) accreditation. The endoscopy senior nurse had undertaken an initial scoping exercise, and completed an action plan in October 2016. This assessed where the department needed to take action, and 32 of 56 actions had been completed at the time of inspection. The endoscopy senior nurse planned to assess the service against the JAG global rating scale (GRS) following our inspection. The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation.
- Staff booked procedures in line with British Society of Gastroenterology (BSG) guidance. This meant that sufficient 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 and used NICE guidance in the care of their patients. A clinical review undertaken by the Spire group in May 2016 had identified the need to update the local neutropenic sepsis policy. The hospital needed to update their local policy to incorporate the national protocol for admission and care within the first three hours. The oncology team introduced the updated neutropenic sepsis policy in August 2016, which is part of the corporate pathway for immediate assessment of suspected neutropenic sepsis.
- When we inspected in 2014 the hospital did not have an end of life care plan. We found their new end of life care plan had been introduced in 2015.
- The hospital used evidence based care pathways for patients. For example, we saw care pathways for upper a patient undergoing a gastrointestinal endoscopy, and for oncology patients having anti-cancer therapy medication.

### Pain relief (medical care specific only)

- Patients undergoing a gastrointestinal endoscopy were offered a throat spray to reduce discomfort and/or

# Medical care

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.
- Nurses monitored patient pain using a numerical pain scale. A patient told us that staff closely monitored their pain level during a procedure. Another patient told us that at one point they were uncomfortable, they alerted staff to help change their position, and the pain was reduced.
- We spoke with a patient who was receiving palliative care (care that focuses on providing relief from symptoms such as pain) on our unannounced inspection on 1 November 2016. The patient told us how staff had effectively managed their pain with painkilling patches, and additional medicines by mouth if required.
- Ward staff told us palliative and end of life care patients had appropriate medication for pain relief. Staff told us anticipatory prescribing was proactively managed. We could see evidence of this in the patient records we reviewed.

## Nutrition and hydration

- Patients due to attend for gastrointestinal endoscopy were given detailed advice on how to prepare for the procedure, including 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 the day care ward explained staff liaised with the anaesthetist for a list if there were delays in the procedure list, to ensure a 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.
- The chef visited a patient in oncology to discuss their dietary needs if required.

## Patient outcomes (medical care specific only)

- The endoscopy senior nurse advised us there was no system for the monitoring and review of the clinical performance data for endoscopy procedures performed at the hospital. The endoscopy senior nurse lead advised they planned to introduce an electronic system to record the outcome of gastrointestinal procedures, for JAG accreditation.
- The lack of data collection meant the hospital was unable to measure the outcomes of gastrointestinal endoscopy procedures, such as the average amount of sedation and analgesia used.
- 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. This was recorded in patient medical notes.
- The hospital audited their compliance with all patients being discussed at a cancer MDT, and from January to June 2016 this achieved 100%. The hospital also included audit of compliance with evidence of MDT in their patient records. The hospital results were 100% compliance from January 2016 to March 2016, and 87.5% compliance from April 2016 to June 2016.
- Cardiology procedures included coronary angiography, cardiac electrophysiology and cardiac device implantation (including pacemakers and defibrillators). There were no percutaneous coronary interventions (PCI) performed at the hospital. The theatre 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). The cardiac catheter laboratory did not undertake a sufficient number of cardiac procedures to be able to measure outcomes on the British Cardiovascular Intervention Society (BCIS) national site.
- The hospital was in phase three of a four phase clinical trial of a radiological procedure called chemo-saturation therapy for treating liver cancer secondary to an eye cancer. Approximately one of these procedures was performed each week, with patients



# Medical care

coming from as far as Ireland and Scotland. The theatre manager registered all these procedures with a speciality pharmaceutical and medical device company, as part of the clinical trial.

- The hospital reported ten oncology readmissions, due to side effects of chemotherapy or complications from patients' disease progression, between January 2015 and December 2015. This represented 1% of patients receiving chemotherapy. The hospital had seen readmissions increasing due to the complexity of treatment the hospital offered. On review, the hospital found all readmissions were appropriate and unavoidable.
- An audit schedule was in place for 2016, supported by an audit calendar. These audits in the medical service monitored compliance with hospital procedures, for example compliance with the controlled drug and record keeping, rather than clinical outcomes. The head of clinical services informed us that the hospital group was working with the private healthcare information network (PHIN), in relation to the collection and publication of clinical outcomes.

## Competent staff

- Consultants worked at the hospital under practising privileges. Practising privileges give medical staff the right to work in an independent hospital following approval from the medical advisory committee (MAC). The hospital checked consultant qualification, experience and carried out disclosure and barring service (DBS) checks. The hospital had effective processes for ensuring updated evidence of GMC registration, insurance, competence and revalidation was in place.
- 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. A senior nurse in oncology told us that two nursing staff had attended an update course in 2016 on the administration of chemotherapy medications, which had been valuable for their practice.
- We reviewed a new member of staff's personnel record in the cardiac catheter laboratory, which showed they had completed a thorough induction programme. The programme included familiarisation with the health and safety policy, the moving and handling policy and hand washing.
- Staff told us there was no specific training for the delivery of end of life care. They said end of life care was delivered effectively through their experience and support of the oncology consultants. The hospital had an end of life care plan, based on relevant evidence in place. A palliative care consultant from a local NHS trust also supported staff when a patient was at the end of their life.
- We reviewed two oncology staff appraisals and found these were fully completed. However, when we reviewed the appraisal records in endoscopy and the cardiac catheter laboratory, we found staff had omitted the behaviours section. This section was for staff to document the behaviours required to achieve their performance objectives. The senior nurse for these services, planned to ensure these appraisals were fully completed over the next few months.
- Staff had not had specific training to care for medical patients, but there was a medical admission care pathway in place. The hospital also had variance sheets in place to support patients care, for example, a variance sheet for patients with a temperature of unknown origin.
- Most staff had completed dementia awareness training and staff we spoke with could describe adjustments they would make to support people living with dementia. The hospital also had nominated dementia champions.

## Multidisciplinary working

# Medical 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 medical staff liaised with colleagues in the NHS, if the findings following endoscopy procedures indicated that further medical treatment would be required.
- The breast care nurse specialist worked closely with the oncology nurses and doctors to ensure effective support for patients.
- Staff offered breast cancer patients a 'breastacise' classes with one of the specialist physiotherapist, and also classes for those patients finishing chemotherapy to promote fitness.
- The oncology lead consultant explained they had links with the local hospice if patients required community palliative care. If patients deteriorated rapidly, end of life care could be provided at the hospital.
- Staff in the medical service were positive about working with other departments. For example, the endoscopy lead said they had good support from the estates department.

## Seven-day services

- 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. This was for patients to discuss or report any adverse side effects.
- Please see the surgery report for further information about seven day services.

## Access to information (medical care only)

- Clinical staff were able to access information about patients, for example, referral letters, blood test results, x rays and other investigation results.
- Staff sent discharge letter to GPs, that included the reason for the endoscopy or cardiac intervention procedures, findings, prescribed medication, any medication changes and details of follow up. They also and placed a copy of the letter in the patient's medical records at the hospital.
- Staff in oncology sent a letter to the patient's GP detailing chemotherapy treatment.

- The consultant contacted a patient's GP directly to convey urgent patient information
- Staff were able to access information on the hospital intranet, which included clinical policies and standard operating procedures.
- The hospital stored patient records off site following discharge. Administration staff could request patient records if needed urgently to arrive on the day of the request.

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

- Consent forms were appropriately completed and signed and detailed the risks and benefits to the procedures.
- Oncology consultants assessed a patient's understanding prior to obtaining consent with specifically designed consent forms for systemic anti-cancer therapy. This included a documented discussion of the benefits and risks. Three staff talked though their understanding of the 2005 Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The sister on ward three told us she had undertaken training about the MCA. Staff we spoke with would seek the support of the matron, if they were concerned that a patient lacked capacity, or if they believed a patient had been deprived of their liberty. The hospital told us at November 2016 they were 93% compliant hospital-wide with MCA and DoLS training.
- We reviewed two 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms, as the hospital also provided end of life care. Staff told us these patients were usually oncology patients, and well known to the oncology consultants. There were no patients at end of life at our planned inspection in October 2016. We reviewed two set of notes and found the DNACPR forms correctly completed. The discussion with the patient and family was documented, and the reason for DNACPR clearly noted. The forms were signed by a consultant.

## Are medical care services caring?

Good 

We rated caring as good

# Medical care

## Compassionate care

- Staff treated patients with dignity and respect, and maintained their privacy.
- Patients found staff to be compassionate, caring and listening. A patient in oncology said 'lovely level of service, incredibly caring'. A patient who had an endoscopy procedure described the experience as 'very matter of fact', 'just got on with the job', which is what they wanted.
- The hospital displayed clinical performance data they had gathered for patients and visitors to read. This was not specific to the medical service, but the whole hospital. From April 2016 to June 2016, 97% of patients rated care as excellent.
- The hospital Patient Led Assessments of the Care Environment (PLACE) from February 2016 to June 2016 scored privacy, dignity, and wellbeing as 64% compared to an England average of 83%. This was not our experience. We spoke with seven patients, two relatives and received three comments cards back from patients who had been cared for and treated within the medical service. These were all positive. The matron told us they believed the hospital had made errors in the data entry for the PLACE audit. The PLACE audit from February to June 2015 scored privacy, dignity and wellbeing at 81%.
- The hospital took part in the Friends and Family Test (FFT for inpatient services. For the reporting period January 2016 to June 2016 the hospitals FFT scores were consistently better than the England average for NHS patients. The average recommend rate was 98% for the hospital against an England NHS average recommend rate of 95%. The FFT survey response rates were also better than the England average in the same period, with an average response rate of 65% compared with NHS England average response rate of 24%.
- 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 that a request for a chaperone had been met.

## Understanding and involvement of patients and those close to them

- Patients undergoing an endoscopy or a cardiac catheter procedure were provided with relevant information by

staff, both verbal and written, to make an informed decision about their care and treatment. Patients said there had been sufficient time at their appointment for them to discuss any concerns they had.

- Patients in the oncology unit stated staff kept them informed about their care, involved them in any decision-making, and listened to them. An oncology patient before treatment commented, '[They] met the oncology nurse who sat for a long time and went through treatment and what to expect. The meeting was well paced and supported with written material'.
- Patients were encouraged to involve their close relatives, if they wanted to. The relatives we spoke with also felt well informed and cared for by staff, and able to support their loved ones.

## Emotional support

- If a consultant found a cancer following an endoscopy, the consultant would discuss their findings with patients and refer them to the NHS. NHS clinical nurse specialists supported patients with their future care and treatment.
- Patients, particularly in oncology, described how they felt emotionally supported. A breast care specialist nurse was available if needed. One patient said, 'nurses gave me a big hug after first chemotherapy finished; the nurses took my cues that I needed a hug'.
- Patients were able to have emotional support from family and friends, with visiting times from 8am to 8pm. Staff asked patients on admission about their beliefs/spirituality. The hospital had access to chaplaincy, if requested by a patient.
- The oncology lead told us there was a charitable organisation that visited each Monday, that provided support for people living with cancer. The support included counselling, reflexology, acupuncture and advice about diet. When we inspected there was not a patient having chemotherapy who had used this support.

## Are medical care services responsive?

Good 

We rated responsive as good

## Service planning and delivery to meet the needs of local people



# Medical care

- The oncologists treated insured and self-pay patients at the hospital on a planned day case based service. The hospital had a chemotherapy suite with eight rooms for private patients for outpatient chemotherapy treatment. This was supported by inpatient services for those that required symptom management and end of life care.
- The oncology unit had been awarded the Macmillan Quality Environment Mark (MQEM) in 2014, 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 provides 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. The oncology unit was due for review and reaccreditation in 2017.
- A patient admitted for cardiac catheter laboratory or an endoscopy procedure went to the day care ward, unless they needed some treatment prior to their procedure. If a patient needed an enema, they were admitted to ward three. The day care sister explained this was because there were no ensuite toilets on the day ward.
- The hospital admitted medical patients to the surgical wards in single rooms. A sister explained oncology patients went to ward three, and other medical patients to ward one.
- The endoscopy suite had limitations due to the physical environment. The endoscopy lead had carried out a risk assessment and implemented a decontamination workflow to minimise any adverse impact to patients. In addition, if a patient needed to go to recovery following a procedure, the patient had to be wheeled a short distance along a corridor. The lead showed us an action plan to add a doorway into recovery to avoid having to use the corridor.
- Consultants undertook gastrointestinal endoscopy procedures on an insured and self-pay basis. The hospital had action plan in place to work towards achieving joint advisory accreditation in gastrointestinal endoscopy.

- Cardiac catheter laboratory interventions were undertaken for insured, self-pay and NHS patients. The hospital had contracts with NHS trusts to undertake cardiac catheter laboratory work.

## Access and flow

- 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,
- 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.
- Consultants usually discharged patients admitted for a day case procedure on the same day. There were five gastrointestinal endoscopy and three oncology patients who stayed overnight between July 2015 and June 2016. The hospital said that two of these endoscopy patients stayed overnight due to the distance from home, and one of the oncology patients needed treatment following blood test results. The hospital did not give reasons for the five other patients in the medical service who stayed for a longer period than planned.
- NHS consultants referred oncology patients to the hospital following diagnosis at an NHS hospital. A patient could have a chemotherapy treatment from Tuesday to Thursday. There was no waiting list for this treatment. The oncology lead advised they saw four to seven patients a day. The lead said that depending on the complexity of patients' treatment regimes, time in the oncology department ranged from two to eight hours. If oncology patients became unwell they could telephone the hospital out of hours for advice. The hospital could directly admit these patients to ward three, depending on their needs. An acutely unwell patient would be advised to go to the local NHS trust.
- If a patient with medical needs was referred to the hospital, the deputy matron was informed. The deputy matron would then ensure a medical consultant was happy to accept responsibility for the care and treatment of any medical patients.

# Medical care

- The sister for day admissions ward explained there was a plan to expand to admit and undertake admission assessments for all patients in the future, to enable inpatient ward staff to focus on patients for discharge in the morning.

## Meeting people's individual needs

- 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 might 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. This included a check for any additional support needs. Staff told us they would discuss patients' individual needs to promote their comfort and care.
- 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 in the medical service had an understanding of 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 an interpreting service was available at the hospital if required. They could also request reading material in braille and request sign language interpreters and pictorial information.
- The hospital provided patient information. These covered specific treatments, as well as information on how the hospital supported people's individual needs. Staff could also print guidance leaflets from the intranet. For example, there was information about flexible sigmoidoscopy (procedure to look at the left lower part of the colon). The information leaflets were written in appropriate language and included information about preparation, consent, what to expect, results, going home and risks associated with particular procedures.
- The oncology unit had a well-stocked supply of leaflets and patients could access those that suited their individual needs.
- Staff provided oncology patients with details about their chemotherapy. For example, a leaflet given by staff

which detailed what to do if they developed a raised temperature. A patient showed us a record of the information a staff member had provided them with, which they had found helpful.

- Patients were given advice leaflets about specific after care when they were discharged.
- The Patient Led Assessment of the Care Environment (PLACE) in 2016 rated the quality of ward food as 82%, this was below the England average of 92%. The patients we spoke with had been happy with ward food.
- Dignity shorts were available for patients having an endoscopy procedure. They were only available in one size, and staff told us they fitted most people but not all.

## Learning from complaints and concerns

- There were patient information folders in the patient bedrooms, which included guidance on how to raise a concern. This information was also available in the oncology department and the day care ward.
- The hospital had received 78 complaints during the period July 2015 to June 2016. CQC assessed this rate of complaints as similar to other acute independent hospitals. There were no complaints relating specifically to medical services between July 2015 and June 2016.
- The senior nurse on the day ward explained there had been concerns about privacy and dignity in the day ward, and this had been confirmed by patients returning the CQC comments cards. We spoke with the senior nurse on the day ward about this, and the hospital were discussing the possibility of installing sliding doors on one side of the day unit and concertina doors on the other.
- The sister on the day unit said they provided headphones for patients to listen to an audio presentation about their procedure.
- Complaints were discussed at the monthly hospital management team meeting, and staff were aware of the complaint themes.

## Are medical care services well-led?

Good 

We rated well-led as good

## Leadership and culture of service

# Medical care

- Staff in the medical service said they were well supported by the hospital senior management team, and felt they were visible.
- The senior team recognised good practice. The senior team at the hospital nominated the oncology nursing team for the Clinical Services award for Nursing Practice at the Lang and Buisson Independent Healthcare Awards and Independent Specialist Care Awards in 2015. The team were among the six finalists who attended the award ceremony in November. The hospital also had a scheme call 'Inspiring People Awards'.
- The senior team were aware of when leaders needed more support. The hospital had recognised the theatre manager needed more support, as they did not have the capacity to support endoscopy and the cardiac catheter laboratory following the expansion of theatres. The endoscopy senior nurse was a new position from June 2016. The senior team had also recognised the need to put a team leader in the cardiac catheter laboratory. This post was planned to commence during December 2016.
- The deputy matron described how staff were given opportunities to develop their leadership skills, with a course called 'stepping stones'. There were two staff being considered for a leadership course in the medical service. The aim of the course was to help them promote and embed the new developments.
- The service leads were supported to improve services by working with peers outside the hospital. The endoscopy lead and staff from the engineering department were due to visit another Spire hospital that had achieved JAG accreditation, to help them develop the service locally

## Vision and strategy for this this core service (for this core service)

- Staff spoke passionately about the service they provided and the care they offered to patients.
- The hospital displayed its vision, values and mission statement for staff and public to see. The mission statement was "to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care." The vision was "to be recognised as a world class

health care business". Their values were as follows: "Caring is our passion. Succeeding together, driving excellence, doing the right thing, delivering our promises and keeping it simple."

- All staff we spoke with were aware of the mission, vision, values of the hospital and wider organisation, and demonstrated commitment to them in their care practices and personal development plans.
- The endoscopy lead said the goal for endoscopy was to achieve Joint Advisory Group (JAG) accreditation in gastrointestinal endoscopy, supported by plans to move endoscope decontamination to the sterile supplies department.
- The vision for oncology was to expand the peripherally inserted central catheter (PICC) service. The PICC lines were used to administer medicines to chemotherapy patients. A senior nurse in oncology planned to extend this for other patients in the hospital, by planning a PICC line clinic.
- A senior nurse in oncology also told us the service planned to develop a link nurse role. These are nurses with additional training. The aim was to train nurses to meet and support patients immediately after diagnosis. The theatre manager told us the vision for the cardiac catheter laboratory was to provide complex procedures, as the hospital had surgical and critical care facilities.

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

- The service governance processes are the same throughout the hospital. We have reported the governance processes under the surgery service section within this report.
- There was a hospital wide risk register. The endoscopy lead advised there were two risks regarding endoscopy on the risk register. These related to the possibility of equipment failure with regard to disinfecting of endoscopes, and the risk to the service if JAG was not achieved. The oncology lead advised there were 10 oncology risks on the risks register. Actions to manage the risks were in place.
- Consultants represented areas within the medical service at the medical advisory committee (MAC), which was held quarterly. The lead consultant for oncology was on the MAC committee, and other named consultants represented endoscopy and the cardiac catheter laboratory. The medical consultant we met was

# Medical care

not on the MAC, but was aware of issues and discussion points as the minutes of each MAC were circulated to all the consultants. The MAC met quarterly and minutes showed these included key governance issues such as incidents, complaints and practising privileges.

- Senior staff from the medical service attended the weekly clinical effectiveness meeting. Items discussed at this meeting included incidents, the risk register and policy changes/ updates. The senior staff also attended the quarterly governance meeting. Items discussed here included the hospital wide action plan, readmissions, incidents and day case conversions to overnight stays.
- The endoscopy and oncology department senior staff held team meetings, although these meetings were not held at regular intervals. The meetings were used to discuss departmental best practice. For example, minutes of the endoscopy meeting showed the improvements in completing tracking and traceability records were discussed.
- The medical service areas also held 'first sight' folders. These included information about risks, meeting minutes and clinical scorecard. The hospital used the clinical scorecard to monitor performance on a range of quality and safety measures. This was monitored locally and nationally for benchmarking against other hospitals in the group.
- The deputy matron held monthly half day meetings for all departmental sisters. This ensured any learning from incidents and complaints was shared across the hospital. Staff were also updated on human resource issues such as recruitment and performance management of staff.
- The deputy hospital matron led a daily multidisciplinary team huddle, which included heads of departments. The senior nurses from the medical service attended if they needed to report an issue. The endoscopy lead advised she had attended during the week commencing 10 October 2016, as there had been a problem with one of the disinfectors in endoscopy.

## Public and staff engagement

- The oncology unit staff gave patients a questionnaire to complete about their experience. At the time of our inspection, there were several recently submitted questionnaires awaiting analysis.

- The endoscopy lead was planning to design a service specific patient satisfaction questionnaire. At our inspection, patients undergoing medical procedures were encouraged to complete a patient satisfaction survey before discharge. A clinical review undertaken by the provider in May 2016, reported that 97% of patients responding to the survey in 2015 rated the overall quality of care from Spire Southampton Hospital as 'excellent' or 'very good'.
- There had been a low attendance at the patient forum in June 2016, with only patients providing feedback. Subsequently in October 2016, staff telephoned 20 patients for feedback to improve engagement. The hospital identified some actions, including changes to the admission process and a review of information sent prior to admission. The next telephone survey was planned for December 2016.
- Staff meetings and handover periods provided opportunities for senior nurses to engage with staff and share information. All staff at the hospital were invited to complete an annual engagement survey by an independent third party.
- The clinical review undertaken by the provider in May 2016, commented that in 2015, 77% of staff at Spire Southampton Hospital completed the survey and the overall score was 70%. That was a 3% decline on the 2014 results and below the Spire Group average. The questions relating to 'my manager' (78%) and 'my work' (78%) scored highest with 'working together' (50% positive) scoring the lowest overall results.
- Subsequently, the hospital director set up staff forums. This enabled staff to hear the latest news and business developments, and ask questions. The hospital published a monthly newsletter with information about, for example, changes in staffing and staff participation in charity and social events.






## Innovation, improvement and sustainability

- Electronic prescribing of chemotherapy was due to be introduced by the hospital group in 2017. The hospital group was testing the system to be used.
- The service leads were supported to improve services by working with others outside of the hospital. Staff in endoscopy liaised with teams in other Spire hospitals to improve their processes, with the aim of achieving JAG accreditation.

## Medical care

- The service was aware of the publication of the National Safety Standards for Invasive Procedures (NatSSIPs) in September 2015 by NHS England. The endoscopy lead was waiting to see how these standards could be embedded into the hospital group safety standards and produce local safety standards for invasive procedures to support staff.

