

# Spire Portsmouth Hospital

## Quality Report

Bartons Road  
Havant  
Hampshire  
PO9 5NP  
Tel: 023 9245 6000  
Website: [www.spirehealthcare.com/portsmouth](http://www.spirehealthcare.com/portsmouth)

Date of inspection visit: 13-14 April 2016 and  
unannounced 28 April 2016  
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

### Ratings

#### Overall rating for this location

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



# Summary of findings

## Letter from the Chief Inspector of Hospitals

Spire Portsmouth Hospital is purpose built and opened 1984, part of Spire Healthcare Limited hospital network. It is a private hospital providing a range of surgical and medical services for outpatient, day case and inpatients. Services are provided to private and NHS patients aged 18 years and over.

The hospital currently operates 50 beds used flexibly for inpatients and day care across two wards, a single bedded room can be equipped for enhanced monitoring. There is no critical care facility or emergency department at the hospital. The first floor ward has four oncology day care pods and a treatment room for day case chemotherapy.

The on-site facilities include an endoscopy suite, three operating theatres (two with laminar airflow) an outpatient department and diagnostic imaging department offering plain X-ray, ultrasound, mammography, MRI and CT scans. Physiotherapy treatment is offered as an inpatient and outpatient service in its own physiotherapy suite of gym and treatment areas. There is an accredited sterile services department and pathology laboratory on site.

Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Orthopaedic services are available to NHS patients through Choose and Book.

We inspected the hospital as part of our planned inspection programme, visiting 13-14 April 2016 followed by an unannounced visit 28 April 2016. This was a comprehensive inspection and we looked at the three core services provided by the hospital: medicine, surgery, and outpatients and diagnostic imaging.

The hospital was rated as 'good' overall.. All services were rated good overall, with safety requiring improvement in surgical, and outpatient and diagnostic imaging services. .

Our key findings were as follows:

### **Are services safe at this hospital?**

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

- We had concerns that the layout and some practices in the operating theatre department did not fully protect patients from the risk of hospital acquired infections. At the time of the inspection the hospital did not follow national guidance recommendations that for surgery carried out under Ultra Clean Ventilation (UCV) systems, the equipment should be prepared under the same conditions.
- In diagnostic imaging a member of staff who was not an authorised health professional under the legislation relating to Patient Group Directions (PGD), had been permitted to issue two contrast media products via PGD. When we brought this to the attention of the radiology manager, this practice was ceased immediately.
- In all other respects medicines were stored securely and managed safely. Pharmacy staff were actively involved in the pre-admission, admission, inpatient and discharge processes.
- Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed and staff clearly demonstrated examples of learning from these. Senior management understood and adhered to the Duty of Candour appropriately
- Clinical areas were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staff received appropriate training to perform their role safely, were supported to keep their skills up-to-date. The hospital set a target of 95% compliance with mandatory training. The compliance rate overall for 2015 was at 84% with some training such as information governance on target at 95%.

# Summary of findings

- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Equipment was safety tested and well maintained, in line with manufacturer's guidance. The estates and engineering department had excellent systems, processes and procedures for ensuring appropriate monitoring and maintenance, and decontamination, of equipment across the hospital.
- Records were managed safely, securely stored on site and available when needed. Processes were in place to reduce risks to private patient records taken off site by consultant secretaries.
- Staff routinely assessed and monitored risks to patients. There were appropriate transfer arrangements to transfer patients to a local NHS hospital if required.
- Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times.
- Plans and arrangements were in place to respond to emergency situations.

## **Are services effective at this hospital?**

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

- Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation.
- Endoscopy staff took account of National Institute for Health and Care Excellence (NICE) guidance, but work was ongoing to achieve Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation.
- Patient outcome data was reported for comparative analysis for surgical services, but outcomes following endoscopy procedures were not monitored at the hospital. The hospital was introducing an electronic system April 2016, to capture outcome data following a procedure.
- The hospital took part, and performed in line with England average, in national audits to measure outcomes for NHS patients undergoing joint replacement surgery.
- Oncology patient outcomes were monitored at cancer multi-disciplinary (MDT) meetings and work was ongoing to ensure 100% of notes of MDT meetings were available at the hospital
- Staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.
- Staff were supported in their role through appraisals. All staff were appraised or had appraisals booked with their managers. Staff were encouraged to participate in training and development to support them to deliver good quality care.
- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. The medical advisory committee (MAC) reviewed patient outcomes and the renewal of practising privileges of individual consultants. It also reviewed policies and guidance and advised on effective care and treatments.
- Communication between Medical Advisory Committee (MAC) Chair and the local trust medical directors was maintained to ensure a coordinated approach to consultant engagement. Consultant concerns were discussed by the hospital management team with the MAC Chair, and if considered serious enough, with the Spire Medical Director.

# Summary of findings

- Radiology staff were aware of competencies of consultants for procedures and use of equipment. Senior staff in outpatient department (OPD) were informed of the competencies or any restrictions on practice for individual consultants by the senior management team if issues arose.
- Patients' pain needs were met appropriately during and following a procedure or investigation.
- The consent process for patients was well structured and included consent for anaesthesia. Although rarely used in practice, staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The hospital offered a choice of meals and drinks and the chef catered for patients requiring special diets. The Patient Led Assessment of the Care Environment (PLACE) in 2015 rated the quality of ward food as 100%, higher than the England average 94%.

## **Are services caring at this hospital?**

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

- During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Staff maintained patients' dignity and respect at all times.
- Patients commented positively about the care provided by all staff and said they were treated courteously and respectfully.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.
- The hospital patient satisfaction survey showed a rating of 93% against the average provider group score of 92% for 'discussing patient care and treatment plans.'
- Staff supported patients emotionally with their care and treatment as needed.
- Hospital performance data January 2016 to March 2016 showed care and attention from the nurses score as 99%.

## **Are services responsive at this hospital?**

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

- Services were planned and delivered in way which met the needs of the local population. Patients told us that there was good access to appointments and at times which suited their needs.
- Facilities and premises were appropriate for the services being delivered.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Physiotherapy and diagnostic imaging appointments were on time and patients were generally kept informed of any delays in outpatient clinics
- The hospital met the referral to treatment time targets for NHS patients.
- Staff assessed patient's needs before admission, and the hospital was able to take the needs of different people into account when planning and delivering services. For example, suitably trained staff ensured the hospital met the needs of patients living with dementia or a learning disability.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 88% for dementia which was higher than the England average of 81%.
- Staff took account of individual patient's spiritual, religious and emotional needs when delivering care and treatment.

# Summary of findings

- There was patient information on specific procedures, conditions and hospital charges. This was in English with other languages or formats, such as braille, available on request. The hospital reported that they had minimal numbers of patients who could not understand English. For those patients, they had good access to translation service, when needed.
- The hospital dealt with complaints and concerns promptly, and there was evidence that the hospital used learning from complaints to improve the quality of care.

## Are services well led at this hospital?

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

- There was a clear statement of goals and a local strategy with a strong focus on continuous learning and improvement across the hospital. This aligned with the corporate vision and mission for excellence and highest quality patient care.
- Staff knew and understood the hospital vision and strategic goals and how that aligned with their services. Staff and