# Surgery

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

## Are surgery services safe?

Requires improvement 

We rated safe as requires improvement

### Incidents

- There was an effective process for managing and learning from incidents, including an immediate scoping meeting, to assign actions and investigation as required. We saw examples of root cause analysis undertaken appropriately and staff attended corporate and local NHS root cause analysis training. The hospital produced and disseminated learning summaries appropriately both within the hospital and externally when completed.
- The hospital held a weekly clinical effectiveness and audit group, which involved the clinical leads, to review serious adverse incidents, trends and learning from root cause analysis.
- The hospital had reported one 'never event' between June 2015 and July 2016. Never events are serious incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. The event related to a retained throat swab in a surgical patient, which staff discovered in recovery. The hospital had completed a full investigation, identified and shared learning with staff, and practice had changed as a result. The patient came to no harm.
- The hospital had reported 1237 incidents to the National Reporting and Learning System (NRLS) between July 2015 and June 2016. Of these, 752 or 61% related to the surgical core service; 169 incidents were low harm, 83 moderate harm, one severe harm. CQC assessed this rate as higher per 100 bed days than other similar independent hospitals. Higher than normal reporting numbers, but with similar levels of harm, may indicate a positive reporting culture.
- There were 15 deaths including six expected deaths due to patients with multiple pathology or risk factors. Nine deaths were unexpected, reported appropriately to the coroner and the CQC and appropriately investigated by the hospital.
- Staff held local specialty-specific mortality and morbidity meetings to discuss clinical incidents, patient outcomes and their findings of any investigations. The minutes of these meetings were discussed at the Medical Advisory Committee (MAC).
- The hospital staff we spoke with were aware of, and could access, the electronic reporting system to report any untoward incidents. Theatre staff completed paper reports, due to time and IT access constraints, which the theatre reception staff entered into the system on their behalf. Staff had an automated email to confirm acknowledgement of the incident report and received feedback if there was an investigation.
- Staff told us how learning from incidents was shared amongst the hospital teams; this was for example via various staff handovers, newsletters, 'First Sight' folders and monthly team meetings. We found staff had a good



# Surgery

awareness of past incidents and investigation outcomes and could describe practice changes as a result. Staff described how they also received important information attached to their payslip.

- The hospital lead for venous thromboembolism (VTE or blood clots in a vein) carried out the investigations and root cause analysis for any patient incident relating to a pulmonary embolism or deep vein thrombosis (clots in the lung or leg). A process to share the investigation and report with the patient or relatives had been set up and this was recorded within the report.
- The hospital reviewed patient safety alerts for example, those issued by the Medicines and Healthcare Products Regulatory Agency centrally before taking any appropriate actions.
- Staff we spoke with were fully aware of their responsibilities under the duty of candour (DoC), they told us that they 'had been already doing this'. The DoC is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We reviewed incidents to see if DoC applied, and we saw that a designated administrator monitored the process to ensure they met the requirements of the regulation. The hospital offered to share outcomes of the learning from investigations with patients and relatives, in a key learning summary.

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

- Spire Southampton reported quarterly performance data, starting in April-June 2016. The hospital displayed their most recent clinical performance data on the wards and in hospital corridors.
- The Safety Thermometer is a national tool for measuring, monitoring and analysing common causes of actual harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE or blood clots). The hospital recorded and reported results of the NHS Safety thermometer to commissioners for the NHS patients using the service. These were displayed by the

restaurant for staff, patients and visitors. The 2015 governance report also included the Safety Thermometer data, which showed there had been one patient who had a pulmonary embolism in 2015.

- The Spire clinical scorecard displayed all hospitals' compliance against 30 key clinical targets; this was used to benchmark them against key performance targets. They included for example, surgical site infections, patient falls and the incidence of pressure ulcers.
- The benchmarked data for September 2016 highlighted individual areas where there may be cause for concern within the Spire healthcare group. There were six targets for Spire Southampton that had not been achieved and showed as 'red', the most significant from a patient safety perspective were:
  - 50% of eligible joint replacement patients received chemical VTE prophylaxis in the recommended timescales, against a target of 80%.
  - 0.93% of patients with hip or knee replacements had a VTE event, against a target of 0.5%.
  - 0.5% patient needed to return to theatre in the same admission, against a target of 0.2%.
  - 0.81% of hip replacement patients had a surgical site infection against a target of 0.6%
  - 0.59% of patients were readmitted within 31 days of discharge, against a target of 0.3%.
- The hospital had participated in the NHS 'sign up to safety' initiative, which coordinated focussed patient safety work streams. The hospital had engaged in recent work to improve patient falls, for example nominating falls champions, staff training, new equipment and changes to patient pathways.

## Cleanliness, infection control and hygiene

- The hospital director of infection prevention and control was the head of clinical services/matron for Spire Southampton. There was a lead infection, prevention and control (IPC) nurse supported by a corporate consultant microbiologist. The IPC committee met quarterly and representatives attended from departments across the hospital including theatres, pharmacy and estates. There was a programme for

# Surgery

actions to reduce healthcare acquired infections. The meetings covered issues such as intraoperative temperature monitoring, non-compliance with waste management and surgical site infections.

- Cleanliness and infection control had been a targeted area of work since the last inspection, and we saw there had been many improvements in the theatres and wards. For example, the segregation process for dirty waste and clean items in theatre had been implemented.
- Ward and department link nurses met with the lead for infection prevention at quarterly IPC meetings and they then shared information with their colleagues. Ward staff were aware of the infection control lead and link nurses. The link nurses received the minutes of infection control meetings and the minutes were available in a folder for ward staff to read.
- Methicillin Resistant Staphylococcus Aureus (MRSA) screening for all patients and additional Methicillin Sensitive Staphylococcus Aureus (MSSA) screening swabs for major surgical cases was done at the pre-operative assessment clinic. This took place preoperatively to ensure patients were not put at risk of a serious infection.
- The IPC lead organised the surgical site infection audits every week, they also visited the ward every day and liaised with staff regarding any patient concerns. However, the senior ward staff we spoke with did not know the infection rates for their area.
- The rates of surgical site infections for the hospital within primary joint replacements, breast, urological and cardiothoracic surgery were in line with CQC expectations for this type of hospital. However, there was an exception with 'other' orthopaedic or elective trauma cases, which had a slightly higher infection rate than expected. There were eight out of 1907 orthopaedic or trauma cases within the last year with a surgical site infection.
- We saw that the ward and day unit areas were visibly clean, staff wore uniforms correctly and adhered to the principles of 'bare below the elbows' to prevent cross infection. Where patients with an infection were in single rooms, adequate personal protective equipment was available outside the patient's room and used appropriately. Hand hygiene gels were available for staff, patients and visitors to use throughout the hospital and we observed ward staff using hand gel between patient contacts.
- The hospital conducted regular hand hygiene audits by assessing the usage of hand hygiene gels over a one-week period, following the normal Spire hospitals audit practice. The level of usage of hand gel per room provided assurance to the organisation that staff were cleaning their hands. The hospital considered the latest hand gel audit was adequate for the patient occupancy and classed them as green. However, there were limitations to this audit as there was no assessment of when the gel was used and by whom, and if it was done so appropriately before and after patient contact.
- The hospital had five 'laminar flow' theatres, which provided extra-clean airflow for procedures with a high risk of infection, such as orthopaedic surgery. Theatre staff maintained the sterile fields and equipment by laying up their trolleys under a laminar canopy environment. There was a newly opened theatre, primarily for the use of the robotic team, which did not require extra-clean airflow. The estates team used an external company to perform routine airflow quality sampling and monitoring. The theatre manager told us examples of how they had actioned air quality issues immediately.
- Theatre staff wore theatre scrubs, including cover-ups, hats and shoes within the theatre complex. We saw adequate supplies of theatre clothing and staff adhered to its use. We observed staff using gloves appropriately for the disposal of soiled trolleys and instruments. There was a policy for safe disposal of human tissue in theatres.
- We observed a good process for floor cleaning between cases in theatres. Theatre staff bleeped a cleaner who attended promptly and cleaned the floors effectively.
- The hospital director told us there was regular deep cleaning taking place in theatres. However, the theatre complex, although visibly clean, was not free from surface dust; we found high dust and dust on some of the equipment trolleys within the operating theatres.
- Cleaning schedules were not fully completed and there was inconsistent recording of anaesthetic machine circuit changes in two of the six theatres. We observed



# Surgery

that some theatre equipment was not able to be cleaned effectively due to the amount of surface rust present, for example, on trolley wheels, equipment clamps and a gas cylinder holder; we fed back these issues immediately to the senior team. On our follow up unannounced visit, we found actions had already taken place to rectify these issues and found the standard of cleanliness had improved.

- We observed the segregation of waste into domestic and clinical waste bags. In theatres, there had been a change in process since the last inspection; staff now left dirty used trolleys in a 'dirty corridor' at the rear of the theatres where staff responsible for cleaning and disinfecting instruments would collect the trolleys. The dirty disposable items were appropriately disposed of, but we queried the lack of covers on used and soiled trolleys to prevent cross infection at the rear of theatres. We saw a queue of a number of trolleys awaiting attention. Staff told us 'dirty' trolley covers were on order, but in the interim, following our raised concerns, theatre managers agreed that dirty items should be covered and not left open awaiting collection. We saw this new process working when we returned for the unannounced inspection.
- We saw that there were uncovered waste bins which were not emptied between cases in the anaesthetic rooms. These presented a risk of cross infection between cases. We raised this with the senior team as a concern.
- We saw that there were staff bags left on the floor in some of the theatre preparation rooms and anaesthetic rooms, which could be potentially an infection risk. There were lockers available outside of the theatre complex for their storage.
- The wards were visibly clean and well maintained, although some ward's weekly cleaning checklists were incomplete. This meant that the hospital had no documentary evidence that some ward staff had completed all ward cleaning tasks. Some ward areas, according to the checklists, may not have been cleaned in two or three weeks.
- There were separate locked storage cupboards for clean linen, dirty linen, clinical and non-clinical waste on the ward. All boxes were stored off the floor to allow for effective cleaning to take place.

- We observed that ward staff cleaned equipment between patients and applied green 'I am clean' stickers for equipment throughout the ward. We observed the dates on some pumps stickers were six days prior to the inspection. The ward sister explained that pumps were cleaned every week and that staff would clean equipment before use if the date on the sticker was not current.
- Four patient mattresses were randomly inspected for any damage or fluid ingress through the waterproof covers, and were found to be clean and in good condition. This was an improvement on the last inspection in 2014 when two out of the three inspected were soiled.
- We saw a stack of toilet seat raisers stored inappropriately balanced on top of a mop bucket. They were still there on our unannounced inspection and it was not clear if they had been cleaned or were dirty.

## Environment and equipment

- Ward equipment had been safety tested and had in date safety stickers applied. Ward staff told us they did not have problems accessing equipment and pressure-relieving mattresses were stored on site.
- We observed a good supply of equipment for moving and handling, located close to the wards and recovery area. In the wards, there were adequate seat raises for toilets, which helped prevent patients dislocating their hip replacements, and the seats in patient rooms were of a safe height.
- The wards, theatre and recovery areas had resuscitation trolleys. Adult and children's resuscitation equipment were available. Records showed the staff checked the trolleys daily (for the correct equipment, in date single use sterile items and medications), and signed the check sheet. The resuscitation trolley on the wards had a tamper evident tag which alerted staff to any potential removal of equipment.
- Call bells were accessible for patients on the ward to enable them to call for assistance if required whilst in bed or sitting out.

# Surgery

- Most patients walked to theatre, and after their operation returned on a trolley, rather than their bed. This meant another transfer from trolley to their bed, which was a potential risk for increased pain or dislocation for hip replacement patients.
- Staff told us there was close working relationships with the local NHS trust theatre teams, and there were reciprocal loans of kit when necessary. Theatres had employed a loans officer to advance plan the loan kits and to reduce the costs of unwanted loans. Their role also included the organisation and tracking of equipment repairs within theatres.
- The cardiothoracic consultants owned the perfusion kit for cardiothoracic surgery. We saw records that evidenced the manufacturer regularly maintained the kit.
- In the theatre complex, we saw bariatric trolleys and theatre tables were available for heavier patients. Staff assisted patients to move appropriately with the aid of a patient transfer board (PAT slide).
- There was a folder for retaining records of the laser audit testing. The last version was September 2015, and the action plan was now complete. There were local rules for safe laser usage, for urology and vascular staff who used lasers.
- The theatre manager assured us that all equipment including anaesthetic equipment had been safety tested or serviced. However, we found that many items of equipment and electrical plugs had out of date safety test labels attached which could be misleading. Most equipment was in date for servicing.
- There were three different types of infusion pump in use within the hospital. This was a potential risk to staff and patients as it meant users had to be familiar with the working instructions, alarms and set-up of different machines. However, this was not on the hospital risk register and staff had not raised it as an issue.
- Anaesthetic staff told us that some of the anaesthetic machines were approaching 11 years old and felt that they would potentially need replacing in the near future. However, it was not clear if they had raised this previously with the management team as a risk.

- We observed the main ward interlink corridor being very noisy, with domestic, waste and linen trolleys moving along the corridor. Patients in their feedback cards to the CQC also mentioned this noise disturbance.
- Disinfectant tablets were seen stored on the worktop in an unlocked ward sluice. This was not in line with Controls of Substances Hazardous to Health (CoSHH) guidelines. The inspector brought this to the attention of the ward staff.
- The cleaner's cupboard in the day case unit was unlocked with accessible chemicals inside; we raised this immediately with the unit sister who rectified this. Cleaning fluids had not been stored securely at our previous inspection in 2014.

## Medicines

- We saw the hospitals medicines management policy was not consistently adhered to. We checked the controlled drugs register on one ward and in August 2016, there were six dates where there was only one registered nurse signature instead of the required two.
- We checked 10 medicine charts for prescribing and administration. Five of the 10 charts did not detail the patients' weight, which may be needed for accurate prescribing.
- On one ward, medication fridge temperatures were higher than the recommended range on three occasions in October 2016 but there was no evidence of any actions. Ambient room temperature readings for the month of October 2016 were high on 5 occasions. The pharmacist responded to this by re-locating the thermometer away from the heat source.
- Records showed staff did not check fridge temperatures every day. On one ward, there were five days in August 2016 when staff did not record fridge temperatures. On all other days in August, records showed fridge temperatures were within the recommended range of temperatures.
- In theatres, the policy was for CD stock to be checked when the theatre was in use. The hospital policy was for twice a day checks but records showed staff checked them mostly once a day. The latest hospital audit in

# Surgery

September 2016 identified theatre staff had been completing stock checks with only one staff member. There were no actions documented as a result of the audit.

- Medicines and controlled drugs (CDs) were stored within locked cupboards in a keypad locked room. The wards kept the CD keys secure in a key safe with a combination code and an 'in and out' record. The wards completed a daily CD stock check at night and documented it in the CD record book. The hospital pharmacists audited practice regularly, there was a recent medicine reconciliation audit (the checking of patients' pre-admission medication against a GP's or other record) and a quarterly controlled drugs audit.
- We observed that medical gases were appropriately stored in holders throughout the hospital including Entonox gas stored appropriately on its side. Intravenous fluids were stored in a locked room within original boxes.
- Anaphylaxis kits were available and easily located hanging on central ward walls; these were readily available if a patient had a severe allergic reaction to a medication. They were within a sealed dated box so staff knew to replace them when out of date. We observed the replacement process on our unannounced inspection.
- There were patient group directives (non-medical prescription and administration of medicines (PGDs)) for patient controlled administration of pain relief via a pump. The anaesthetist commenced PGDs in recovery, and the patient administered their pain relief by pressing a handset. Registered nurses had signed off competencies for their use.
- We saw staff records of competencies for patient group directions were signed off each year,
- The prescribers adhered to local microbiology protocols for safe antibiotic stewardship; the local microbiologist was actively involved in recommending suitable antibiotics when required.

## Records

- Theatre operation logbooks were found to be incomplete across all of the theatres. The worst was in theatre six where of 255 cases operated on from June 2016, 99 of the records were not complete. The

inspection manager raised this as a major concern at the time of the announced inspection. At the unannounced inspection on 1 November 2016, we saw action had been taken and operation logbooks were now fully completed.

- Theatre staff recorded the relevant surgical implant details into required logs, for example, recording individual identification codes of joint replacement prosthesis or implants. This was for contacting patients in the event of a product recall.
- The hospital's latest medical records audit in June 2016 showed there were issues with the documentation of patients fasting preoperatively, with 65% compliance. This audit showed 95% of consultants completed patient's records in line with the hospital policy. However, when we reviewed patient's notes, we found not every consultant made daily entries consistently in their patients' records. We reviewed 18 clinical records and found that four of the 18 records did not evidence daily medical review.
- Patient records were either stored with the patient in their room or they were stored within an open trolley in a secure office. The records contained divided medical notes made by consultants working under practising privileges, patients consent documents, admission letters, pre-operative assessment documents and results pages.
- The nursing care records contained an appropriate broad range of records. The patients having joint replacement surgery had integrated care pathways, which prescribed the pre and postoperative multidisciplinary care for that patient. The staff signed for completed care or stated the reason for non-completion (known as a variance).
- We saw completed and updated fluid balance charts within nursing records, these are important to ensure that patient's fluid intake and output is functioning following surgery.
- The medical staff completed patients discharge summaries via e-discharge, which enabled a speedier information transfer to the patient's GP

## Safeguarding

- The matron/head of clinical services was the hospital lead for safeguarding both adults and children. They

# Surgery

had close links with the local authority safeguarding leads and attended the independent hospitals forum. The matron had aligned the safeguarding training with the local safeguarding board. The hospital had a safeguarding champion for adults and an overall children safeguarding lead.

- Staff we spoke with were aware of their responsibilities for safeguarding patients from harm and could describe their local escalation process and the principles of the Deprivation of Liberty safeguards. They were also aware of female genital mutilation and their duty to report if discovered. There had been six safeguarding concerns reported to the CQC between July 2015 and June 2016.
- The clinical teams overall safeguarding training compliance was 84% for adults and 83% for Level 2 children.
- The staff recruitment processes, including for those under practising privileges, included employment reference checks and a current and enhanced disclosure and barring check specific to the hospital.

## Mandatory training

- All staff working with Spire Southampton were required to complete yearly mandatory training to ensure that they were able to care for patients safely. New staff had mandatory training as part of a two-week supernumerary induction period.
- The hospital staff, most of whom were involved in surgical services, had achieved 86% compliance for Spire E-learning mandatory training modules overall, against the organisational target of 95%. A reminder in the form of a monthly report was sent to managers every month to help monitor staffs' compliance. The hospital was aiming to be 100% compliant by the end of 2016.
- There were eight mandatory elements of E-learning, which included for example, fire, health and safety and infection control. All registered nurses had immediate life support training. Care support workers had basic life support training. The resident medical officers (RMO) received advanced life support training as part of their employment contract. Staff working in recovery had completed paediatric competencies and there was a plan for them to complete paediatric immediate life support in the near future.

- Staff had achieved 88% compliance in information governance training. This covers the protection of patient data and records. 'Prevent' training was undertaken by staff
- Most staff told us that they were given time to access training, but they could also access the system from home if there were time constraints. Theatre staff told us that despite access to computers in the downstairs staff room, time constraints meant that they could often not use them. Therefore, theatre staff usually did their mandatory training in their off duty time and claimed it as overtime which was honoured by the hospital.

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

- We observed theatre staff used the five steps to safer surgery (World Health Organisation –WHO) check list correctly at each operation. The hospital regularly audited the checklist by unannounced observational audits. The results in 2016 showed that although the steps were followed correctly, on occasions the theatre was not quiet. It is regarded nationally as 'best practice' to have a quiet environment when the checklist is done.
- Staff we spoke with informed us that the new National Safety Standards for Invasive Procedures (NatSSIPs) had encouraged the development of a new local surgical checklist process, which matched the one in use in the local acute NHS trust.
- The NatSSIPs bring together national and local learning from the analysis of never events, serious incidents and 'near misses' through a set of recommendations that help provide safer care for patients undergoing invasive procedures. This enhances the existing five steps to safer surgery (WHO) checklist by looking at additional factors such as the need for staff education and training. The principle behind the NatSSIPs is that organisations, working in collaboration with staff, review their current local processes for invasive procedures and ensure that they are compliant with the new national standards. It was the intention that organisations will develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs).
- The pre-assessment clinic was nurse-led and operated from a local Spire Healthcare clinic ten minutes away from the hospital. The pre-operative assessment nurses

# Surgery

did not have day-to-day clinical support although they were able to access the anaesthetist or a clinician for advice if there was a query or concern over their patient's fitness for surgery.

- All patients self-completed a health questionnaire; which guided the nurses in assessing them over the phone or face-to-face. Staff told us there had been recent improvements in the patient completion of the pre-admission medical questionnaire from 30% to 80%. The target was for 100%.
  - All major orthopaedic and spinal surgery patients had a full pre-assessment in person. Bariatric, cardiothoracic and cosmetic surgery patients had pre-assessment at the hospital site, which included a cardiac and anaesthetic consultant review, due to the high-risk nature of the surgery. The hospital had not yet trained nurses in physical chest assessment, therefore any patients requiring chest examination or with previous health issues had a consultant review rather than one completed by a nurse.
  - The risk assessments included, for example, the patient's risk of developing venous thromboembolism (VTE), of falling and any nutrition and hydration risk (MUST score). At the patient's pre-operative assessment their identified risks were discussed and advice given, for example stopping current medication such as warfarin (blood thinning medication). The nurses also carried out a mini mental assessment to assess the patient's capacity for understanding instructions after their surgery if appropriate. They escalated any concerns to the consultant and the ward sister.
  - At the pre-operative assessment clinic, staff took the patient's blood samples, recorded their weight and height and carried out urine screening and a tracing of their heart activity. This provided a full record of the patient's health status before surgery.
  - Theatre staff monitored patient temperatures intra operatively every 30 minutes to ensure their temperature was above 36° centigrade within theatre. This was one of the recommendations of the national 'Saving Lives Care Bundle' guidance to prevent surgical site infections. The IPC lead had audited patients' notes and the patients' temperature regulation with theatres was 90% compliant. Other recommendations were
- using a clipper with a disposable head for hair removal, appropriate antimicrobial medicines given within 60 minutes of the incision and keeping a lower blood sugar in diabetic patients, although these were not monitored.
  - The pre-operative assessment team completed, signed and dated risk assessments for ward patients prior to their admission. However, we reviewed 23 sets of patient records and we saw that ward staff had not appropriately reassessed seven (30%) of patients' risks following their surgery.
  - We saw that if patient bedside rails were in use within the ward, there was a risk assessment for their use.
  - Nursing staff carried out observations on patients as regularly as was appropriate to their post-operative recovery. Nurses used a combined document to record patient's vital signs and pain scores, which, depending on the results calculated and provided a national early warning score (NEWS). This score alerted the staff of the patients' deterioration and gave specific actions to follow when the score increased. Patients we spoke to described how they had frequent observations carried out when they were in the recovery area or on the ward.
  - Fully completed NEWS charts were located within the notes, with appropriate actions recorded when there was an escalation in score, which could show the patient's condition was deteriorating. This was to escalate their concerns to a senior nurse, the RMO or consultant. The critical care outreach team reviewed patients that ward staff identified as having a raised NEWS score and escalated care as required.
  - The outreach nurse could administer oxygen and fluids in an emergency under a PGD directive. They were able to admit patients to the critical care unit for closer observation and monitoring if required. Staff on the wards considered the outreach to be a good and valuable service in supporting the care and treatment of a sick patient and providing support and education to ward staff.
  - At night, the critical care outreach nurse carried out a 'triage' role, which is not a specific role of a critical care outreach service. This meant that staff on the general wards referred queries about patient care and requests for RMO assistance through the outreach nurse.



# Surgery

- In some circumstances, the outreach nurse could carry out investigations such as blood tests and examinations so the RMO or consultant called had all the necessary information to make a clinical decision. The outreach nurse collated and triaged all RMO requests, so the RMO was not repeatedly disturbed overnight.
- The outreach nurse also carried out cannulation for patients who had lost their intravenous access overnight in order to support the services of the RMO. Staff told us the service they could provide for the hospital depended on the demands of the critical care unit workload. This meant the level of support they were able to provide to the rest of the hospital was variable. If the unit was busy the RMO would be asked to perform this service.

## Nursing and support staffing

- The hospital assessed ward-staffing requirements using a nationally recognised staffing tool (the Shelford Safer Nursing Care Tool) in conjunction with professional judgement. The patients were assessed daily using a three level acuity or dependency score (a-c). Staffing and patient numbers were recorded hospital wide and staff were re-allocated to work in another department if needed.
- There was a weekly planning meeting, attended by the deputy matron and senior leaders in the hospital, looked at the following week's staffing requirements and skill mix.
- Ward handovers occurred at 7am, 1pm and 8pm, using the Spire corporate handover sheet. We observed three at different times and found them to be confidential, with a good exchange of information taking place.
- Ward staff told us that agency staff were rarely used, but if they were employed it was from the same company, which helped in providing continuity of care to patients. They had a brief induction to the ward, which the agency nurse would sign as given. We did not see this as there were no agency staff on duty on the days of our inspection.
- As at July 2016, there were six WTE (9%) ward based registered nurse (RN) posts vacant, which CQC compared to other independent hospitals and found to be lower. Sickness was less than 1%, and there was a 5% use of bank and agency RNs which was also lower in comparison. There was high, over 18% turnover of ward RNs from June 2015 until July 2016, which was higher than other similar independent hospitals and had increased from 12% the previous year. The hospital stated the turnover included the regular cleansing of staff contracts which was done routinely in Spire hospitals. The hospital planned to fill all vacancies by the end of 2016.
- The hospital stated that the planned ratio for RN to patient was one to five for early shifts, one RN to five or six patients on the late shift and one RN to six patients on the night shift. We looked at off duty rotas for August and September 2016. We saw Ward 2 regularly had the RN numbers required on early and late shifts but frequently had lower than required numbers of RNs for the numbers of patients at night. Sixteen shifts out of 31 in August and 14 shifts out of 30 in September did not have sufficient RNs according to the hospitals planned ratio. The lower numbers of RN nurses may cause delays in patients receiving pain relief or intravenous antibiotics being given. The wards had health care assistants on night shifts providing the numbers if not the appropriate skill mix required for the numbers of post-operative patients.
- Some staff told us they were concerned about staffing on one of the wards and had raised concerns to the senior management team. Staff said they were 'listened to', but were unsure if the senior team had taken any actions. They acknowledged that there were national problems with recruitment, but were still worried. Different grades of staff we spoke with on the wards confirmed that levels of staff concerned them and were 'challenging'.
- Patient feedback via anonymous comment cards to CQC indicated that there were sometimes delays at night for assistance. Comments included, 'staff seemed to be stretched', 'nurses were run ragged', and 'insufficient staff numbers for the numbers of intravenous drugs to be given.' This suggested there were insufficient numbers of RNs on duty at night.
- Patients told us that an agency nurse who had worked overnight for the first time in the hospital had been very anxious and did not appear to know what they were doing. The patient described this as the 'worst part of their stay'. The ward sister was informed about the patient's concerns.

# Surgery

- The hospital followed Association for Perioperative Practice (AfPP) guidelines when determining theatre staffing with appropriate numbers of RN or ODPs and HCAs for the cases on each list. There were currently 38.4 WTE of ODPs and HCAs, and 13.7 RNs employed in theatres at the hospital. The hospital reported using low rates (less than 3%) of bank and agency staff in theatres..
- Some theatre staff told us that staffing was a concern with frequent difficulties in getting breaks, particularly for scrub staff, although other staff confirmed that staffing usually adhered to the AfPP model and had four staff for each list. All staff told us that there were frequent overruns of lists into the evening, which meant staff had to stay beyond their planned working hours. Staff stayed late for overtime payments as they were not able to take time owed back. This happened at least two to three times per week. Staff told us 8pm was the cut off time for starting a new surgical case, but occasionally they were pressurised by the consultant to continue after that time. This was not raised as an issue by the theatre management team.
- The theatre manager had a register of staff acting as first assistants, which supported the requirements outlined within the Perioperative Care Collaborative Position Statement (2012). Some theatre staff had completed first assistant accredited training, others who had worked for the hospital for a long time had their competencies mapped using the AfPP toolkit.
- Any externally provided first assistants, for example brought in via the consultants, had their curriculum vitae, general medical council number, current disclosure and barring service document, immunisation status, and individual indemnity insurance checked. The theatre manager did the checks personally and kept records of the documents.
- The ITU lead nurse managed recovery as there was no local team leader for the recovery staff. Recovery staff escalated staffing issues to ITU for support however they told us this was often difficult as ITU had natural priority over staffing. At the time of the inspection staff working in recovery said they were not supported by the ITU staffing team. They told us they had not had meal breaks, because ITU staff had not been able to relieve them. They felt concerned about the safety of patients in recovery as the staff group on duty did not have

extensive experience of working in a recovery area. We raised their concerns with the senior management team, who immediately took action to assess the situation and provide support for the staff.

- At the unannounced inspection on 1 November 2016, we spoke to the senior member of staff working in the recovery area. She told us she had reinforced to the recovery team that if the ITU workload meant support was not available, they needed to escalate staffing concerns to the management team. On that day, a member of staff from ITU was working in the recovery area to support their staffing numbers. We observed the ITU nurse in charge of the shift liaised with the recovery staff to ensure staff numbers were appropriate for the planned admissions to recovery.

## Medical staffing

- There were 326 consultant surgeons and anaesthetists employed at the hospital with practising privileges. Practising privileges were granted to consultants who agreed to practice following the hospital's policies and provided evidence of appropriate skills and registration. The Medical Advisory Committee oversaw and ratified practising privileges for the consultants. We saw evidence of processes in place for ensuring sufficient checks and references were undertaken prior to granting practising privileges and these were kept updated on an ongoing basis. Most consultants undertook a similar role in the NHS, and so received their appraisal and revalidation with the trust they worked for. Ten were not NHS employees, having retired from NHS careers, and their revalidation was done by the Spire group medical director.
- All surgery was consultant led. This meant that consultants were responsible for their own patients 24 hours a day. It was the responsibility of each consultant, who had been granted practising privileges, to cover their absences and ensure that the person appointed to cover for them had the appropriate skills and a practicing privileges agreement in place.
- The Spire Healthcare consultants were required to live within 45 minutes of any emergency request as part of their practising privileges agreement. There was a resident medical officer (RMO) onsite twenty four hours per day to manage emergency situations who called the consultant as needed. However, staff said consultants

# Surgery

with patients on the critical care unit had to be able to access the unit within 20 minutes. This met the standards of 30 minutes set out in the Guidelines for the Provision of Intensive Care Services (2015). Staff told us that in practice consultants had 'buddy' cover arranged for when they were not able to attend the hospital.

- The hospital directly employed seven resident medical officers, (RMOs). One was on maternity leave and one on a bank contract. The remainder worked a one in five, 24 hour shift pattern Monday to Friday, and worked one weekend (48 hours) in five.
- Nurses reported they were able to access support if needed from the RMO at night, as the RMO was resident at the hospital. Overnight, the critical care outreach team screened the RMOs calls initially, so the RMO was able to get sufficient sleep.
- Ward staff described good working relationships between nurses and medical staff, including senior consultants.
- The perfusionists required in supporting cardio thoracic surgery were available to book through the hospital bank. Staff reported there were no problems with booking perfusionists when they were required

## Emergency awareness and training

- Theatre had its own backup generator in case of electrical failure. The hospital regularly tested the backup generators as part of business continuity every Sunday. There were plans to close the hospital completely for a week over the Christmas period to allow for upgrade of the backup generator.
- We were told that due to the close proximity of the hospital to the acute NHS Trust, if there were a Major Incident, Spire Southampton hospital would support wherever they could. Major incident plans were kept at reception.

## Are surgery services effective?

Good



We rated effective as good.

## Evidence-based care and treatment

- Care and treatment took account of current legislation and nationally recognised evidence-based guidance. Policies and guidelines were developed in line with the Royal College of Surgeons and the National Institute for Health and Care Excellence (NICE) guidelines. For example, the national early warning system (NEWS) was used to assess and respond to any negative change in a patients' condition. This was in line with NICE guidance CG50.
- There was a local and corporate annual audit programme, which measured the hospital's compliance against policies and national guidance. This included audits such as patients' records, cosmetic reflective period of consent audit, 'five steps to safer surgery' checklist, controlled drugs, infection prevention and control (IPC), VTE assessment and resuscitation. Staff discussed results at the clinical effectiveness group meeting, appropriate team meetings and senior nurse group meetings at corporate level. We observed that patients in theatre had regular temperature observation and recording as per NICE CG 65 management of peri-operative hypothermia, both in the anaesthetic room and within theatre.
- The hospital had just started to contribute to the national blood transfusion audit; all new staff were trained in data collection.
- Staff assessed patients for venous thromboembolism (VTE) risk and took steps to minimise the patient's risk of developing a thrombosis (blood clot) in line with the NICE guidelines. The consultants gave patients chemical prophylaxis to prevent the formation of a DVT. However, the hospital clinical scorecard for July 2016 to September 2016 showed that for patients undergoing hip and knee replacements only 50% had VTE prophylaxis given within the recommended timescale (according to NICE).
- Nursing staff told us this was due to consultants concerns that chemical prophylaxis given immediately post operatively could cause wounds to ooze and increase the risk of infections. The patient safety lead and the haematologist were following up the incidence of events with individual consultants. This issue had been discussed and was documented within the MAC minutes.

## Pain relief



# Surgery

- During the pre-admission assessment process, staff gave patients an information leaflet about pain relief after surgery. This ensured patients knew the type of pain relieving medicines available; any previous sensitivity to pain relieving medicine was noted at this point.
- Ward staff assessed patients' pain and the effectiveness of pain management regularly using a nationally recognised numerical scoring system. Ward staff were able to access a lead nurse for pain who was provided advice on different options of pain control if needed.
- Some patients received postoperative pain relief via patient controlled analgesia infusion pumps. Nursing staff checked these regularly and monitored their effect.
- The majority of surgical patients we spoke to said they had received adequate and timely pain relief following frequent pain assessments. However, four patients told CQC that waiting for pain relief, or some nurses not understanding their levels of pain, were issues.
- According to the hospital clinical scorecard, staff assessed and recorded pain scores in 100% of all patients observations taken. A recent internal audit of pain relief in recovery indicated a 90% compliance with pain relief, when indicated, and identified actions to improve this to achieve 100%.

## Nutrition and hydration

- Staff advised patients about fasting times prior to surgery at pre-assessment and in their booking letter. The hospital aimed to ensure fasting times were as short as possible before surgery to prevent dehydration and for clear fluids to be available as long as possible. The hospital monitored patient fasting times; recent compliance was 65% of patients were fasted within the organisational fasting times. This was to drink clear fluids up to three hours before surgery. The organisational target was 50%
- Staff monitored fluid intake and output for some major operations to ensure patients were adequately hydrated and kidney function was within expected range. We observed that staff correctly recorded this on fluid balance charts. Patients also told us that crushed ice was available if this was easier for them.
- The hospital offered light snacks and drinks for day case patients before discharge home and were able to access snacks for post-operative patients returning late from theatre.
- Nursing staff assessed patient's risk of malnutrition using the malnutrition universal screen tool (MUST) scores and recorded them in patient notes. Staff could access a dietitian if indicated, for either malnourished or bariatric patients.
- The majority of patients reported to us that the meals were 'very good' and there were very few negative comments. Iced water was freely available and very popular; they felt there were many menu choices. Patients said meals 'exceeding expectations', meals were 'well presented,' 'lovely' and 'exactly what they had asked for'.

## Patient outcomes

- The Spire organisation was fully engaged in the Private Healthcare Information Network (PHIN). PHIN is an independent, not-for-profit organisation that publishes trustworthy, comprehensive data to help patients make informed decisions regarding their treatment options, and to help hospitals improve standards. PHIN had carried out a readiness assessment of Spire's strategic plans on 16 March 2016 which raised no concerns.
- The Spire organisation attended the implementation and data quality forums, so that submitted patient outcome data was in accordance with legal requirements regulated by the Competition Markets Authority. Nine consultants across three Spire hospitals had contributed to a pilot testing of the new consultant portal of PHIN to submit patient outcomes. There was an internal bi-monthly PHIN Steering Group locally to provide senior level governance and oversight within the hospital.
- The hospital provided data to the Society for Cardiothoracic Surgery in the UK and Ireland. This showed for the period April 2012 to March 2015, survival rate for patients undergoing cardiothoracic surgery at Spire Southampton hospital was 99.6% compared to a national average of 97.5%. The data showed these results were achieved despite the hospital carrying out complex surgery and surgery on a comparatively high-risk patient population as well as carrying out straight forward elective or booked surgery.

# Surgery

- The hospital and surgeons had also inputted anonymised cardiac data into the National Institute for Cardiovascular Outcomes Research (NICOR) since 2005. This is part of the National Centre for Cardiovascular Preventions and Outcomes (NCCPO), which sits within the Institute of Cardiovascular Science (ICS) at University College, London.
- Various reports were available for patients to view on the NICOR website, for example the National Adult Cardiac Surgery Audit and National Audit of Percutaneous Coronary Interventional Procedures. These reports inform patients about surgical procedures, the expected and actual outcomes, risk factors and the long-term expectations following the surgery.
- The National Joint Registry was used to record patient outcomes following replacement joint surgery and PROMS were collected from suitable NHS patients following their procedures. The hospital was just beginning to collect PROMs for private patients undergoing hernias, cataracts and joint replacement surgery as part of the PHIN data commitment.
- The hospital had agreed Commissioning for Quality and Innovations (CQUINs) with the clinical commissioning group for patient reported outcome measures (PROMs) for hip and knee replacements, hernias and cataracts for NHS patients. The PROMs national database indicated that reported outcomes for these procedures carried out at Spire Southampton patients were within the expected ranges.
- The Spire group benchmarked the hospital's performance compared to others in the group using a scorecard. The hospital gathered information about patient outcomes using a clinical scorecard, the National Joint Register (NJR), patient discharge questionnaires, information provided by insurance companies and complaints data. The hospital flagged 'red' for any patient outcomes that were not achieving the organisation's target. For example, surgical site infections in total hip replacements flagged 0.8% against the organisational target of 0.6%, and other Spire organisations of 0.15%.
- All patients having joint replacements were consented to register their details on the National Joint Registry (NJR), which monitors, for example, infection, revision rates and the prosthesis used. The data held within the NJR indicated that Spire Southampton was an 'outlier' for revisions of total knee replacements, although it was within expected rates for other procedures. This meant that the revision rates were higher than at other hospitals. The hospital had investigated the reasons for this since 2015, but not updated the NJR so it still displayed the outlier data.
- The hospital's audit for VTE, reported 10 VTE events since the previous April 2016. The two main causes identified were patient dehydration and noncompliance of thromboprophylaxis prescribing against NICE guidance.
- The hospital informed us that all cosmetic surgery breast implant prostheses were registered into the hospital implant register. There was a plan for data to be submitted into the national database of implant data via the Clinical Audit Platform (CAP), managed by the Health and Social Care Centre (HSCIC).
- The hospital reported 38 unplanned returns to theatre between July 2015 and June 2016 and when compared to other similar hospitals this was high. However, the case mix of this independent hospital was not the usual case mix, for example few other independent hospitals undertook cardio thoracic surgery.
- There were 50 unplanned readmissions of patients to the hospital in the same reporting period. This is similar to other independent hospitals as analysed by the CQC. Twelve patients needed to be transferred to the local acute NHS hospital because of deterioration in their condition. This was within the normal ranges for the number of patients admitted to the hospital.

## Competent staff

- The hospital undertook recruitment checks to ensure that new staff were appropriately qualified and suitable for the posts. All new staff, including agency and bank staff, had a formal induction process. The components of the induction included core organisational information plus role-specific training.
- Theatre staff role-specific induction included allocation to a team, buddy and mentor. There was one day training for theatre specifics. Staff also had a competency pack, which included corporate competencies, specific competencies in perioperative care, management of medicines and extubation. We

# Surgery

also saw the induction pack for sterile services, which was very comprehensive. Theatres also held education sessions in anaesthetics and robotic surgery to support continuing professional development.

- There was an embedded newly qualified registered nurse preceptorship programme. The hospital had good links with the university and offered a rotational programme. Preceptorship is a key part of maintaining and enhancing skills and ensuring continuing fitness to practise for staff.
- Newly qualified operating department practitioners (ODPs), part of the allied health practitioners (AHPs) group, did not have preceptorship in place. The theatre management team had not acknowledged this as required for AHPs, however, when we returned on the unannounced visit, this was already being addressed.
- New recovery staff had an induction and worked in a supernumerary status for a period of three months. Each staff member had a folder containing signed competencies for example on airway management, extubation, intravenous administration of controlled medicines. The files were completed and up to date, the staff told us that they were able to attend a two-day 'non-assessed' course in London. Newly qualified nurses reported they had received a full day hospital induction. All staff were allocated time to complete mandatory training and had a regular performance review. The hospital supported nursing staff they with time to complete their revalidation.
- Staff reported that they had access to further training, and financial support was available for training relevant to their role. A senior staff nurse on the day surgery unit was undertaking a leadership and management course that developed leadership competencies.
- Ward health care assistants were trained and competent to undertake theatre transfers; they could undertake phlebotomy and administer prescribed oxygen. They had access to approximately three to four study days every year specific for their grade.
- Within surgery, 23% (140) staff had received medical gas training for handling or administering medical gases, however not all staff were required to administer or transport medical gasses. Of those, 67% had training which was an improvement.
- All staff (100%) had completed an annual appraisal. Their self-assessments were paper based, but fully completed on line, to maintain staff confidentiality.
- There were various clinical nurse specialist roles to support patients within the hospital, some of which were shared roles. For example, the discharge-planning nurse and the VTE nurse specialist were part of a ward nurses role. Other specialist roles were available when required from the local NHS trust, for example a stoma nurse.
- Consultants and anaesthetists worked under a practising privileges agreement. The medical advisory committee (MAC) were responsible for granting and reviewing practising privileges. New consultants provided evidence of qualifications, training, accreditation, scope of practice and indemnity insurance and there was a process at their biennial review. Consultants who did not produce supporting documentation did not have their practising privileges renewed. Those consultants who had not practised regularly within the Spire hospital had their privileges withdrawn, if they could not prove their competencies had been maintained.
- There were close links with the local NHS trusts whose medical directors were responsible for the General Medical Council revalidation of the consultants. The Spire medical director was responsible for revalidation with the GMC for any consultants who did not work for the NHS.
- Spire Healthcare employed RMOs if they had relevant skills; they were directly employed and worked or were research fellows at local NHS trust. The RMOs we spoke with said that they were not expected to work outside their competencies.
- There was a professional development programme for all staff, linked with the local NHS trust on key issues such as acute kidney injury or falls. Any additional training was in response to new policy or following incidents
- The hospital organised successful education evenings for external and internal staff. for example, on cardiothoracic and robotic surgery, delivered by consultants.

## Multidisciplinary working

# Surgery

- Physiotherapy staff supported effective recovery and rehabilitation and followed up at outpatient clinics. They visited the wards daily including weekends. The hospital did not employ occupation therapists, as the physiotherapists picked up their role.
- Our observation of practice, review of records and discussions with staff, confirmed effective multidisciplinary team (MDT) working practices were in place. MDTs included nurses, medical staff, pharmacists and physiotherapists. We saw regular local team handovers and wider hospital coordination meetings, where patients and organisational issues were discussed.
- The regular daily planning meetings gave good examples of operational planning to ensure that patients' surgery went ahead and any risks were mitigated or reduced.
- The hospital had service level agreements in place to access the services of local NHS hospitals. These included microbiology and pathology services.
- There was excellent working with the local NHS trust where there were agreements for the transfer of critically ill patients for care or expertise not provided within the hospital.
- There were links with local GPs to ensure that effective transfer of care took place.

## Seven day Services

- The hospital was open seven days a week, although there were no operations performed on Sundays. There was timely access to key diagnostic services 24 hours a day, seven days a week. Pharmacy service was available on call for discharge medicines on a Sunday.
- The offsite pre-assessment clinic was open 8am – 1pm and 2:30pm – 7pm, Monday to Friday. The senior nurse had plans for a Saturday morning clinic in the future.
- The physiotherapists were available out of hours for emergencies, such as chest physiotherapy for compromised patients.
- Consultant surgeons provided cover for their inpatients 24 hours a day, seven days a week. They arranged alternative cover by a named consultant if they were not

available. A consultant anaesthetist on call rota ensured there was anaesthetic support available 24 hours a day. Staff confirmed that consultants were always available out of hours for advice and guidance.

- An on call surgery team that consisted of a surgical consultant, anaesthetist, and three hospital theatre staff were available outside normal working hours. The hospital theatre on call staff included a practitioner to support the anaesthetist, a surgical first assistant and a circulating practitioner.

## Access to information

- Theatre staff planned to introduce an electronic theatre booking system to enable all staff to check lists and book equipment, although this was still paper based when we inspected.
- Staff accessed policies and procedures via the hospitals intranet, although some staff such as theatre staff stated they had no time to access the computers within the staff room. The theatre manager printed off information, any newsletters, as staff were unable to access emails due to time constraints. We saw updated information, policies, and procedures printed out and on notice boards in theatre.
- Staff reported timely access to blood test results and diagnostic imaging. Results were available for clinical review of the findings and if necessary to change the patient's treatment plan. There was secure access to the hospital's digital imaging records, NHS imaging reports, as well as pathology reports
- There were appropriate systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for treatment. Medical staff we spoke with confirmed the transfer methods used and understood the security requirements of data transfer.
- GP referral letters were available for NHS and private patients, unless self-referred and filed within the patients records.
- The hospital emailed discharge letters to GPs and district nurses about the patients' treatment and care, which informed them of their patient's medical condition and treatment they had received. This ensured the GPs knew of their patient's discharge within the agreed timeframes of four days.

# Surgery

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent forms were completed correctly within patient records we looked at and appropriately detailed the risks and benefits of the procedure. The operating consultant routinely recorded consent on the same day of the operation, with the patient's 'reflection' on information given to them taking place between their initial consultation and admission. Patients we spoke with confirmed that they felt well informed about the procedure they were consenting to.
- Cosmetic surgeons were required to adhere to GMC Good Medical Practice and The British Association of Aesthetic Plastic Surgeons (BAAPS) Code of Conduct. This included ensuring a two week 'cooling off period' or reflection period after the pre-treatment consent process. Staff we spoke with were aware of this requirement and confirmed it took place.
- We followed two patients through their peri-operative journey. We saw staff asked for patient's consent before delivering any care and treatment. We observed nurses on the wards and in theatres sought verbal consent from patients before taking observations and delivering general nursing care. Staff we spoke with were able to access interpreters to assist with the consent processes if required, those patients needing this support would be identified through the preoperative assessment process.
- The pre-operative assessment nurses asked patients having joint replacements to consent to their details being uploaded into the National Joint Register (NJR), this register collated national data and helped to identify patient outcomes and care 'outliers'. The nurses gave patients information on the NJR and we located the completed consent forms within patients' records.
- Staff undertook training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory safeguarding training. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been authorised by the local authority. Staff we spoke with could explain their responsibilities within MCA and DoLS.

## Are surgery services caring?

Good 

We rated caring as good

### Compassionate care

- We observed compassionate and caring interactions from all staff. Patients were consistently positive about the care that they received, they told us the care was 'first class' and were especially positive about the staff who were described as 'sympathetic and supportive' and 'so friendly, they'll do anything for you.'
- Patients told us that nurses, physiotherapists and head of housekeeping always introduced themselves, and we witnessed all staff having a friendly rapport with patients, including for example, porters and administration staff.
- Patients reported that staff respected their privacy and dignity at all times. We observed knocking on patient doors and waiting for a response before entering. We witnessed staff in theatres being mindful of patients' dignity when they were in a vulnerable condition.
- We saw various consultants talking with patients in a caring and reassuring manner.
- The hospital had employed customer service coordinators to meet and greet patients and support them with any practical issues needing addressing.
- We observed a 'pamper nurse' giving a foot massage to a patient. The 'pamper nurses' were nurses on the ward who were allocated time to provide relaxation treatments to patients. The patients spoke highly of the care and attention the 'pamper nurses' gave them.
- The hospital's Friends and Family Test (FFT) scores of patients who would recommend the hospital to their friends and family ranged between 96-99%. These were equal to or slightly lower than the England average of NHS patients for independent hospitals across the period January 2016 to June 2016. The hospital's FFT response rates ranged between 26% and 44% and were mainly lower the England average of NHS patients in the same period.



# Surgery

- The hospital's own satisfaction feedback indicated 65% patient satisfaction against the target of 71% from July until October 2016 for patients feeding back 'excellent' overall to the way they were prepared for their discharge home.
- We observed some patients being referred to by staff giving out meals as room numbers instead of by their individual names. This could demonstrate that some staff did not treat patients as individuals in a respectful way.
- The patient lead assessments of the care environment (PLACE) score for the hospital for the period February 2016 to June 2016 were lower than the England average for other independent hospitals. They were lower for privacy, dignity and wellbeing (64% compared to 83%) This is a process when
- The hospital encouraged and supported patients to maintain contact with friends and family, therefore visiting times on the ward were between 9am to 9pm. The ward sister may shorten visiting hours if the patient was not feeling well enough.
- Ward staff could access additional services if required by patients, for example, counselling services were available if needed from additional private resources external to the hospital.
- Wards displayed signs offering patients a chaperone at nurses' desks. Patients we spoke with did not raise a lack of chaperoning as an issue, either verbally or by any of the comment cards.
- Staff asked patients on admission about their beliefs/spirituality. The hospital had access to chaplaincy, if requested by a patient.

## Understanding and involvement of patients and those close to them

- Surgical patients on the ward told us they understood their care and treatment and had enough opportunities to discuss their surgery and the risks involved.
- The staff kept patients well informed, prior to and during their surgical procedure. Some patients told us that the ward team had phoned their relatives to reassure them that they had returned to the ward safely. One patient who was ready for discharge described how they had sufficient information regarding their post-operative care and they were expecting a visit by the pharmacist before discharge.
- Patients with infections were given contact details to be able to contact the lead infection prevention and control nurse for advice or reassurance post discharge.
- One patient who spoke with us felt they needed more time to speak to their consultant, saying 'he just came and went quickly'. We discussed this with the ward sister who was trying to get the patient a further visit.

## Emotional support

- Ward staff showed sensitivity towards the emotional needs of patients and their relatives. At a ward handover meeting, we observed staff discussing a patient's anxieties and how they could best support them.

## Are surgery services responsive?

Good 

We rated responsive as good

## Service planning and delivery to meet the needs of local people

- Spire Southampton hospital provided elective surgery to NHS and private patients for a variety of specialities, which included orthopaedics, ophthalmology, general surgery, gynaecology and urology. The hospital actively worked with the local clinical commission groups (CCGs), the NHS acute trust and NHS England in the planning of services, including specialist services, for NHS patients.
- Spire Southampton hospital was commissioned by the CCGs to provide NHS choose & book services, weight management and was funded centrally by NHS England to provide bariatric services.
- The hospital had a joint venture with the local NHS trust to provide robotic surgery for the local population. Spire Southampton hospital had purchased a surgical robot and consultants using the robot facility at Spire

# Surgery

Southampton also worked at the local NHS hospital and were able to refer suitable patients to the service. A new theatre had opened specifically to house the robotic services.

- The hospital met regularly with the local NHS trust and supported waiting list initiatives for breast surgery, spinal surgery and general surgery.
- The CCGs monitored the hospital's performance for NHS patients at quarterly contract meetings. The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments whose post-operative needs were met through ward-based nursing care or for a short post-operative stay within the ITU. The hospital routinely planned surgical lists between Monday and Friday, with occasional lists running on Saturdays to meet demand. The hospital offered patients a choice of admission dates to best suit their needs.
- The hospital had a regular weekly planning meeting every Monday to look at the patients for admission. Operational staff attended this in order that the patients' care needs were planned for appropriately.
- A new theatre coordinator post was developed and recruited to within the past year, to support theatre staffing and planning to meet increased demand for services.
- There were single rooms available for patients with en-suite facilities and a few areas, such as recovery or the day surgery ward, had larger bays. Staff we spoke with were aware of the need for segregation to preserve single sex accommodation.
- There was a larger patient room available for patients who had additional care needs, for example, a carer to stay with a patient.

## Access and flow

- The hospital accepted referrals from local NHS trusts. Referral to treatment times (RTT) were measured for NHS patients. Less than 90% of patients were admitted for treatment within 18 weeks of referral from December 15 to June 16 in the reporting period (July 15 to June 16).
- The hospital had discussed the issues with the local clinical commissioning group (CCG) and explained that

a new triage and treatment pathway had adversely affected the RTT. This was due to delays in patients having to have scans, physiotherapy and the podiatry pathways prior to the referral being received. This meant that referrals were not received in reasonable timescales to achieve the 18 week pathway. Following the discussion with the commissioners, the RTT had recently improved.

- There were 8,554 visits to theatre and 5,871 day case attendances in the reporting period July 2015 to June 2016. The majority of surgical cases were orthopaedic.
- From July 2015 to June 2016, the hospital had cancelled 33 procedures for non-clinical reasons. Of these, 32 patients were offered another appointment within 30 days of their cancelled appointment. Current national guidance relating to hospitals managing non-clinical patient cancellations indicated that another appointment should be offered within 28 days.
- From July 2015 to June 2016, there were 50 unplanned patient readmissions, which was 0.46% of total patient discharges, and although higher than other independent hospitals was within the CQC expected variance. During the same time period, there were 38 unplanned patient returns to theatre, which was 0.35% of total patients. This was higher than other independent hospitals.
- From July 2015 to June 2016, there were 12 patients who had unplanned transfers to another hospital. This was not high compared to other independent hospitals
- The hospital did not admit patients routinely the day before surgery unless clinically indicated. If the patient's home location was a problem for early morning admission, then hotel facilities would be used overnight.
- The hospital had redeveloped the day surgery unit to improve capacity and increase day case provision. This had been open for two weeks at the time of the inspection. The unit was open from 8am to 8pm. The hospital audited day case 'conversions' to overnight inpatient stays. The latest data available for July to September 2016 showed that 14 patients had needed to stay overnight due to pain, drains still being in place and a lack of mobility. Five of the 14 had no reason recorded

# Surgery

for their unplanned overnight stay. It was reported that inpatient beds were 'always available' if a day surgery patient deteriorated and needed to be admitted overnight.

- At the time of the inspection, all day surgery patients were admitted at 8am, which some patients felt was inappropriate. For example, a day surgery patient was told to arrive for 8am but was not seen until 9am and felt they had not been kept informed of the reason for the delay.
- The lead nurse for discharges had designed a patient information leaflet and checklist for discharge; patients were given them on admission to help them prepare for their discharge. The hospital planned to discharge patients before 11am, this was monitored on the hospital scorecard. The latest rates showed 43% compliance against a target of 55%.
- Each ward submitted a patient length of stay breach report every week; this was measuring actual length of stays against the expected. The hospital recorded 30 patients who breached their expected length of stays during the previous month (September 2016). This could be a problem when the hospital was paid for a pathway of certain length of stay.
- Wards each had a discharge resource folder containing referral numbers for both NHS and private patients. The ward staff discussed patients' discharge progress at 9am daily, via the patient status boards to identify any issues
- Theatre staff worked flexibly to ensure that scheduled operations went ahead where possible. During our inspection, theatre staff told us they routinely worked late in theatre on at least 2 evenings per week. 8 pm was the latest permitted time to call for a patient, after this time only the on call team were available for emergencies.
- The theatre recovery staff told us they were concerned that were not alerted and prepared for a patient coming out of theatre. We were told that 'patients just turn up' without any prior communication as there was no formal process for informing them.

## Meeting people's individual needs

- We saw that since the last inspection, the hospital had made many improvements in this area. Staff knew how to support people with complex or additional needs

and made adjustments wherever possible.

Pre-assessment identified patient's individual needs in relation to communication, dementia or learning disability so that arrangements for additional support could be made. They had leaflets about how to prepare for their procedure before and after the operation and their discharge. Although, staff told us there were rarely patients who had complex or additional needs.

- All written information, including pre-appointment information and signs were in English. These were available on request in other formats, such as other languages, pictorial or braille, through a national contract. Staff described there were rarely patients whose first language was not English. Staff could organise face to face or telephone translation as necessary if the patient's communication needs were highlighted as required.
- Pre-operative assessment also identified and documented Jehovah's Witnesses, so staff could respond to their wishes appropriately. This may mean using specific equipment in theatre to avoid them needing a blood transfusion.
- There was a consultant ortho-geriatrician to assess patients when staff identified a need. They also assessed any orthopaedic patients living with dementia, prior to planning surgery.
- The PLACE score for the hospital for the period February 2016 to June 2016 was lower than the England average for dementia (36% compared to 80%). The hospital had identified dementia care as an area for improvement and had a hospital dementia lead, champions and a dementia action plan.
- The dementia lead described setting up a new staff group to raise awareness in the hospital; and a new database of patients living with dementia. Most staff had completed dementia awareness training and staff we spoke to could describe adjustments they would make to support people living with dementia. There was a designated patient's room on Ward 2, which was large enough to accommodate the patient living with dementia and their carer. There were resources available, for example a sensory bag and a dementia box that could be used to support patients living with dementia. Staff told us that there were sensor mats (to



# Surgery

alert staff of patient's movement) on order but no additional signs yet. (Picture signs such as for showers and toilets can assist patients living with dementia with recognition)

- The hospital also had nominated dementia champions throughout the hospital. Staff told us that they had very few patients living with dementia admitted to the hospital due to the effective screening in preoperative assessment.
- A nurse described how they had supported an adult with a learning disability, involving the patient and the carer and offering extra reassurance throughout the procedure.
- The day surgery unit occasionally admitted 16-17 year old young people after a paediatric nurse had assessed their suitability for inclusion in an adult area
- The chef catered for the needs of patients with specific dietary needs for religious, cultural or medical reasons. A patient who was not able to eat solid food said that nurses brought them crushed ice whenever they wanted it. Bariatric gowns and equipment were available in the hospital.
- However, in the Patient Led Assessment of the Care environment (PLACE) the hospital scored from February 2016 to June 2016 82% for ward food against the England average of 92% for other independent hospitals.

## Learning from complaints and concerns

- The hospital employed two customer relations co-ordinators who visited patients daily to gain patient feedback. The senior managers received the feedback and tried to resolve patient complaints before discharge. Staff told us that complaints and any positive feedback were discussed at ward meetings.
- The hospital informed us that all patients were actively encouraged to complete a patient satisfaction survey that encouraged feedback. Patient feedback forms were part of the standard room set up for all admitted patients, and left on the bedside table.
- The hospital had received 78 complaints from July 2015 and June 2016. One had been referred to the independent Healthcare Sector Complaints Adjudication Service for support in its resolution.

- All complaints were acknowledged in three days, the wards described how they had invited relatives back for a meeting to discuss issues and changed practice as a result of their comments. However, responding to level 1 complaints within 20 days was only 58% achieved against an organisational target of 75%.
- Staff were able to give examples of learning from complaints. For example, housekeepers were now changing inpatient sheets every day by after a recent complaint from a patient's relative regarding stained sheets. The new day surgery unit described receiving five recent complaints about noise; mainly from televisions, the response was to get patients WIFI headphones, these were on order when we inspected. The day surgery unit also reminded medical staff to lower their voices when speaking to patients.
- Minutes of meetings we reviewed showed complaints were discussed at monthly hospital management team (HMT) meetings and the hospital monitored complaints quarterly to identify trends.

## Are surgery services well-led?

Requires improvement 

We rated well-led as requires improvement.

## Leadership / culture of service

- The hospital director had been in post for the past four years, and was previously a clinical matron at the hospital. Ward staff told us that the senior management team were regularly visible on the wards. The hospital director had weekly walk arounds of ward areas. The matron visited the wards at least daily. All ward sisters were managed by the deputy matron.
- Most staff we spoke with felt there was an 'open door' policy within the hospital. There were staff forums, staff questions, newsletters and the departmental meetings for dissemination of information.
- Ward staff we spoke with were proud to work at the hospital and proud of the standard of patient care they delivered. Staff meetings and handover periods provided opportunities for senior nurses to engage with their staff and ensured information passed to staff. This

# Surgery

was confirmed by records of staff meetings and discussions with staff. Staff were encouraged to develop and there were examples of opportunities on notice boards.

- Some ward staff told us how they were supported to work flexibly, one staff member had a bank contract which allowed her to flex her working and living overseas.
- We witnessed surgical ward and departmental sisters who were visible and accessible and those we spoke with were visibly proud of their areas.
- The deputy matron described how staff were given opportunities to develop their leadership skills, with a course called 'stepping stones'. The skills and knowledge intended to support staff in implementing and embedding any new developments.
- The hospital supported leaders to improve services by working with others outside the hospital and organisation. For example, there was close working with the local NHS hospital in cardiothoracic surgery, and sharing recent educational events in robotic surgery with the local university and NHS trust.
- The MAC chair told us that the MAC was a useful link between consultants and the management team. He described a positive reporting culture that worked well and open communication between the MAC, hospital director and matron. The MAC reported to be committed to its responsibilities and provided constructive challenge.
- The hospital director had recognised the need to support leadership in theatres, due to the increased theatre capacity, staffing and activity. The hospital was actively recruiting a deputy theatre manager. There was a new endoscopy lead in post, and a new lead for the catheter laboratory had been appointed reporting to diagnostic imaging. These posts released the theatre manager from some duties.
- However, some theatre staff shared concerns over the culture within theatres, and spoke of an excessively high workload. Some staff felt under constant pressure to manage the workload, with examples of frequent list overruns and missed breaks. They spoke of the management being aware of the work pressure but no actions being taken.

## Vision and strategy for this core service

- The hospital displayed its vision, values and mission statement publicly for staff and public to see. The mission statement was "to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care." The vision was "to be recognised as a world class health care business". Their values were detailed as "Caring is our passion. Succeeding together, driving excellence, doing the right thing, delivering our promises and keeping it simple."
- All staff we spoke with were aware of the mission, vision, values of the hospital and wider organisation, and demonstrated commitment to them in their care practices and personal development plans within their appraisals. Staff spoke passionately about the service they provided and the care they offered to patients.
- The hospital had agreed a three-year business and clinical strategy, which included six areas of focus. Three of them were for example, to increase self-paying private patients, to develop off-site diagnostics, and improve patient satisfaction.

## Governance, risk management and quality measurement

- Following the previous CQC inspection in 2014, the hospital had been working to an action plan to address the issues raised with the management team. These included for example actions for children's services, the management of medicines and infection control processes.
- The hospital had a clear governance meeting structure. Local committees such as the patient and safety quality group or clinical effectiveness meeting fed into one of three core meetings, which in turn fed into the senior management team.
- There was a governance structure and meetings designed to provide assurance at all levels of the hospital. There was a senior management team, a hospital management team and clinical governance committee that were informed by a range of subcommittees covering key areas of quality and risk. The clinical governance committee minutes showed detailed discussion and actions against each of the CQC

# Surgery

key quality domains. The clinical effectiveness and audit group met regularly and identified if actions arising from incidents were not being processed and additional support offered.

- The clinical effectiveness and audit group discussed the Duty of Candour register.
- The patient safety lead was also associate medical director at the local NHS trust; Spire Southampton hospital employed them for a small proportion of their time. They were a member of the clinical governance committee and the medical advisory committee.
- Consultants represented specialities at the quarterly medical advisory committee (MAC). The newly appointed chairperson for the MAC was an orthopaedic consultant. All the consultants received the minutes of each MAC to promote learning and understanding. The MAC minutes showed discussions included key governance issues such as incidents, complaints and practising privileges.
- Surgical team meeting agendas and reports were standardised and included a review of risks, team leads presented monthly governance templates and quarterly reports at governance meetings.
- There was a hospital wide risk register, divided into operational groups, managed by the risk manager. Actions and timescales to manage some of the risks were in place. A quarterly controls and assurance board discussed the high-level risks. Managers discussed clinical risks at the clinical audit and effectiveness committee and non-clinical risks at the health and safety committee. It was not clear why some risks had actions and timescales and some did not. Some of the higher scoring risks had no actions or time scales, which did not provide the assurance that the hospital had taken actions, to lessen the risks.
- Surgical departmental risk registers commenced in March 2016. The governance lead provided training, and worked with heads of department and attended team meetings to keep the registers updated. The risk registers were reviewed at clinical effectiveness committee to check risk ratings and appropriate actions.
- The surgical wards and departments had local risk assessments in folders, to manage risks within their

departments. The health and safety coordinator managed these and collated all risk assessments to monitor their compliance actions. There were 'first sight' folders for staff to look at as a priority which included learning from incidents or alerts for dissemination, information about risks, clinical score card and meeting minutes.

- Senior staff attended the clinical effectiveness meeting; the minutes showed that incidents, risk register and policy changes or updates were discussed. The senior staff also attended the quarterly governance meeting. Items discussed included action plans, incidents, unplanned patient readmissions or transfers, unplanned patient theatre revisits and day case conversions to overnight stays. There were local morbidity and mortality meetings held for some of the specialities such as orthopaedics and bariatrics. The critical care manager attended the local cardiac mortality and morbidity meeting in the local NHS trust, to discuss specific Spire Southampton hospital patient cases.
- The deputy matron also held a monthly meeting for all departmental sisters, to share any learning from incidents and complaints across the hospital. Updates also took place relating to human resource issues such as performance management of staff.
- The deputy hospital matron led a daily internal multidisciplinary team huddle, which included heads of department to discuss operational management and any risks.
- The clinical governance manager had recently developed an action plan tracker for all outstanding actions from the governance framework meetings. There were plans to use this to improve implementation of all actions, inform conversations between the governance leads and heads of department and to inform further development of departmental risk registers.

There were regular monthly meeting between the RMOs, the matron, governance manager and deputy matron to discuss any concerns.

- However, there were themes of poor practice, for example, patients' risk assessments not being updated, cleanliness and infection control, medicines management, VTE compliance, theatre log recording

# Surgery

and poor equipment maintenance. The staff had undertaken audits and were aware of some of the issues but had not addressed them. We were therefore, not assured that quality monitoring and risk management was effective due to these concerns being known but not addressed or linked to the risk registers governance.

## Public and staff engagement






- The hospital used various means of engagement with patients and relatives, including the 'friends and family test' and inpatient satisfaction surveys. Customer service coordinators collected and collated patient satisfaction daily. This led to immediate local improvements and longer-term plans such as refurbishments. The hospital had held open patient forums. The hospital had noted that in June 2016, two patients attended although 12 were expected. The feedback was positive.
- Due to the low attendance, four non-clinical hospital staff telephoned twenty patients at a subsequent patient forum in October 2016. Following this feedback from patients, the hospital identified some actions. These included changes to the admission process and a review of information sent prior to admission. The hospital had planned the next telephone patient feedback forum for December 2016. Some of the patient feedback comments that CQC received, showed patients found the restaurant central corridor very noisy, particularly at night, which could disturb patients
- The surgical specialties had also held specialty specific education evenings for patients in the hospital restaurant.
- The hospital director held staff forums. This enabled staff to hear the latest news and business developments, and ask questions. The hospital published a monthly newsletter with information for staff about changes in staffing, and staff participation in charity and social events. 'Hot gossip' emails and 'Whitney's words' were examples given of positive communication channels by staff.

- The operations manager held regular meetings to update staff on the hospitals' development plans. Day surgery staff confirmed they had felt well informed throughout the re-development of the day surgery unit.
- Staff completed an annual engagement survey by an independent third party to allow for anonymity, and national benchmarking of results. The clinical review undertaken by the provider in May 2016, commented that in 2015, 77% of staff at Spire Southampton Hospital completed the survey and the overall score was 70%. That was a 3% decline on the 2014 results and below the Spire Healthcare Group average.

## Innovation, improvement and sustainability

- The service was implementing the NHS Accessible Information Standard. From 31 July 2016, all organisations that provide NHS care are legally required to follow the Accessible Information Standard. The standard aims to make sure that people who have a disability, impairment or sensory loss have information that they can easily read or understand with support so they can communicate effectively with health and social care services.
- There were plans to move the pharmacy to the outpatients department to improve the accessibility for patients.
- The recent new theatre opening and adoption of the robotic service had been an opportunity for closer working with the local NHS trust, staff felt that there would be further opportunities for liaison within this service.
- There was a plan to admit and undertake admission assessments for all patients within an expanded day surgery ward, to enable ward staff to focus on patients for discharge in the morning. However, it was not clear how the privacy and dignity of those patients having day surgery was going to be maintained, when the area would be admitting other patients to the same area.

# Critical care

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

## Are critical care services safe?

Requires improvement 

We rated safe as requires improvement

### Incidents

- Staff knew how to report incidents using the hospitals electronic incident reporting system. They understood the different types of incident they needed to report.
- Between July 2015 and June 2016, the critical care department had reported 44 clinical incidents or near misses. Of these, two were serious incidents for which root cause analysis processes were carried out. We viewed a sample of root cause analysis documents which showed incidents were fully investigated. Where required, actions plans were developed and followed to ensure improvements in practice were embedded.
- Staff told us they received feedback about incidents they reported. Records from unit meetings showed staff reflected on incidents and identified points for learning.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents. Staff understood their obligations towards the Duty of Candour legislation. The electronic incident reporting processes included prompts for staff to consider whether process needed to be followed. There was a duty of candour checklist, that ensured staff

followed all steps in the process. Examples given by senior staff of when they had invoked duty of candour procedures showed they had a good understanding of the process.

- Records and discussions with staff showed the unit held meetings where they discussed mortality and morbidity incidents on the unit. The meetings were held at the local acute NHS trust. This meant staff reflected on care and treatment and any subsequent learning was shared both across Spire Southampton Hospital and the local NHS acute trust.

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

- The Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (VTE) which are blood clots in veins. Information was submitted for NHS patients, but this was not used as a tool within the hospital for monitoring clinical quality.
- The hospital collected the same information as part of the hospital's clinical score card. Data on the scorecard showed there were two incidents of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) during the period April 2016 to August 2016, and no new pressure ulcers, catheter or urinary tract infections. Detail on the scorecard was not broken down to identify incidents by clinical area.
- Records of critical care team meetings showed all incidents were reviewed, and this identified no VTE, PE or pressure ulcers for the period June 2016 to September 2016.



# Critical care

- The VTE screening rate target of 95% for the period April to August 2016 was consistently achieved across the hospital.
- Results from the hospital scorecard relating specifically to the critical care unit were not displayed in the unit, so visitors and patients did not have access to this quality information. Staff knew about the quality information from attending unit meetings and reviewing records of the meetings.

## **Cleanliness, infection control and hygiene (only include if there is evidence relevant to this core service)**

- The hospital had a service level agreement with the microbiology service at the local acute NHS trust. Staff reported they received good input and prompt support from the microbiologist team in relation to managing and preventing infections.
- If a patient was identified as having a potentially communicable infection, a side room facility was available to reduce the risk of spread of infection. The side room had an air handling to reduce the risk of air contamination into other areas of the unit.
- Patients, who were identified as needing an isolation room with this airflow system at their pre-admission assessment, were referred to alternative providers who had such facilities. If a patient developed an infection during their admission to the hospital that required the specified airflow system to reduce risk of cross contamination, staff made arrangements for the patient to be transferred to the local acute NHS hospital that had such facilities.
- There was no clean clinical room on the unit. This meant equipment for sterile and clean procedures had to be prepared in the open area in the unit where there was traffic of people, patients and equipment. This presented an increased risk of infections for patients. However, data did not indicate hospital acquired infections occurred as a result of this practice. Staff had assessed the risk presented by the lack of a separate clean clinical room on the unit. This detailed action staff took to lessen any risks posed to patients.
- Records from the infection control and prevention meetings in February 2016 and May 2016 showed staff on the critical care unit consistently followed the

hospital's hand hygiene and bare below elbows policies. A hand washing technique audit carried out in the critical care unit and recovery area for the period January to March 2016 showed that all staff washed their hands in line with recommended techniques.

- Handwashing facilities were available throughout the unit. This included two wash basins on the open ward, a wash basin in the side room and hand gel sanitisers by bedsides and strategic positions throughout the unit. We observed all staff washed their hands before and after attending to patients.
- Personal protective equipment, such as disposable gloves and aprons, were easily accessible for staff. We observed staff wearing protective equipment when delivering care and treatment to patients. Staff disposed of this equipment after completing a task of patient care or treatment, which reduced risks of cross infection.
- There was a cleaner dedicated to the critical care unit and recovery area. They maintained a cleaning audit folder that evidenced daily and weekly cleaning of the unit and bed areas.
- At the previous inspection, cleaning equipment was stored in an area that posed a risk of cross contamination of equipment. The hospital had addressed this risk. Staff now kept the cleaning equipment on a dedicated trolley, which when not in use was covered and stored on the landing of a stairwell that was only used by hospital staff.
- Bedside curtains were disposable and replaced every six months in line with recommended guidance.

## **Environment and equipment**

- The critical care unit had seven beds, six beds in an open ward setting and one bed in an isolation room. Staff used bed spaces flexibly to accommodate patients who required level 2 or 3 support.
- Bed spaces and facilities did not fully comply with current Department of Health building note 04-02 for Critical Care Units published in March 2013. Bed spaces did not have individual wash-hand basins, there was no ceiling hoist and bed spaces did not meet the recommended minimum space of 25.5 metres squared.

## Critical care

The bed space size had the potential to make access to the patient difficult in an emergency. However, because the unit was built before the publication of this building note, the hospital did not have to comply with it.

- Despite that, the hospital had identified there were risks, such as risks of moving and handling injuries to patients and staff and cross infection due to the closeness of bed spaces. Staff on the unit had completed a risk assessment that identified the risks and actions taken to mitigate the risks. Staff reported no concerns with the bed space available. There were no reported incidents of cross infection relating to the closeness of bed spaces, patients reported privacy and dignity was maintained and there was appropriate equipment available for each bed.
- All equipment was listed on a corporate computerised maintenance management system. The information included frequency of required maintenance (in line with manufacturer's guidance and best practice) and the details of who held the maintenance contract agreements. The system flagged up when maintenance was due.
- There was a contract for safety testing of electrical equipment, this was conducted on an annual basis. The hospital maintained a record of these checks.
- Staff knew who to contact if they identified broken equipment or identified equipment that needed attention. Staff said the maintenance team attended to faulty equipment promptly.
- The critical care unit had ready assembled trolleys, containing all the stores and equipment supplies to prepare a bed space once a bed became vacant. Records showed staff used the equipment checklists, to replenish and check the trolleys were ready for immediate use.
- Resuscitation equipment was available on the unit and a difficult airway trolley was available in the adjacent theatres. We saw staff completed daily checks of the resuscitation equipment.
- Staff carried out audits of the resuscitation equipment every three months. The audit for the period January,

February and March 2016 showed staff completed all daily checks of the equipment, all equipment was in date and the equipment was accessible without any obstructions.

- Due to limited space in the unit, some equipment was stored in a storeroom shared with the operating theatre department. We saw this room was overfull; equipment was stored in a disorganised and cluttered manner, which posed risks of injury to staff accessing equipment in the room and delays in accessing equipment.
- Critical care equipment was stored on a freestanding shelf unit. The unit was not fully stable and there was a risk that might topple when staff were getting equipment off it. When we raised this with the clinical lead, they arranged for the unit to be placed against the wall for additional stability. Staff had to negotiate stepping over and around other equipment to access the shelves. Staff had completed two risk assessments for the use of this area. One of the risk assessments detailed to reduce risks, "Walkways are kept clear of clutter at all times." At the time of the inspection, staff did not keep the walkways in the storeroom clear.
- The unit did not have a formal equipment replacement programme. At the time of the inspection, the unit considered replacing equipment if advised to do so by the company who serviced the equipment. The hospital was rolling out a software programme in partnership with another organisation that would rate the condition of equipment and support the development of a planned equipment replacement programme.

### Medicines

- Staff administered medicines following national guidelines and the Spire Hospital's medicine policy.
- Medicines were stored in locked cupboards with the exception of medicines stored in the medicines fridge. Staff explained this was so staff could access those medicines in an urgent situation and they explained that staff were always in attendance. There was no formal assessment completed by staff to identify any risks this practice might pose. Despite staff stating there was always a member of staff present, at times when there were no patients on the unit, there would be not always be a member of staff on the unit. This meant the medicines fridge would be unlocked and unattended.

# Critical care

- Staff recorded the temperature of the medicines fridge daily. However, the records showed the temperature was consistently outside the recommended range and there was no evidence any action was taken to address this. This meant there was a risk that patients were receiving medicines that were not fully effective. We raised this with the unit manager at the time of the inspection and when we returned to do the unannounced inspection we saw action had been taken and the medicines fridge was within the recommended temperature range.
- Nursing staff had responsibility for stock control, and the ordering and receiving of medicines. A member of the hospital pharmacy team visited the ward each week day, Monday to Friday. They checked patient prescriptions were completed accurately and patients were prescribed the most appropriate medicines in the correct doses for their conditions.
- Patient Group Directions (PGD) provide a legal framework that allows some registered health professionals to supply and administer a specified medicine(s) to a pre-defined group of patients, without them having to see a doctor. The PGD should be used in situations that offer an advantage to patient care, without compromising patient safety. The critical care unit had PGDs for the use of intravenous and nebuliser saline and oxygen by nursing staff. These were in date, appropriately authorised and had been signed by staff working from them.

## Records

- Patients had one set of records and all staff, including consultants, wrote in the same set of records while the patient was an inpatient. Although all entries were dated and signed, not all entries detailed the time they were made.
- Pre-printed protocols and pathways of care were added by staff as required. Patients had appropriate pathways in their records with the exception of neuro surgical patients who were placed on a spinal surgery pathway.
- Staff had completed an assessment to identify the risk to patients of not having a neurosurgical pathway. The assessment detailed actions staff were taking to mitigate risks to the patient.

- In discussions, staff evidenced they were aware of this shortfall. They demonstrated they knew how to assess patients for the risk of neurological deterioration and the actions they needed to take in the event of neurological deterioration occurring. Records we looked at confirmed staff assessed patients for risk of neurological deterioration.

## Safeguarding

- Records provided by the hospital showed all critical care staff had completed combined level 1 and 2 safeguarding adults and safeguarding children training.
- The children's safeguarding policy for the hospital detailed that all clinical staff were required to complete level three safeguarding children training. The hospital provided details about staff compliance with this. The records showed that only two members of the critical care nursing team had completed this training. However, staff we spoke with were aware of the need to complete this training and we saw evidence they had booked to attend this training.
- The children's safeguarding policy provided clear details about what action staff needed to take if they had any safeguarding concerns about children. This included contact details for the relevant local authorities who investigated child safeguarding concerns and details of the children's safeguarding leads in the hospital.
- The hospital had a local safeguarding adult's policy, which referenced local authority safeguarding contacts, who the adult safeguarding leads were at the hospital and provided clear instructions about what action to take if staff had any safeguarding adults concerns. Staff demonstrated a good understanding about safeguarding adults and children and knew who the children and adult safeguarding leads were for the hospital.

## Mandatory training

- Information provided by the hospital showed that all critical care staff were up to date with their mandatory training for 2016. The information detailed mandatory training included fire safety, health and safety, infection control and prevention, safeguarding vulnerable adults, safeguarding children, moving and handling, safe transfer of patients, information governance and management of medical gasses.



# Critical care

- Staff said they had sufficient time allocated to complete mandatory training.

## Assessing and responding to patient risk

- Staff completed risk assessments about the risk of falls, pressure ulcers, venous thromboembolisms (deep vein blood clots known as VTEs) and use of bed rails for each patient. Where staff identified risks, the risk assessment tool supported staff to take appropriate action to reduce the level of risk for the patient. However, review of patient records showed that VTE assessments were not always fully completed.
- Staff on the unit used either observation charts that were specific to the needs of patients receiving level 3 critical care or National Early Warning Score charts for patients receiving level 2 care. Consultant surgeons and intensivists gave written instructions about the parameters for each patient's observations and instructed staff about the actions to take if outside these parameters. This included altering medicine doses and contacting medical staff.
- Patient pathways and observation charts included triggers for identifying patients developing sepsis, and guidance for the management of patients with sepsis. Staff competency assessments, included the management of patients with suspected or actual sepsis.
- 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. The outreach service did not fully meet the national guidelines regarding the type of service and skills of critical care outreach staff. However, the hospital had developed their critical care outreach service to meet the needs and demands of the hospital service.
- The critical care outreach service followed up patients on wards within 24 hours of their discharge from the unit. Discussion with staff evidenced that due to workload on the critical care unit, it was not always possible to attend the wards to carry out follow up outreach work and sometimes the follow up was a telephone conversation with the nurse on the general ward. The ward manager told us that sometimes the workload on the critical care unit meant there was no capacity to carry out telephone follow up calls. They told us they escalated these situations to the matron or deputy matron, who would follow up the patients on behalf of the critical care outreach service.
- The critical care outreach team also reviewed patients that ward staff identified as having raised NEWS score (National Early Warning Score system) and escalated care as required. The outreach nurse could administer oxygen and fluids in an emergency under a PGD directive. They were able to admit patients to the critical care unit for closer observation and monitoring if required. Staff on the wards considered the outreach to be a good and an invaluable service in supporting the care and treatment of a sick patient and providing support and education to ward staff.
- At night, the critical care outreach nurse played a triage role, which is not a specific role of a critical care outreach service. Staff on the general wards referred queries about patient care and requests for RMO assistance through the outreach nurse. In some circumstances, the outreach nurse could carry out investigations such as blood tests and examinations so the RMO or consultant called had all the necessary information to make a clinical decision. The outreach nurse collated all RMO requests, so the RMO was not repeatedly contacted. The outreach nurse also carried out cannulation for patients who had lost their intravenous access overnight. Staff told us the service they could provide for the hospital depended on the demands of the critical care unit workload. This meant the level of support they were able to provide to the rest of the hospital was variable.
- The hospital had not carried out an assessment to identify if there were any risks to patients in relation to the variable availability of the outreach service.
- For patients whose conditions deteriorated to the extent that multi organ support was required, a service level agreement was in place with the local acute NHS trust which allowed patient transfers to their critical care facilities. Some patients had a contractual referral back to the NHS if their condition meant they required critical care.
- The hospital resuscitation team consisted of the RMO, critical care outreach nurse, sister or staff nurse holding the hospital bleep, a porter and an operating

# Critical care

department practitioner. The hospital undertook adult cardiac arrest scenario audits, which were simulation exercises to assess the emergency response for a collapsed patient in clinical areas. We saw records evidencing the hospital's resuscitation lead reviewed the exercises and learning points were identified and shared with staff.

## Nursing staffing

- There was one nurse manager, six critical care sisters and eight critical care nurses employed on the unit.
- In accordance with the guidelines for the provision of intensive care service, patients requiring level three care were cared for on a one to one basis. Patients requiring level two care were cared for on a two patients to one nurse ratio.
- The nursing establishment was calculated on the unit occupancy of four patients requiring level three care and three requiring level two care with reduced weekend activity. This came to a total of 18 whole time equivalent nursing staff. If needed the hospital used bank nurses in order to maintain adequate staffing levels. Staff also worked flexibly to ensure the unit was staffed safely, working extra shifts or hours, if required. Staff worked on the wards or took time back when the unit was quiet.
- Staff told us agency staff were rarely used. The preference was for staff to work flexibly to fulfil vacant shifts or use regular bank staff rather than agency staff. For the period, 1 July 2016 to 1 October 2016 there had only been one shift where an agency nurse had been employed. Agency nurses completed an induction checklist that covered the location of essential emergency equipment, fire safety procedures, confidentiality agreement and staff facilities.
- The Guidelines for the Provision of Intensive Care Services (2015) and the British Association of Critical Care Nurses for Nurse staffing in Critical Care (2009) detail there should be a supernumerary clinical coordinator (sister/charge nurse bands 6/7) on duty 24 hours a day in units that have more than six beds. The unit did not meet these guidelines. The nurse who was rostered to be in charge of the shift was not always supernumerary. This meant they had to look after a patient, as well as coordinate the shift, provide support

to the staff team, carry out the outreach role and carry the hospital arrest bleep. At night they carried the hospital bleep and took calls that would have otherwise gone straight to the RMO.

- Nursing staff were supported five days a week by an administrator and a patient services assistant who undertook housekeeping and hostess duties.
- There were sufficient number of physiotherapist staff to meet the needs of patients. Records showed and staff confirmed all patients were seen daily by a physiotherapist.
- There was a transfer information form that was completed by the nursing staff for patients who were transferred to the wards. The sheet was intended as an aid to handover essential information. We observed a handover that was structured and followed the format of the transfer form.

## Medical staffing

- All patients were admitted under the care of a named consultant. Anaesthetists with a special interest and training in critical care, known as intensivists, supported the consultants with the care and treatment of patients.
- There were 10 cardiac intensivists and eight general intensivists with practising privileges that allowed them to work with patients in the critical care setting.
- Most patients admitted to the critical care unit were admitted as elective patients following surgery. This meant they were always assessed by a consultant within 12 hours of admission to the unit. Staff confirmed that patients admitted to the unit from the general wards due to deterioration in their condition, were reviewed by an appropriate consultant within 12 hours of their admission.
- Intensivists had active involvement in the management of patients who required level 3 critical care. Patients who required level 2 care had their care and treatment managed by their admitting consultant with support and advice from an intensivist if needed.
- Whilst Intensivists were not on site at the hospital 24 hours a day, sufficient arrangements were in place. There was an on call rota for both general and cardiac intensivist, which ensured an intensivist was available for advice and support at all times. The Spire Healthcare

## Critical care

consultants were required to live within 45 minutes of any emergency request as part of their practising privileges agreement. There was a resident medical officer (RMO) onsite twenty four hours per day to manage emergency situations who called the consultant as needed. However, staff said consultants with patients on the critical care unit had to be able to access the unit within 20 minutes. This met the standards of 30 minutes set out in the Guidelines for the Provision of Intensive Care Services (2015).

- General intensivists did not routinely keep any patients requiring level 3 care in the critical care unit overnight. If a general patient required intubation and ventilation overnight, the usual practice was that the hospital transferred them, using the service level agreement or contractual agreements, to the critical care services in the local acute NHS trust.
- Cardiac intensivists occasionally had patients intubated and ventilated overnight. If the patient was stable the intensivist provided support remotely and would come into the hospital if there was a problem. If there were concerns or the patient was unstable, the intensivist stayed at the hospital overnight to provide clinical support.
- Nursing staff said intensivist support was always available and they were very responsive when support and advice was requested.
- There was a resident medical officer (RMO) in the hospital at all times. All RMOs employed were doctors at specialist registrar level and trained in advanced life support. Nursing staff said they had good support from the RMO and felt the RMO had the necessary skills and experience to support the delivery of care and treatment to patients in the critical care unit.

### Emergency awareness and training

- There was a hospital wide major incident policy that included business continuity plans. The bleep holder for the hospital held a hospital folder that included guidance about the actions that staff needed to take in the event of a major incident or interruption to the service. At night the bleep holder was the senior member of staff on duty on the critical care unit.
- There was no separate business continuity plan for the critical care unit. However, discussion with members of

staff evidenced they understood the action that needed to be taken in the event of an interruption to the service, which could include interruption to the power supply and telephone services. Backup generators ensured the unit had uninterrupted electrical power supplies in the event of power failures and all equipment had back up batteries that could run for several hours.

- In the event of CT facilities at the hospital failing, there was an agreement with the local acute NHS trust to use their CT facilities in urgent situations.
- Staff told us that in the event of a major incident happening in the local area, the unit had an agreement to take stable patients from the local acute NHS trust to facilitate admission of critically ill patients to the trust's critical care facilities.
- Discussion with staff evidenced they understood the actions that needed to be taken in the event of a major incident.

### Are critical care services effective?

Good 

We rated effective as good

### Evidence-based care and treatment (this core service only)

- The unit used national clinical guidelines to inform the delivery of care. We saw staff competency requirements, policies and procedures all referred to National Institute for Health and Care Excellence (NICE) guidelines and the Guidelines for the Provision of Intensive Care Services (2015).
- The unit had a programme of audits to monitor staff adherence to policies and procedures that related to the specified care provided in the unit. These included audits of the management of chest drains, arterial lines, extubation processes and different types of ventilation processes.
- Review of care pathways used on the unit showed they referenced relevant national guidance. This included the detection and management of sepsis.
- However, there was no appropriate pathway to follow for neurosurgical patients. Spinal surgery pathways

# Critical care

were used for neurosurgical patients. While there were some similarities in the patients care needs, risks specific to patients undergoing neurosurgery, such as risks of seizures and cerebral oedema (swelling of the brain), were not identified on the pathway. This had been raised with the hospital at the previous inspection in November 2014. Staff told us the development of new patient pathways was the responsibility of the Spire Hospitals corporate team. Staff understood the corporate team had developed a draft neurosurgery pathway, but it was yet to be made available. This meant there had not been a pathway for staff to use to guide the treatment and care for patients undergoing neurosurgery surgery for the last two years.

## Pain relief

- Staff monitored patient's pain levels. Staff used pain scores on the NEWS charts to monitor the pain and effect of pain relief for those patients who were awake.
- Staff used the internationally recognised Richmond Agitation–Sedation Score, to help identify whether a patient's agitation could be caused by pain.
- The pathway for patients who were intubated and ventilated, included administration of pain relieving medicines.
- Staff explained the process for 'weaning and extubating' patients included the administration of pain relieving medicines as the patient's sedation and other medicines were reduced.
- Patients told us their pain was well controlled and that nurses gave them pain relieving medicines when they needed them.

## Nutrition and hydration

- Patients in the unit were usually only ventilated for a short period of time and required minimal support with meeting nutritional needs. If patients were ventilated for longer periods of time, enteral feeding was commenced after 24 hours. Staff followed protocols and the dietician provided guidance for staff to follow about the patients' feeding regime. A service level agreement with the local NHS trust was in place so staff could access advice and support from a speech and language therapist for patients who had swallowing and eating difficulties.

- While patients were not eating and drinking post operatively, they received intravenous infusions to ensure they were hydrated. Fluid intake and output records were maintained for patients on the unit, as well as food charts where required.
- The hospital had recently signed up to the NHS England Sign up to Safety pledge. As part of their patient safety improvements, the hospital focused on reducing and preventing acute kidney injury. The critical care unit was focussing on ensuring patients, who could, were drinking sufficient water to reduce risk of acute kidney injuries.
- Patients we spoke to who had been patients on the unit said they received sufficient food and fluid whilst being cared for on the unit.

## Patient outcomes

- Critical care transfers of level 2 and 3 patients were monitored quarterly. Between June 2015 and June 2016 there were 10 unplanned transfers of self-funding patients or patients who were funded by insurance policies to the local NHS trust for critical care. This represented less than 0.1% of all discharges from the unit.
- The unit provided data to the Society for Cardiothoracic Surgery in the UK and Ireland. This showed for the period April 2012 to March 2015, survival rates for patients undergoing cardiothoracic surgery at Spire Southampton hospital was 99.6% compared to a national average of 97.5%. The data showed these results were achieved despite the hospital carrying out complex surgery and surgery on a comparatively high risk patient population as well as carrying out straight forward surgery.
- The unit did not participate in a benchmark system to review its outcomes for general critical care patients and the overall service provided by the unit. However, the provider was making arrangements to submit data to the Intensive Care National Audit & Research Centre to enable the service compare their outcomes with other units who provided a similar service.

## Competent staff

- The unit used the National Competency Framework for Adult Critical Care Nurses, developed by the Critical Care National Network Nurse Leads Forum, to ensure staff

# Critical care

had the appropriate skills and competencies to provide safe and effective care and support to patients. We viewed a sample of the competency documents, evidencing staff completed the assessments and were assessed, demonstrating they were competent to deliver critical care effectively.

- Staff we spoke with confirmed they had competencies assessed by one of the senior members of staff and that if they personally did not feel competent about a particular care practice they could approach senior staff for help and support.
- However, there were no role specific competency assessments for staff who carried out the critical care outreach role.
- The unit had an annual education programme that related to the services provided on the unit.
- The Guidelines for the Provision of Intensive Care Services (2015) detail that each critical care unit should have a dedicated clinical nurse educator responsible for coordinating the education, training and continual professional development framework for critical care nursing staff and pre-registration student allocation.
- At the time of the inspection, there was no dedicated clinical educator for the unit. However, to address this, the manager had recently appointed a bank member of staff who was a critical nurse educator in the NHS acute service and was going to carry out the clinical educator role in their bank hours on the unit.
- The hospital supported staff to complete post registration training in critical and high dependency care. At the time of the inspection over 50% of the nursing staff held a post registration qualification in critical care nursing, which met the Guidelines for the Provision of Intensive Care Services (2015). However, although the unit manager had full knowledge about the qualifications of members of staff, such as how many had completed a post registration qualification in critical care nursing, records were not held on the unit to evidence this detail.
- Nursing staff confirmed they received regular supervision and appraisals. We saw records that evidenced supervision and appraisals were carried out.
- Appraisals for consultant surgeons and intensivists were carried out in their main place of work, the local NHS

acute trust. The appraisals were shared with the hospital and processes were established to enable the hospital to provide relevant information for the appraisal process. There were agreements with the local NHS acute trust to share information if it had any impact to the consultant's ability to carry out their role effectively and safely.

- As part of the annual review of consultants practicing privileges, the consultant had to provide evidence to show they had the skills and experience to carry out the planned procedures at the hospital.

## Multidisciplinary working

- Due to the nature of the service provided the unit did not have formalised multidisciplinary working processes as described in the Guidelines for the Provision of Intensive Care Services (2015).
- There was no formalised multidisciplinary ward round. Consultant surgeons and intensivists reviewed their patient's daily with the nurse caring for the patient. Nurses cascaded information, directions and queries from consultants to the relevant member of the multidisciplinary team.
- A named physiotherapist had responsibility for the physiotherapy treatment of cardiothoracic and general surgical patients on the unit. Any orthopaedic patients were treated by an orthopaedic physiotherapist. Pharmacy support was provided to the unit daily.
- For patients who had nutritional or swallowing difficulties, support was available from the local NHS hospital dietician and a speech and language therapist through a service level agreement with the local acute NHS trust.
- We observed effective working relationships with staff working in theatres and staff in the recovery area.
- Patient pathways indicated expected date and time for discharge from the critical care setting to the general wards in the hospital. We observed good communication with wards and the hospital site management team about the availability of beds and times patients could be transferred out the wards.

## Seven Day Working

- Consultants provided a 24 hour on call (off site) service for their patients. The hospital had a policy that all



# Critical care

consultants, when they had patients in the hospital, had to be able to return to the hospital within 45 minutes. This did not meet the guidance from the AHIO. However, staff on the unit said all consultants who had patients on the unit had to be able to access the hospital within 20 minutes of being contacted. Staff reported there were no problems with contacting consultants.

- Records evidenced consultants reviewed their patients daily. However, the records did not evidence consultants reviewed their patients twice a day, as set out in the standards of the Guidelines for the Provision of Intensive Care Services (2015).
- A RMO was available on site 24 hours a day, every day of the week including weekends and bank holidays.
- There were on-call technicians available at all times (day and night seven days a week) to provide support for patients who underwent hemofiltration.
- The radiology department operated from 8am to 9pm Monday to Friday and 8.30am to 1pm on Saturdays. There was an on call CT scan service 24 hours a day and an agreement with the local acute NHS hospital to provide radiology support if there were any problems with the radiology service provision at the hospital.
- Physiotherapy services were available seven days a week. There was no on call physiotherapy service at night. This service had been withdrawn because monitoring had identified the on call service previously provided was rarely used. Nursing staff on the unit had the necessary skills to manage the physiotherapy needs of patients at night.
- A dietician was available to assess and support the care of patients requiring nutritional treatment Mondays to Friday.
- Pharmacy services were available at the hospital 8.30am to 5.30pm Monday to Friday and 9am to 1pm on Saturdays. At all other times an on call service was shared with another Spire hospital.
- Pathology services were available from 8am to 9pm Monday to Friday and 8.30am to 1pm. At all other times there was an on call service. Some specialist pathology service, such as histology for neurosurgery and urgent samples was carried out by the local acute NHS trust under a service level agreement.

## Access to information (critical care only)

- Patient records were held in a single record, which meant all clinical staff could access patient information. The exception to this was detail of the outreach follow up service. Detail about patients seen by the outreach service, following discharge from the unit, were recorded in a separate outreach folder held on the critical care unit.
- Staff used a formalised handover document when patients were discharged from the unit to one of the general wards. This ensured all relevant information was handed over the nursing staff on the ward. Patient's notes followed them through the hospital, ensuring clinical staff had access to them at all times.
- There were formal handover processes, including handover documentation, for patients transferred to acute NHS trust critical care facilities, to ensure all relevant information was provided.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training records evidenced all nursing staff had completed training about the Mental Capacity Act 2005 (MCA). Discussion with staff showed they had a good understanding about their responsibilities towards the MCA. However, in practice there was one example where staff did not fully consider the MCA.
- Patient care pathways included provision for assessment of the use of bedrails. However, records we reviewed did not clearly demonstrate the reason for use of bed rails and there was no evidence of the involvement of patients in the decision to use bed rails. There was no record of patient's consenting to the use of bedrails. This meant the unit could not demonstrate they were using bedrails with the patient's consent or if they did not have consent from the patient, they were taking into account the MCA to ensure bed rails were used in the best interest of the patient. This concern was also identified at the previous inspection in November 2014.
- In all other areas of practice staff demonstrated, they took account of their responsibilities towards the MCA. Whenever possible, patients were asked for their

# Critical care

consent before receiving any care or treatment, and staff acted in accordance with their wishes. We observed staff discussing proposed care and asking patients permission to deliver the care prior to delivering it.

- Patient records evidenced informed consent was obtained prior to surgical procedures being carried out.
- Patients were chemically sedated and ventilated following cardiothoracic surgery for up to four to six hours post surgery. The consultation and consent processes prior to surgery involved discussion about the need for sedation and ventilation post operatively.
- The unit used the nationally recognised Richmond Agitation – Sedation Scale to identify the minimal level of sedation required to ensure the safe and effective care and treatment for patients.

## Are critical care services caring?

Good 

### Compassionate care

- Patients we had conversations with were very complimentary about the care and support received in the critical care unit.
- We observed staff (nursing, medical and physiotherapists) speaking to patients and their relatives in a caring and compassionate manner, providing reassurance and support.

### Understanding and involvement of patients and those close to them

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

- All patients' records we reviewed and patients we had conversations with, received their treatment either through the NHS or through insurance policies. This meant there had been no need to discuss costs of treatment.
- However, records indicated that for patients funded by the NHS they were made aware of specific details in the pathway and contract. If they had unexpected complications post surgery that resulted in the need of an increased length of treatment in a critical care setting, they would be transferred to the local NHS critical care services.

### Emotional support

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

## Are critical care services responsive?

Good 

We rated responsive as good

### Service planning and delivery to meet the needs of local people

- The unit provided care and treatment for patient's undergoing complex elective surgery. The majority of this work was cardiothoracic surgery, but also included neurosurgery, spinal, bariatric and general surgery. The unit did not take emergency admissions, although would admit patients who had unexpected complications following planned surgery at the hospital.
- The hospital had an agreement and worked with the Clinical Commissioning Group (CCG) in the planning of



# Critical care

specific treatment and care for NHS patients. This included some cardiothoracic and spinal surgical patients who required postoperative care and treatment in a critical care setting.

- Surgeons notified the unit about their operating lists (NHS and private) and who would require post operative nursing care. Staff told us this information was provided two weeks in advance so appropriate staffing numbers were arranged.
- The average bed occupancy rate in critical care (June 2015 to June 2016) were for patients requiring Level 3 care was 60% (peaking at 75% in February 2016). For patients requiring level 2 care the average occupancy was 69% (peaking at 87% in November 2015). This was generally below the national established bed occupancy rate of 85% required to ensure functional efficiency of the critical. There had been an increase in the bed occupancy in the unit since the last inspection in November 2014.
- Relatives could get food and drink from the hospital canteen that was located on the same level as the critical care unit. Relatives could use a relatives room located opposite the unit and arrangements could be made for relatives to stay overnight in the room if necessary.

## Access and flow

- The Guidelines for the Provision of Intensive Care Services detail that admission to intensive care services should occur within 4 hours of making the decision to admit. At the Spire Southampton hospital most patients admitted to the critical care unit were planned admissions from the operating theatre, following elective surgical procedures. This meant the decision to admit the patient to the critical care unit was made prior to admission to hospital and prior to the surgery being carried out.
- The hospital told us that although they did not collect any data about the timeliness of admissions to the critical care unit, historically this had not been a problem as all patients admitted to the critical care unit were admitted as soon as a problem was identified. There were no recorded incidents where there had been a delay in admission to the critical care unit.

- Patients were cared for in a planned way and were not discharged from the unit at night.
- Patients were only admitted to the unit as an emergency from the wards following decisions by medical staff or the critical care nurse carrying out the outreach service. Staff told us the need to admit a patient in an emergency was rare. Staff reported all unplanned admissions as an incident. Between January 2016 and June 2016 there had been 25 unplanned admissions to the unit. Between January 2016 and June 2016 there had been two patients who had to be readmitted to the unit for level 2 or level 3 care and treatment.
- Between June 2015 and June 2016, there were a total of 22 transfers from the critical care unit to the acute NHS trust. Twelve of these were planned transfers under contractual arrangements for patients receiving NHS treatment at the hospital. The remaining 10 were unplanned transfers of self-funding patients or patients who were funded by insurance policies. This represented less than 0.1% of all discharges from the unit.
- Staff expressed concerns there was a risk that the critical care unit might become a 'bottle neck' in patient flow through the hospital. They explained that since the theatre suite had increased capacity there were more patients operated on and more patients in the hospital. They told us this resulted in increased challenges in getting patients discharged from the critical care unit to ward beds in a timely manner order to admit planned patients from theatres. However, they did not collect any data to support this view.

## Meeting people's individual needs

- Staff said they could access translation service for patients whose first language was not English. They said any need for translation services were identified at preadmission assessment processes
- Staff reported they rarely had to care for patients who were living with dementia or who had a learning disability. However, they described how they would make reasonable adaptations to the delivery of care to support people living with a dementia or who had a learning disability. This included accommodating the patient in the side room if it was appropriate and involving the patient's relative or carer in the delivery of

# Critical care

personal care if appropriate. Staff told us that information about how to best communicate with the patient was obtained during the preadmission assessment process.

- Information about Spire Southampton Hospital was available on the Spire website. However the information on the website was not easily accessible to people who had any difficulties with reading written literature. There was no process to enlarge the writing for people who had visual difficulties. There was no process to change the background colour for people who have dyslexia. This meant that some people might not be able to fully access the information.

## Learning from complaints and concerns

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

## Are critical care services well-led?

Good 

We rated well-led as good

## Leadership and culture of service

- In line with the Guidelines for the Provision of Intensive Care Services, 2015, there was a designated lead cardiothoracic and a lead general intensivist to oversee the running of the clinical service and represent the intensivist staff on the hospital's Medical Advisory Committee. The unit had a nurse manager to lead the nursing team.

- However the unit did not consistently meet the Guidelines for the Provision of Intensive Care Services 2015 that there should be a supernumerary clinical coordinator (sister/ charge nurse bands 6/7) on duty at all times in critical care units with more than six beds.
- The critical care manager was highly visible on the unit. In the event of staff shortages, or increased number or acuity of patients, they prioritised clinical care over administrative duties. The critical care manager had an in-depth understanding of her role and the nursing team she worked with. However, some of this knowledge could only be evidenced verbally and not as documentary evidence. Nursing staff were highly complementary about the unit manager, describing her as being supportive and encouraging co-operative relationships among staff and teams and compassion towards patients.
- The unit manager had identified a need to develop a leadership programme specifically for staff working on the unit. She explained this was on her agenda to complete in the next 12 months. There was a Spire corporate leadership programme, but the manager felt this did not fully meet the requirements of critical care service leadership.
- Staff told us the culture of the service was focused on meeting the needs of patients. Staff told us it felt like a 'family' working in the unit and it was a supportive place to work.
- Staff described a culture of openness and honesty with patients. All staff understood their obligations to the Duty of Candour legislation.

## Vision and strategy for this this core service (for this core service)

- There was no documented vision or strategy for the critical care unit. However, all staff we asked said the vision for the unit was to provide excellent and compassionate care to patients.
- The critical care leads and staff understood the vision and strategy of the hospital. They understood that the critical care service was a key component for the hospital to continue to carry out complex surgical procedures.

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

# Critical care

- The hospital governance processes have been reported in under surgery service within this report.
- The critical care unit held meetings where staff were given updated information from the hospital clinical governance and head of department meetings. This included information about complaints, incidents, audits and the development of the hospital services.
- The hospital wide risk register had three items on it relating to critical care services. These were; the risk of the unit failing to meet the intensive care core standards 2015, the unit not meeting the current ITU building requirements and difficulties for staff maintaining competencies in specialised treatment and therapies that they did not routinely carry out on the unit. The unit completed detailed risks assessments associated with each of these risks that detailed all the actions taken to mitigate risks. Staff reviewed the risk assessments annually by staff and amended as needed.
- However, there were some risks to the service that either had not been identified, or if identified, an assessment had not been completed to identify the level of risk and determine what mitigating action should be taken. This included the medicine fridge temperatures being out of range, the medicine fridge being left unlocked at all times, the cluttered and unorganised store cupboard shared with the theatre department and the risk of the critical care outreach service not always being fully available. The risk that patients would not be admitted to the unit in a timely manner due to the increase in capacity in theatres and associated surgical procedures was also not included in the risk register.
- The unit did not have a clinical director, but had a lead cardiac intensivist, a lead general intensivist and an unit nurse manager. The critical care delivery group, consisting of the two lead intensivists, the unit manager, the hospital matron, the pharmacy manager and the infection control lead, met every three months.
- Records from these meetings showed the group reviewed patient transfers, compliance with infection control practices, equipment issues, staffing including staff competencies and training and any relevant information from the local critical care network.

- Practicing privileges for consultant intensivists were reviewed on a biannual basis by the Medical Advisory Committee to ensure they had the relevant skills and experience to carry out their role.

## Public and staff engagement

- Patient feedback on the service was obtained informally, for example through discussion and thank you letters and cards. There were no formal processes for seeking feedback. Staff told us that the use of staff meetings and handover sessions meant they were fully informed and involved in the running of the critical care unit and the hospital.
- Staff surveys were undertaken on an annual basis. The information was published and available for staff to read along with any actions being taken to make improvements. Staff felt confident to raise concerns and that the hospital management was accessible and responsive to any concerns or suggestions.

## Innovation, improvement and sustainability

- A member of the critical care nursing team attended the local critical care network meetings. This provided opportunities to network and learn about innovations occurring in critical care services.
- The unit had established a hemofiltration service so patients who required short term hemofiltration did not have to be transferred to the acute NHS trust.
- The service planned to submit data to the Intensive Care National Audit & Research Centre so they could compare the effectiveness of their service with later similar services and identify areas for improvement.
- Senior medical leadership of the critical care service had confidence refurbishment of the critical care unit would lead to improvements to the environment of the unit. However, there were no formalised plans to refurbish the unit.

# Services for children and young people

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

## Are services for children and young people safe?

Good 

We rated safe as good.

### Incidents

- The safety incident record for children and young people was good. The service had only recently been expanded and no clinical incidents had occurred within the service at the time of the inspection visit. However, discussions with staff confirmed that they were aware of how to report incidents and would not hesitate to do so.
- The service did not hold routine children's and young people's mortality and morbidity meetings. This was because there had been no recorded deaths of children and young people. The hospital specialised in straightforward procedures and operations for children, such as ear, nose and throat procedures where the mortality risks were low.
- The lead children's nurse received national patient safety alerts for children and knew the actions required to respond to these alerts. So far, they had not received alerts of relevance to the hospital. For example, although there had been an alert regarding coin batteries in children's toys, the hospital had no toys of this type.
- The head of children services held a briefing session on the 'Duty of Candour' and nurses in the department were clear about their responsibilities. They told us if nurses or clinicians made a mistake they would explain

this and apologise to the patient and their parents. They would also have to rectify the mistake if they had not done so previously. There had been no incidents where staff had needed to apply the duty of candour.

### Cleanliness, infection control and hygiene

- The hospital had a cleaning policy specifically for toys. The hospital's facilities staff cleaned the toys in outpatients every day, and maintained cleaning records. The lead children's nurse cleaned the toys she used with child inpatients before and after each use.
- The outpatient's area, soft play area and children's equipment appeared visibly clean. The ward areas and the recovery area were also visibly clean
- We observed nurses in outpatients and wards using hand gel frequently and washing their hands before and after seeing patients.
- Staff who worked with children had received online infection control training. The lead children's nurse was the link nurse for infection control. She also used hand washing colouring packs with the children to encourage them to wash their hands.
- The service worked well with patients and parents on infection control. The lead children's nurse used hand washing colouring packs with the children to encourage them to wash their hands. We saw patient literature tailored to children on after-care, which explained how to help prevent infections after an operation. We heard from parents that nurses gave them verbal advice on keeping wounds clean.

# Services for children and young people

- The hospital had recently implemented the new children's infection control standards. Staff had not completed an audit of these standards at the time of the inspection.

## Environment and equipment

- The outpatient's service used an environmental checklist. This helped monitor whether children's toys were compliant with national safety standards. It also helped staff check that items such as sharps (syringes), medicines and cleaning products were properly stored out of the reach of children.
- Resuscitation trolleys contained specialist equipment for children. We checked all of the resuscitation trolleys, which were located in outpatients, ward 2 and recovery. These included Broselow bags (bags with resuscitation equipment colour coded for children of different sizes). All necessary items were available and within their expiry date.
- There were no children-only waiting rooms or consulting rooms, but staff accompanied children through their treatment pathways. As far as possible, the hospital arranged child-only operation lists. The children's recovery area was partitioned, rather than completely separate.

## Medicines

- Staff completed medicine records for children and these included information on children's allergies. We reviewed notes for three inpatient and three day case children. Staff had prescribed a good range of post-operative analgesics so they could respond quickly if a child was in pain. Children's weights were clearly documented, which ensured that a child would be prescribed the correct dosage of medication.
- The hospital had procedures to ensure the safety of controlled drugs administration. Two qualified members of staff checked the controlled medicines and recorded this in the controlled drug book. For children's drugs, one member of staff had to be a registered children's nurse.
- Staff had access to the 'British National Formulae' (BNF) for matters related to administration of drugs for

children. The hospital pharmacist told us that copies of the children's BNF were available in pharmacy, on the wards and in outpatients. We saw a copy in the outpatients consulting room.

- For our detailed findings on medicines please see the Safe section in the [main service] report.

## Records

- Patient records were stored securely in a staff office, behind a manned reception desk, with access by authorised staff only.
- We reviewed 10 sets of children's notes and found they were informative and legible. Risk assessments were not consistently completed or signed. We also observed information gaps in fluid charts. The hospital had recently audited medical records for children and the compliance for this audit was met.
- Records included risk assessment tools to address frequent child health risks. These were for deterioration of a child patient under 16; chicken pox; child having blood tests; and a child who may hurt themselves. These showed that staff managed the risk of a child's health deteriorating. They used the paediatric early warning system (PEWS), which was included in the patient's notes. There were different scoring charts for children of differing ages, to support early detection of changes in their condition. This ensured that a child was cared for according to their condition, and was monitored more frequently or transferred to another hospital if necessary.
- Care plans and nursing assessments were in line with the Nursing and Midwives Council guidance on record keeping. For example, they included notes of conversations and information given to a child's family.

## Safeguarding

- The hospital checked that all consultants had the correct level of safeguarding training to care for children in July 2016. Consultants were only granted practising privileges (contracts enabling consultants working in the NHS to work in private hospitals) if they had correct and up to date training.

# Services for children and young people

- All children's nurses had level three safeguarding training accreditation. This included the lead children's nurse, who was the children's safeguarding lead, and the matron.
- Nurses were able to monitor child patients closely. The hospital admitted a limited number of children and young people at one time, usually a maximum of four. Staff rotas meant the lead children's nurse was on duty to supervise children's care personally. If a child was admitted overnight, a children's nurse stayed on site to look after them.
- The hospital set safeguarding standards for other clinicians who worked with children. It stipulated that anaesthetists who worked with children at the hospital should have level two safeguarding training, and confirmed that this was the case. The hospital's physiotherapists who worked with children had level three safeguarding training, in line with good practice.
- Staff and managers discussed safeguarding issues at monthly clinical governance and ward staff meetings. None of the safeguarding events at the hospital involved patients under the age of eighteen years.
- The hospital took measures to safeguard children and young people at risk of female genital mutilation (FGM). Spire Healthcare's corporate policy, the 'Procedure for the care of Children and Young People in Spire Healthcare' outlined how staff should treat FGM as child abuse and make a safeguarding referral to the local authority.
- The hospital had a clear response if a child was abducted. The procedure for the care of children outlined what staff should do if a child was missing. If staff did not find the child within 15 to 30 minutes, the police and the safeguarding team would be alerted. There were also arrangements for children admitted under a Child Protection Plan, which included protocols for safeguarded children.
- The hospital did not have an electronic alert systems to flag up children on the child protection register. Children on the child protection register are those at risk of abuse or neglect. This meant staff might not be alerted to the risks identified through child protection processes.

## Mandatory training

- The children's nursing team completed the agreed mandatory training to support safe children's care. The hospital's records showed that the children's nursing team achieved 100% compliance with mandatory training.
- The children's lead nurse held the European paediatric intensive life support qualification. She was proactive in training other nurses on basic and intensive life support for children during the monthly training days. She attended the Spire group networking days to further enhance her knowledge.
- Clinical staff treating and caring for children had life support training. Consultants and anaesthetists had European paediatric life support qualifications. Physiotherapists worked with children had European basic life support training.

## Nursing staffing

- Staffing arrangements were safe for children and met Royal College of Nursing (RCN) guidelines. The children and young people's service was staffed by a children's lead nurse, and a children's recovery nurse in theatre. The hospital had a team of trained paediatric nurses for the service.
- Spire Southampton did not employ agency nurses. If the service could not ensure that staffing was at a safe level, it did not admit children.

## Medical staffing

- Medical staffing for children was safe. All children were cared for by a named consultant at all times. A named consultant paediatrician was available for liaison and immediate cover when a child was admitted.

## Emergency awareness and training

- The hospital had a backup electricity generator so that children's services continued running during a power failure. The generator could cover essential services with one or two other functions such as x-ray machines and autoclaves. The generators were tested every month and serviced every six months.

**Are services for children and young people effective?**



# Services for children and young people

Good 

We rated effective as good.

## Evidence-based care and treatment

- Staff said they had good access to all policies through the hospital's intranet. The policies relating to children's services were based on national guidance, and these had been reviewed and ratified.
- The paediatric admission pathway reflected evidenced based practice with relevant risk assessments embedded in the pathway and the use of the paediatric early warning scores.
- Staff used the 'World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery' tool. This reflected evidence-based practice to improve safety for surgical procedures.
- The service audited compliance with policies. For example, staff carried out audits of hand hygiene and patient records, and took action when necessary to improve care. Staff followed a schedule of audits through the year to assess care and treatment practices.

## Pain relief

- We reviewed four patient records. These showed staff carried out hourly pain assessments following surgery.
- Five parents confirmed that staff had completed pain assessments regularly and given pain relief in a timely way.
- Child-friendly pain charts were embedded into the PEWS tool, which helped younger children explain their pain.

## Nutrition and hydration

- Staff assessed and recorded children's dietary needs on admission. We reviewed five records and these showed that food and fluid charts had been completed accurately.
- Patients had access to water at all times, with refilled jugs at their bed sides. Parents and carers had access to tea and coffee facilities on the ward and in the outpatients department.

- Children were offered meals at mealtimes. Children and their parents said the food was good and there was a selection of choices on the menu.

## Patient outcomes

- The hospital did not participate in national audits relating to the care of children and young people. The numbers of children treated were low and participation in national audits was not feasible.
- Treatments offered to children and young people were of low risk. There had been no unplanned (i.e. emergency) transfers to local NHS trust in the last 12 months.
- Children and young people had a dedicated pathway for day surgery and overnight stays.

## Competent staff

- Staff reported that they had access to education and training courses relevant to their area of specialism. Evidence of participation was seen in theatres and the ward areas.
- All staff we spoke with reported they had completed a yearly appraisal. The senior nurse said the appraisal rate was 100%.
- Staff said they were supported to complete the Nursing and Midwifery Council (NMC) revalidation process.

## Multidisciplinary working

- There was a service level agreement with the local NHS trust for paediatric consultant access and advice. Three members of staff told us there was a good working relationship with the local NHS and they were able to contact consultants for advice at any time of day.
- The pharmacist reviewed all patients each day from Monday to Friday and gave advice regarding medications to the medical and nursing staff. Weekend pharmacy support was available if children were admitted over the weekends.

## Access to information

- Patient records were kept in the staff office and were available for authorised staff to access.
- There was a system to ensure that medical records generated by staff holding practising privileges were available to staff.

# Services for children and young people

- Discharge letters were typed and posted to patients' GPs with a copy sent to the patient or parent/guardian.
- Staff reported that parents were given a telephone number to get advice 24 hours a day following discharge.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff obtained consent for treatment appropriately. In some of the documented consent forms we viewed, the child had signed the form as well as the parent. Gillick competence was assessed in children and young people to ensure they understood the risks and benefits to treatment in order to make an informed decision.
- Children and their parents told us that staff gained consent before undertaking any care or procedures.

## Are services for children and young people caring?

Good 

We rated caring as good.

## Compassionate care

- We spoke with five patients and five parents and they all said the nursing care was very good or excellent. They all told us that staff could not do enough for them and were understanding. They provided assurance and were sensitive to the family's needs.
- We observed the children's nurse and consultant interacted very well with children who had come to the hospital for an operation. Nurses were compassionate and caring with children, young people and their relatives.
- Staff respected the privacy and dignity of children and young people. A chaperone was always present for an examination, in addition to the parent or guardian, to provide additional support.

## Understanding and involvement of patients and those close to them

- Patient and parent feedback showed they were satisfied with communication and care. Parents said paediatric

nurses were sympathetic and encouraging towards children and offered play, reassurance and advice. Parents told us they felt reassured that their child was being provided with the highest level of care.

- Staff helped children make their own decisions about their care by explaining procedures in a child-friendly way and using appropriate guides.
- Children, young people and their parents were involved in care planning. Parents said they discussed different options for treatment and care, and potential outcomes, with clinicians. This enabled them to weigh up the risks and advantages of a given treatment.
- Older children were able to talk to a clinician without their parent(s) present. The hospital had a clear policy on consent at different age ranges, and that 16 to 17 year olds were entitled to withhold consent. The treating doctor made a decision whether the young person had the competence to make their own decision, and this was documented.
- We reviewed ten recent patient surveys, which children and young people had completed. Most were very pleased with communication before, during and after surgery

## Emotional support

- Staff provided children with appropriate emotional support. Children came to the hospital on pre-operative familiarisation visits where they met nurses, clinicians and the anaesthetist. This was important in reducing their anxiety when they were away from home.
- One of the paediatric nurses was on hand to play with children who were scared or upset. They had toys that showed what procedures would be done to the child. Parents told us that children found this approach reassuring.
- Staff did not have experience in breaking bad news to parents as the service carried out routine, low risk operations. The lead nurse had set up links with the local NHS hospital and had received bereavement and palliative care training. She told us they could easily access the local NHS hospital psychology team and bereavement team for additional support.

# Services for children and young people

## Are services for children and young people responsive?

Good 

We rated responsive as good.

### Service planning and delivery to meet the needs of local people

- Since the last inspection the hospital had developed the facilities for children and young people inpatient services, a dedicated six bedded paediatric facility was now in place, and the service was growing. They also needed to assess staffing for their expansion plans.
- The hospital was in the process of highlighting its services to the local clinical commissioning groups, with proposals to expand specific day care services for children.
- At Spire Southampton, most of the procedures were routine day cases such as ear, nose and throat (ENT) operations, with very few children staying overnight.
- Parents told us that consultants and managers discussed cost issues with them in a sensitive manner, and informed them of their options.

### Access and flow

- The hospital offered good access for children's routine operations. Outpatient's clinics were available in the evening as well as during the day. Children could choose to have operations during the school holidays. Consultants also offered flexibility when it was needed, for example to perform a day case procedure at short notice, providing there was sufficient time for the pre-operative assessment.
- There were no next-day clinics, but parents told us consultants fitted in urgent child outpatient appointments in a few days.
- The hospital had a specific policy for admitting children, which was different from the adult pathway. Children had an appointment with the consultant, then a further appointment for pre-assessment and familiarisation, introducing them to the environment through a visit, so that everything would be familiar.

- The paediatric service did not routinely measure how long children waited for their operations. Waiting times varied depending on whether families preferred to schedule procedures during the school holidays.

### Meeting people's individual needs

- The hospital co-ordinated appointments for children with complex needs. There was a multidisciplinary team approach for children who needed to see a number of professionals, for example, a paediatrician, an ENT specialist and a speech therapist.
- Staff responded to a patient's individual needs. Parents told us the hospital had planned treatment around their child's emotional, mental, physical and spiritual needs. One set of medical records we reviewed included a school report and details of the child's hobbies. This ensured that staff had a better understanding of their individual care needs. The service had considered how to improve children's experiences of hospital care, and offered young children a 'special car' to drive to theatre, to help reduce their anxieties.
- The hospital offered outpatients appointments and operation times to suit the individual family. Most parents chose operation times during the school holidays, as this did not disrupt schooling or draw attention to the child's operation.
- Consultants and managers explained the options and possible timescales to parents without exerting any pressure, ensuring that parents could decide about treatment in a measured and unhurried way.
- Nurses encouraged children and young people to keep in touch with friends and family. Parents told us that they helped children plug in their electronic devices and access Wi-Fi. Staff also encouraged parents to stay overnight on a temporary bed in the same room as their child to reduce anxiety, and would provide a meal if needed.
- Parents told us the children's lead nurse responded quickly if their child was in pain or discomfort.

### Learning from complaints and concerns

- The Spire corporate complaints policy and process were clear. Parents said they would have no difficulty giving feedback. The service had not received any complaints relating to children's care in the past year.

# Services for children and young people

- Children were invited to provide feedback. Small children received a bright pictorial patient survey, which was easy to follow. Older children received a specially designed survey that was in the pilot stage of roll out. Children and young people said they were happy with the service but would be confident in making a complaint if they felt a need.

## Are services for children and young people well-led?

Good 

We rated well-led as good.

### Leadership and culture of service

- There was a 'can-do' culture within the service and staff felt respected and valued. The senior managers recognised that the lead children's nurse provided good leadership and had represented the service well within the Spire group.
- Staff said all senior managers were approachable and presented good role models. They were aware of the hospital's values and there was effective two-way communication between management and staff, for example via the staff forum.
- The culture was centred on the needs of the children using the service. We heard from parents how hospital staff and doctors tailored treatment and hospital stays to the needs of the child.
- The children's nurses worked well with consultants to develop policies and plan services.

### Vision and strategy for this this core service

- Staff we spoke with were aware of the mission, vision, values of the hospital which focused on quality and patient experience. They demonstrated commitment to these in their care practices.
- Hospital managers, paediatric nurses and consultants had a vision for the children and young people's services. They were developing a strategy that included expanding their range of children's services and agreeing this with the local clinical commissioning groups. The role of the newly appointed children's nurse had been essential to this development.

### Governance, risk management and quality measurement

- The lead paediatric consultant represented the interests of children and young people at the Medical Advisory Committee. The hospital's governance arrangements meant the matron, who was also the senior safeguarding contact, took the lead at executive level.
- Staff who worked with children and young people were aware and engaged in the hospital governance structure, to support delivery of quality care. Following the last CQC report, there had been significant progress in implementing stronger governance arrangements. For example, the service had appointed a lead children's nurse. The lead children's nurse met regularly with the paediatric consultant to review and discuss service developments.
- There were effective risk management processes in place, to underpin the safety of the service.
- Staff and managers recognised they needed to strengthen quality and performance management, by introducing quality monitoring measures and learning from audits and benchmarking.

### Public and staff engagement

- The hospital gathered views through patient satisfaction forms and informal parent and patient feedback. However, it had no formal group for parents to help shape services or future facilities for children. This had already been identified as an area for development and there were plans in place to address this at the time of the inspection.





### Innovation, improvement and sustainability

- The management team recognised Southampton Spire's paediatric early warning system (PEWS) chart, developed by the lead children's nurse, as good practice.
- The service had introduced a new approach for gaining feedback comments from older children. This had also been recognised as an area of good practice by the management team.
- Staff were focused on continually developing and improving the quality of care. For example, staff had introduced a new mechanism to raise awareness of cleanliness with children and young adults.

## Services for children and young people

- Staff and managers were aware also needed to assess staffing needs for their expansion plans.

# Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Good 

## Are outpatients and diagnostic imaging services safe?

Good 

We rated safe as good

### Incidents

- In the outpatients department (OPD) and diagnostic imaging department, staff were aware of their responsibility to report incidents. Staff reported incidents via a hospital-wide electronic system. Staff we spoke with were confident to report incidents and challenge poor practice of staff at any level. In the diagnostic imaging department, there were clear processes for reporting incidents relating to Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). Staff were fully aware of these procedures.
- There were 80 clinical incidents reported in the period July 2015 to June 2016, across the OPD and diagnostic imaging service. This rate of clinical incidents was below the average of other independent acute hospitals that we hold this type of data for.
- There was one non-clinical incident reported within OPD and the diagnostic imaging service in the reporting period July 2015 to June 2016. The rate of non-clinical incidents was lower than the rate of other independent acute hospitals that we hold this type of data for.
- We saw evidence that all incidents reported had been investigated and appropriate action taken.
- The hospital reported no serious incidents requiring investigation in outpatients or diagnostic imaging

during period July 2015 to June 2016. In same period, there were no deaths and no never events. Never events are serious, wholly preventable patient safety incidents that should not occur if a hospital has implemented the available preventative measures. The occurrence of a never event could indicate unsafe practice.

- 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. Senior staff told us they had received information and training on the duty of candour and that this was embedded practice within the hospital. Staff we spoke with demonstrated a good understanding of the duty of candour requirements.
- We saw that key learning summaries, root causes and learning from incidents from across the hospital were shared with staff. These were available in the 'first sight' folders in each department. Departmental 'first sight' folders were where staff accessed important operational communications.
- In the diagnostic imaging department Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) incidents were all within normal ranges. The hospital was not an outlier for under or over reporting of IR(ME)R incidents.

### Cleanliness, infection control and hygiene

- All areas of the OPD, both waiting rooms and clinical rooms, were visibly clean and well maintained. The hospital scores for the patient-led assessments of the care environment (PLACE) were higher than the England average for cleanliness.



# Outpatients and diagnostic imaging

- Hand sanitiser points were available for patients, staff and visitors to use. This encouraged good hand hygiene practice. However, there was no signage to promote hand hygiene to visitors and staff.
  - Equipment in the department was cleaned and this was indicated by an 'I am clean' sticker indicating that it was ready for use with patients.
  - During the inspection staff we observed that staff adhered to the 'arms bare below the elbow' policy, to enable thorough hand washing and prevent the spread of infection between staff and patients.
  - Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff to use in clinical areas when performing procedures. We observed staff using them appropriately.
  - The PPE equipment, including x-ray protection lead coats, were clean and in good condition. There was an annual check of the safety of this equipment.
  - There were 'sharps' disposal bins in all consultation rooms, and we noted that none of these bins were more than half full. This reduced the risk of needle-stick injury.
  - In line with current best practice, Spire Southampton had an effective MRSA screening programme and had experienced no cases of MRSA (July 2015 to June 2016). In the same period, there was one incident of E-coli and one of C.difficile.
  - The consultation rooms in OPD had hard flooring that could be cleaned easily. One room, used for eye examinations only, was carpeted.
  - There was a cleaning rota for mobile x-ray machines that were stored away from the diagnostic imaging department.
  - Staff took part in hand hygiene and infection control and prevention audits. Compliance against hand hygiene standards was over 90% from July 2015 and June 2016.
- and an audiology room. Since the last inspection in October 2014, the environment in the department had been improved. The layout of the reception area meant there was now more privacy for patients booking in.
- In diagnostic imaging there were two x-ray rooms, and a further ultrasound room. Services provided included plain x-ray, ultrasound, and fluoroscopy. The department had a reception and waiting area. There were changing rooms for patients with lockers for their clothes. The department had two rooms used by radiologists for the reporting of images, and facilities for downloading x-rays onto the imaging system.
  - In addition, there was a suite of rooms including a waiting area and patient changing facilities for the computerised tomography (CT) and magnetic resonance imaging (MRI) scanners. The MRI scanner was located in a secure area, with access only for patients that had been assessed by staff as being safe to be near the strong magnetic field.
  - The OPD had a minor operations suite that was well equipped; this included a separate area that was used for patient recovery and blood tests. There were three additional treatment rooms and these were well equipped and appropriate for their intended use.
  - We saw labels on the equipment with the last service date and review date. There was also an asset number to ensure the item could be tracked if it required servicing or planned maintenance.
  - Items of electrical equipment had been tested for electrical safety within the last year. Staff we spoke with were clear on the procedure to follow if they found faulty or broken equipment. Repair work was completed by the facilities management team.
  - Staff did not report any concerns regarding availability or access to equipment.
  - The housekeeping team managed the disposal of waste. There was clear labelling of the clinical waste bins and sharps boxes.
  - There was resuscitation equipment available in radiology and outpatients departments. Single-use items were sealed and in date, and emergency equipment had been serviced. We saw evidence that the equipment had been checked daily by staff and was safe and ready for use in an emergency.

## Environment and equipment

- In the outpatients department, there were 16 consulting rooms and four treatment rooms that included a minor operations suite. There was also an ophthalmic room

# Outpatients and diagnostic imaging

- We observed that specialised personal protective equipment was available for use by staff within radiation exposure areas. There was a process for annual checking of x-ray protective aprons. Staff wore personal radiation dose monitors to assess their exposure levels.
- The diagnostic imaging department also had two mobile x-ray units that could be used for a patient on the ward. These were clean and well maintained.
- The department staff were also responsible for cleaning and maintenance of the hospital's two 'C' arm x-ray units that were used in theatres. These units that were in use during the inspection and we saw completed the cleaning logs appropriately.
- In diagnostic imaging, quality assurance checks were in place for each piece of imaging equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R 2000). These protect patients against unnecessary exposure to harmful radiation. We saw records of annual radiation protection and performance checks of all the x-ray equipment in the department.
- The diagnostic imaging department had service and maintenance contracts in place for all the x-ray and ultrasound equipment, as well as the MRI and CT scanners. Staff told us that contractors were responsive to breakdowns of equipment. We saw documentary evidence that this equipment was regularly maintained.
- Medical physicists advised on radiation safety and conducted quality checks. The Regional Radiation Protection Service (RRPS) provided this service under a service level agreement.

## Medicines

- Medicines were stored safely in outpatients. We saw locked medicines cupboards and the keys were held by the nurse in charge. Staff we spoke with knew who held the keys.
- There were no controlled medicines kept within OPD and the diagnostic imaging department. We checked medicines stored in diagnostic imaging such as radiological contrast media and found these to be in

date. The diagnostic imaging department told us that the pharmacy were responsive in dealing with requests for medicines. Any medicines that went beyond the date for safe use were returned to pharmacy.

- Private prescription pads were stored in unlocked drawers in consultation rooms. Although, these were locked away at night there was a risk they could be accessed by unauthorised persons when the department was operating. The accessibility of prescription pads was discussed with the OPD sister, who ensured these were held securely at all times. The department did not hold a stock of FP10 NHS prescription pads.
- An emergency oxygen cylinder in the MRI scan recovery area was found to be out of date, this was escalated to staff and it was immediately replaced.
- Medicine refrigerators in OPD and diagnostic imaging were locked and staff checked and recorded the temperatures. Staff could tell us actions they needed to take if the refrigerator was found to be out of temperature range.

## Records

- We saw patient personal information and medical records were managed safely and securely. During clinics, all patient records were kept securely with reception staff and transferred to the consultant when the patient arrived.
- Staff told us that they had no difficulty in retrieving patient notes for clinic appointments. There had been no incidents of patients being seen in the OPD without all relevant patient records being available in the three months prior to the inspection.
- All the staff we spoke with were aware of their responsibilities around the safe keeping of records and the confidentiality of patient information. Patient identifiable information was stored securely.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was used across the diagnostic imaging department. Image transfers to other hospitals were sent electronically via a secure system.

# Outpatients and diagnostic imaging

- Patient records were only permitted to be taken off site by consultants, who were registered as data controllers with the information commissioner's office. This was a requirement of their practising privileges agreement. Consultants were personally responsible for the security of patient records when off site. Patient records from the OPD were not taken off site unless they were the consultants' own records.
- Records that were transferred from the hospital's pre-assessment centre were sent in a sealed container and were never left unattended by the hospital driver.

## Safeguarding

- There had been six safeguarding alerts reported across the hospital to the CQC between July 2015 and June 2016.
- The hospital had safeguarding children and vulnerable adult policies in place. The dedicated leads for safeguarding vulnerable adults and children demonstrated they had the necessary training to enable them to fulfil their safeguarding roles.
- Hospital training records showed 78% of all staff were compliant with child safeguarding training and 79% with adult safeguarding training. The target was 100% by the end of December 2016.
- Staff in outpatients knew how to access information about the statutory duty of notification of female genital mutilation.

## Mandatory training

- Staff completed a number of mandatory training modules as part of their induction and updated them in line with the training policy. Training included infection control, fire safety, conflict resolution, equality and diversity, information governance, children and adult safeguarding, manual handling and dementia awareness.
- The diagnostic imaging team had a comprehensive induction checklist, and we saw evidence that competencies were checked for individual staff.
- Training was delivered through an online learning package or by face-to-face teaching and practical sessions. Staff reported they completed online learning and booked dates for the practical or face-to-face teaching sessions.

- Hospital-wide mandatory training was 88% at time of inspection with target of 100% by end December 2016.
- We saw evidence refresher training was booked for those who were due to for renewal.
- All training was monitored by the departmental managers, who notified members of staff when their mandatory training was due for renewal.
- No staff we spoke with reported any issues finding time to complete their mandatory training.

## Assessing and responding to patient risk

- Patients at the hospital always had access to a resident medical officer (RMO), that were employed by the hospital. RMOs were trained in advanced life support. They provided medical support to the OPD or diagnostic imaging department staff if a patient became unwell. Patients who became medically unwell in outpatients were transferred to the inpatient ward or to the local acute NHS trust, in line with the emergency transfer policy. Staff in OPD could explain the process for the escalation of a deteriorating patient.
- Emergency resuscitation equipment was available and was appropriately checked daily in the OPD and diagnostic imaging departments. This emergency equipment included anaphylaxis kits for adults and children. The hospital had also carried out emergency scenario training in the MRI scanner.
- Staff told us that they used a checklist based on the 'World Health Organisation (WHO) five steps to safer surgery' for patients undergoing minor surgical procedures in the outpatients department. We did not look at any checklists that had been completed on the inspection. The use of the checklist was audited in May 2016 in the OPD and achieved a compliance rate greater than 85%. The diagnostic imaging WHO safety checklist audit achieved an 80% compliance for the first two quarters of 2016. As a result of the audit staff were reminded to fully complete the WHO checklists and ensure that these were correctly recorded against the patient that underwent the procedure.
- In diagnostic imaging safe ways of working were in place to mitigate risks posed by radiation. All staff had access

# Outpatients and diagnostic imaging

to and worked within the comprehensive local rules. Local rules are the way diagnostics and imaging departments work in accordance with national guidance.

- In accordance with the ionising radiation (medical exposure) regulations (IR(ME)R 2000), policies and procedures were in place for staff to identify and manage risks. The policies had been reviewed and signed by staff to confirm these had been read and understood.
- There was clearly visible and appropriate radiation hazard signage outside all x-ray rooms for staff and patients.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed radiographers before any exposure to radiation. There were posters displayed in waiting and changing areas to remind women they needed to check with the radiographer if there was any chance they could be pregnant.
- The hospital had two mobile x-ray units that could be used for imaging patients in critical care areas or wards if they deteriorated. The OPD had a designated member of staff to check on point of care testing (POC). This included the training of other staff to use POC testing equipment such as glucometers.
- There was a cross checking system in outpatients to ensure staff checked patient identity and treated the correct patient. Reception staff checked patient details on arrival, this was checked against the information held on the department's computer system. We observed patients having investigations in diagnostic imaging having their identity checked by radiographers.
- Processes were in place to ensure the right patient received the correct radiological investigation at the right time. A senior radiographer reviewed all x-ray requests before patients were x-rayed. Consultant radiologists reviewed all GP referrals before x-ray.

## Nursing and radiology staffing

- The OPD used the Shelford acuity tool in conjunction with professional judgement to determine what staffing was required to ensure that department was run safely.

There was an escalation system in place should staffing fall below safe levels. There had been no incidents reported by the OPD or diagnostic imaging relating to staffing levels in the year prior to the inspection.

- Staff teams had daily meetings to share important updates, such as changes to planned clinics or staffing for the day.
- Staff told us they were willing to be flexible with work patterns when needed, and patient safety was their priority.
- In OPD there was a low usage of agency staff with no agency staff used during the period July 2015 to June 2016. In the same period, there were no vacancies for nurses and care assistants in OPD.
- The hospital had a member of clinical staff in charge of the hospital 24 hours a day, and a senior manager was always available to support any staffing issues.
- There was sufficient suitably trained staff in the diagnostic imaging department. There was some use of agency staff, but this was a single radiographer that was covering a member of staff on extended leave.

## Medical staffing

- Consultants with practising privileges that admitted patients to the hospital were required to live no more than 45 minutes journey away, to allow responsive access to a patient that was deteriorating.
- The hospital at the time of the inspection employed 326 consultant medical staff, 30 of whom were radiologists, working under rules or practising privileges. The hospital completed relevant checks against the disclosure and barring service (DBS).
- The hospital director and MAC chair liaised appropriately with the GMC and local NHS trust to check any concerns and restrictions on practice for individual consultants.
- There was sufficient consultant staff to cover outpatient clinics, including those on Saturdays.
- Nursing staff told us that doctors were supportive, and advice could be sought whenever it was needed.
- There was a registered medical officer (RMO) on duty 24 hours a day to provide medical support to the OPD and diagnostic imaging departments.

# Outpatients and diagnostic imaging

## Major incident awareness and training

- Staff were aware of their roles and responsibilities during a major incident.
- The hospital had local and corporate business continuity plans with supporting action cards to use in events such as internet or electricity failure. The business continuity plans were also available electronically.
- The diagnostic imaging department had a reciprocal arrangement with another local independent hospital in the event of a failure of the CT scanner to ensure that patients would have their scans completed. There were also arrangements in place to use facilities at the local NHS hospital if needed in the event of a critical failure of x-ray equipment.

## Are outpatients and diagnostic imaging services effective?

We did not rate effective as there is currently insufficient evidence to do this.

## Evidence-based care and treatment

- Staff in OPD and diagnostic imaging reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- Radiation exposure and diagnostic reference levels were audited regularly and evidence of these were seen during the inspection.
- Clinical audits were undertaken in diagnostic imaging. Staff carried out audits in areas such as clinical records, duplicate imaging requests and ionising radiation,
- IR(ME)R audits were undertaken in line with regulatory responsibility, copies of these audits, outcomes, actions and results were seen during our inspection.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure.
- All radiology reports were checked and verified by a radiologist, before the report was sent to the referrer.

## Pain relief

- In the outpatient department, staff discussed options for pain relief with the patient during their consultation, before any procedure was performed. Many procedures could be performed with the use of local anaesthetic, enabling the patient to go home the same day. Patients were given written advice on any pain relief medications to use at home, during their recovery from their outpatient procedure.
- Patient records evidenced pain relief was discussed and local anaesthesia was used for minor procedures.

## Patient outcomes

- All radiology reports were audited for compliance with the reporting times. The hospital reported that 85% of images were reported within 2 days. The data was not broken down into CT and MRI but include all examinations together.
- A designated staff member oversaw this process, and discussed the audit results with radiologists. This ensured that a system was in place to prevent unverified reports causing delay to patient care.
- Staff had completed a duplicate x-ray audit. This had been identified as a problem as patient details were sometime entered twice on computer systems. Since the audit, staff checked more carefully that patients were not requested for duplicate x-rays and this had been effective in preventing patients being called for duplicate x-ray examinations.

## Competent staff

- Staff had competencies for their roles set out in individual files; these were signed off once completed. There was an annual review of competencies for registered nurses in the OPD.
- Staff confirmed they were supported to maintain and develop their professional skills and experience. Checks were made annually to ensure that all nursing and allied health professional staff remained registered with their professional body. There was a disciplinary process in place if they were not.
- Practicing privileges is authority granted to a physician by a hospital governing board (medical advisory committee) to allow them to provide patient care within that hospital. There were appropriate systems in place



# Outpatients and diagnostic imaging

to ensure that all consultants' practising privileges were kept up-to-date, this included evidence of appraisal and revalidation. Consultants undertook similar work in the local NHS trusts.

- There were close links with medical directors of the local NHS trusts, who were the responsible officers for revalidation of consultants. The Spire medical director was the responsible officer for any non-NHS medical staff.
- The competency of consultants was reviewed biennially and those who had not practiced for a long time may have practising privileges withdrawn
- In the OPD and diagnostic imaging service all staff had completed an appraisal in the period January 2016 to December 2016.

## Multidisciplinary working

- From the care we observed, there was effective team working, with strong working relationships between all staff groups particularly between the OPD, diagnostic imaging and pharmacy.
- If there were unexpected findings following a radiology imaging, the radiologists contacted the referring clinician and the radiographers followed up on the results to ensure that if any further action was needed it was fully completed.
- The department sent letters to the patient's GP within 48 hours of an outpatient appointment.

## Seven-day services

- The majority of outpatient clinics were held Monday to Friday, with clinics running from 8am to 8pm Monday to Friday. Clinics were also held on Saturdays between 8am and 4pm. Patients we spoke to reported good access to appointments and at times which suited their needs.
- In diagnostic imaging, x-rays were performed from 7.30am to 6pm. The MRI scanner was in operation from 7am until 10pm, and 8am to 4pm at weekends. The CT scanner operated between 8am and 6pm. Radiographers were on call during the weekends and overnight.

## Access to information

- Staff we spoke with reported timely access to blood test results and diagnostic imaging. Results were available for the next appointment or for certain clinics, which enabled prompt discussion with the patient on the findings and treatment plan.
- X-rays were available electronically for consultants to view in the clinic, and to show patients if appropriate.
- There were systems in place to ensure safe transfer and accessibility of patient records if a patient needed to be transferred to another provider for treatment. Medical staff we spoke with confirmed the transfer methods used and understood the security requirements of data transfer.
- GP referral letters would also be available for private patients, unless self-referring.
- In each of the outpatient consulting rooms staff could gain secure access to the hospital's digital imaging records as well as NHS imaging reports and pathology reports.
- Clinical guidelines and procedures could be found by staff on the hospital intranet.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards was covered in the staff mandatory safeguarding training. Staff demonstrated good understanding of their role with regard to the Mental Capacity Act.
- The consent process for patients was well-structured, with written information and verbal explanation provided before consent for a procedure was sought.
- For patients preparing for cosmetic surgery there was a two-stage consent process that allowed for the required two week 'cooling off' period.
- Staff were able to access the policy and procedure for the statutory reporting of incidences of female genital mutilation (FGM) from the hospital intranet.
- Staff sought verbal consent for most general x-ray procedures and OPD procedures. Some consultants also sought written consent from patients for some specific procedures.



# Outpatients and diagnostic imaging

- We observed that staff explained procedures to patients and asked their consent before delivering care or treatment.

## Are outpatients and diagnostic imaging services caring?

Good 

We rated caring as good.

### Compassionate care

- Patients told us they were treated with privacy, dignity and respect and they felt staff cared for them.
- All the patients we spoke with were positive about the care and treatment they had received. We received positive comments from patients about the staff being helpful and pleasant in OPD and diagnostic imaging.
- Throughout the inspection, we saw staff speaking in a calm and friendly way to patients. Patients told us staff were supportive and efficient.
- Information on how to access a chaperone was available on the hospital website. Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms.
- The hospital took part in the NHS Friends and Family Test (FFT), and asked patients whether they were happy with the service provided, or if improvements were needed. There was no breakdown of the results so it was not possible to identify their significance with regards to the OPD and diagnostic imaging department. For the reporting period January 2016 to June 2016 the hospitals FFT scores were mainly lower than the England average for NHS patients. However, in June 2016 the FFT score was similar to the England average. The FFT survey response rates were mainly lower than the England average in the same period, except for in April 2016.

### Understanding and involvement of patients and those close to them

- Patients told us they had been provided with the relevant information, both verbal and written, to make informed decisions about their care and treatment. There had been sufficient time at their appointment for them to discuss any concerns they had.
- During our inspection, we saw there was a range of health promotion literature in waiting areas. This included leaflets on; joint replacement orthopaedic surgery, breast surgery, general surgery and physiotherapy.
- We saw patients' families or carers were welcome to accompany them into their consultation. This provided them with the opportunity for another person to hear what the doctor or nurse told the patient, to offer clarification later if needed.

### Emotional support

- Patients commented that they had been well supported emotionally by staff, particularly if they had received upsetting or difficult news at their appointment.
- During our conversations with staff it was clear they were passionate about caring for patients and put the patient's needs first. Staff gave us examples of where they had to provide emotional support for patients and those close to them.

## Are outpatients and diagnostic imaging services responsive?

Good 

We rated responsive as good

### Service planning and delivery to meet the needs of local people

- Since the last inspection the outpatient department had been expanded and improved. Insufficient car parking had been identified from patient feedback and there were now more spaces available. There were also plans to relocate staff parking to a new site nearby. Clinical areas such as the minor operations suite had been redesigned. This now provided a scrub area and a recovery room (this also doubled for a phlebotomy room when not in use). A new electronic staff call system had been put in place.

# Outpatients and diagnostic imaging

- Physiotherapy and surgical pre-assessment had been relocated to an offsite centre, which functions under a separate registration so is not included in this report.
- Services were planned around the needs and demands of patients. OPD clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- Clinics were held on Monday to Friday, 8am to 8pm, with outpatient clinics held on Saturdays to meet patient needs.
- There were pleasant waiting areas for OPD, diagnostic imaging departments with a receptionist in each area. There were complimentary refreshments available for waiting patients and a separate waiting area for children and young people.
- The hospital was a provider of Choose and Book, which is an electronic booking system that allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP. Patients are able to book a convenient date and time for their outpatient appointment.
- The hospital had free Wi-Fi for patients to use.
- Between January 2016 and June 2016, the hospital did not meet the target of 92% of NHS patients on incomplete pathways waiting 18 weeks or less from the time of referral to treatment. This was data from the reporting period July 2015 to June 2016. Incomplete pathways are the time patients have been waiting to start treatment, when reviewed at the end of each month.
- The hospital did not meet the target of 95% of non-admitted NHS patients beginning their treatment within 18 weeks of referral in September 2015 and from January to June 2016.

## Meeting people's individual needs

### Access and flow

- Patient appointments were arranged through the consultant's individual secretaries and with the outpatient reception team.
- NHS patients who used the choose and book system, were subject to the NHS waiting time criteria. This was managed by the hospital's own dedicated NHS administration team.
- The hospital had very low 'Did not attend' rates. All patients who missed their appointment were contacted by the individual consultant's secretary.
- The hospital had no patients waiting six weeks or longer from referral for MRI, CT or diagnostic ultrasound, in the period July 2015 to June 2016.
- The turnaround times for MRI and CT scans were audited. The hospital reported that 85% of scans were reported within 48 hours during the period July 2015 to June 2016. This was an improvement since the last inspection in October 2014.
- Staff recognised the need for supporting people with complex needs. Staff we spoke with could give of examples of where patients' individual needs had been taken into consideration. For example, a young patient with a learning disability was seen immediately on arrival in the department to reduce their anxiety. Staff had selected a quiet room for the consultation.
- All staff had undertaken dementia awareness training, as part of their mandatory training. Staff were able to explain to us the care that would be required for a patient living with dementia.
- All written information and signage, including pre-appointment information was provided in English. Staff had access to a telephone interpreting service, and knew how to access this service if required. This service also provided information in a wide variety of formats to meet peoples individual needs, and ensured the hospital met the accessible information standard (required by law from 31 July 2016). Staff we spoke with did not always know about the range of formats provided by this service.
- We noted there was a 'Pregnancy Safety Poster' displayed in the diagnostic imaging waiting area, providing importance safety information to patients.
- Chaperones were available to patients and there was information displayed in the waiting areas for both OPD and diagnostic imaging. The signage informing patients about the chaperone service not easy to read as it was small and printed in pale colours. The signs would be difficult for a person with a visual impairment to read.

# Outpatients and diagnostic imaging

- There were suitable private patient changing facilities in the diagnostic and imaging department, these were fitted with call bells to summon help.
- There was ample seating in waiting areas. All consulting rooms and communal spaces were accessible to patients that used wheelchairs.
- The diagnostic imaging department was spacious and fully accessible to patients attending for x-rays on beds, for example after orthopaedic surgery.
- In the diagnostic imaging department patients could help themselves to a range of information cards describing the procedures offered by the department. They were written in accessible language and were also available in large print on request.
- There was a separate children's waiting area in the OPD with age appropriate toys. The hospital were trialling an electronic toy in this area to amuse younger children. The area was also suitable for older children. Young people could use this area or choose to wait in the main waiting area.
- There was a selection of toys in the diagnostic imaging department within the main waiting area.
- There were complimentary refreshment facilities provided for patients in the hospital waiting areas.

## Learning from complaints and concerns

- Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the complaints leaflet, and on the hospital's website.
- Staff were aware of the complaints procedure.
- Complaint themes and key learning was reviewed at the clinical governance committee and disseminated throughout the hospital.
- In addition, all complaints, concerns, compliments and themes were discussed within the hospital leadership team's monthly meetings, the quarterly integrated governance committee meetings and within the monthly executive board meetings.
- Staff told us if someone had a concern or a complaint they would try and deal with the matter there and then.

Failing that, they would provide the patient with a feedback card and escalate the issue to their manager. This was in accordance with the hospital's policy on handling complaints.

- Formal complaints were received by the governance team and were documented on the incident reporting system. Any complaint response letters were checked by both the governance team and the hospital director to ensure the complaint had been dealt with effectively.
- Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had wished to make a complaint.

## Are outpatients and diagnostic imaging services well-led?

Good 

We rated well-led as good

## Leadership / culture of service

- Managers in the OPD and diagnostic imaging departments had clinical roles and were highly visible and easily accessible to staff. Staff reported good support and guidance from their managers. Managers were experienced and spoke passionately about their teams and caring for their patients. Staff felt listened to and were confident to raise concerns or suggest improvements to services.
- In OPD the team leader for administration worked to ensure that patient appointments were scheduled correctly and that any patients who did not attend appointments were contacted.
- Staff told us their immediate managers had appropriate skills, qualifications and experience to be able to lead and run departments, and were supportive.
- The OPD and diagnostic imaging departments has a staff sickness rate of below 1%. This was lower than other independent acute hospitals we hold this type of data for (July 2015 to June 2016). There were no staffing vacancies for nurses or healthcare assistants in the outpatients department as at July 2016. There was no staff turnover for nurses working in the OPD.

# Outpatients and diagnostic imaging

## Vision and strategy for this core service

- The Spire Southampton Hospital had a clear statement of vision and values. The strategy was to deliver the highest quality outcomes, the best patient care and to be the patients' number one choice.
- The hospital had its own statement of purpose. This described their purpose, parameters and principles for healthcare provision. The hospital's vision and strategy were displayed throughout the areas we visited. Staff in the OPD and diagnostic imaging were able to refer to the hospital's vision and strategy and explain how their role supported these.
- All staff demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner.
- Vision and values were discussed and reviewed regularly during hospital leadership team meetings, senior management team meetings and staff forums.
- The individual service plan included the construction of an additional x-ray room in the department. Work had not started on this.

## Governance, risk management and quality measurement for this core service

- All policies were approved at a local and corporate level. Staff had access to policies on the Spire intranet.
- Policies for radiological examination were written up as standard operating procedures.
- Local guidance information was on display in every x-ray room.
- There was a risk register in place for the hospital. We saw this was up to date and risks were identified and mitigated. Each risk had a named lead that was responsible for the mitigating actions and final resolution. The risk register had recently been devised for the diagnostic imaging department and contained some constant risks that were already appropriately mitigated.

- We saw minutes of meetings that demonstrated outpatients and diagnostic imaging staff reported to, and regularly attended hospital governance meetings. The departments presented their action plans to the clinical governance committee and discussed risks.
- At the time of our inspection, the consultant practising privileges database demonstrated 100% compliance with practising privileges requirements for the 326 consultants working at the hospital.

## Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction feedback card and by the Friends and Family Test that was collected from all NHS patients.
- During our visit we saw there were a number of collection boxes for patients to return their completed feedback cards. These survey results were tracked and shared with all departments. In addition, results were discussed at the leads meetings each month.
- There was a regular publication called 'Hot Gossip' that carried information for staff about changes in staffing, and staff participation in charity and social events.
- Important operational information that was shared with staff was put in to a 'first sight' folder, where staff could sign to confirm they were aware of communications. We found 'first sight' folders in both the OPD and diagnostic imaging. These contained the most up-to-date information for staff and a sign-sheet showing staff who had read it.

## Innovation, improvement and sustainability

- Staff in OPD and diagnostic imaging reported the hospital management were supportive and responded to requests and suggestions for improvement. For example, there was an interactive electronic toy on trial in the children's waiting area of outpatients. There were also plans in place for the provision of a further x-ray room to increase resilience and capacity.
- The Hospital Director held staff forums. This allowed staff to ask questions and hear the latest news and business developments.

# Outstanding practice and areas for improvement

## Outstanding practice

- The oncology suite was exceptionally welcoming and comfortable for people with cancer, and patients felt their privacy and dignity always to be respected. Patients felt very well supported, and very comfortable with contacting the hospital with any concerns.
- The OPD and diagnostic imaging departments had a staff sickness rate of below 1%.

## Areas for improvement

### Action the provider **MUST** take to improve

#### Action the provider **MUST** take to meet the regulations:

- Ensure medicines are securely stored in the medicines fridge on the critical care unit.
- Ensure records evidence patients on the critical care unit are reviewed twice a day by their consultant, in line with current national guidance.
- Ensure entries in critical care patient records include the time as well as the date staff made the entry.
- Ensure patient records on the general wards are updated following medical review.
- Ensure bedrails are used with the patients consent or if they cannot get consent from the patient, they apply the Mental Capacity Act to ensure bed rails are used in the best interest of the patient.
- Ensure all areas of the critical care service, including areas used outside the unit, are assessed for potential risk of harm to patients and staff, and appropriate action taken to mitigate identified risks.
- Ensure there is appropriate pathway documentation and guidance for patients undergoing neurosurgical procedures.
- Ensure adequate theatre cleaning to support infection control and safe operating practices.
- Review ward staffing for safe levels at night, so that the ratios reflect the actual numbers employed at night for safe delivery of care

- Ensure that risks to patients are re assessed and monitored consistently on each ward, and that records are updated and contain enough detail to enable staff to reduce those risks effectively
- Improve storage of cleaning chemicals covered by Control of Substances Hazardous to Health Regulations 2002.

### Action the provider **SHOULD** take to improve

- Ensure that all patients are given enough support and opportunity to be fully involved in the planning of their own care.
- Ventilation in the endoscopy treatment room should be compliant with department of health heating and ventilation systems guidance.
- Consider undertaking observational hand hygiene audits.
- Tracking and tracing records for equipment in endoscopy should be fully completed.
- Develop systems for monitoring patient outcomes following gastrointestinal endoscopy.
- Provide staff with formal training in end of life care.
- Review the outreach service to assess whether it meets current national guidelines.
- Consider removing the word 'cot side' from care pathways and using the more respectful wording of 'bed rails'.
- Ensure entries in critical care patient's medical records include the time as well as the date staff made the entry.

# Outstanding practice and areas for improvement

- Consider monitoring any impact the increase in surgical procedures has on patient flow through the hospital.
- Ensure consistency in ward cleaning to support safe care.
- Ensure that there is consistency in checking of CDs.
- Improve completion rates for VTE thromboprophylaxis assessment and treatment.
- Provide safety testing of theatre equipment.
- Ensure that theatre logs are always completed.
- Review theatre staffing levels to ensure sufficient staff are employed to allow for staff breaks.
- Ensure that staff bags are secured in lockers rather than left on anaesthetic room floor.



## 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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent  <b>11(1) Care and treatment of service users must only be provided with the consent of the relevant person.</b> <ul style="list-style-type: none"><li>Consent was not obtained from patients when bed rails were used.</li></ul>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment  <b>12(1) Care and treatment must be provided in a safe way for service users.</b>  <b>12(2). Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include</b> <ul style="list-style-type: none"><li>(a). assessing the risks to the health and safety of service users of receiving the care or treatment;</li><li>(b). doing all that is reasonably practicable to mitigate any such risks;</li><li>(g). the proper and safe management of medicines;</li><li>(h). assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.</li></ul> <ul style="list-style-type: none"><li>Theatres and theatre equipment were not cleaned adequately</li><li>Patients were not re-assessed for risks following surgery.</li><li>The medicine fridge on the critical care unit was unlocked.</li></ul>

This section is primarily information for the provider

## Requirement notices

- There was a risk that medicines could be accessed by unauthorised personnel.

### Regulated activity

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

### Regulation

Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

**15 (1).All premises and equipment used by the service provider must be**

**(b) secure,**

**(c) suitable for the purpose for which they are being used.**

- Control of Substances Hazardous to Health 2002 items were not stored securely.
- The storeroom shared between the critical care unit and the operating theatres department was disorganised and cluttered. This posed a risk of injury to staff when accessing equipment in the cupboard and risk of delay accessing equipment when needed for patient care and treatment.

### Regulated activity

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

### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

**17(1)Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.**

**17(2)Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to**

**(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.**

This section is primarily information for the provider

## Requirement notices

- Records did not consistently demonstrate daily medical reviews.
- Patient records in the critical care unit did not consistently include the time as well as the date staff made the entry.

### Regulated activity

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

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.**

- There were insufficient numbers of staff at night according to the hospital agreed ratios.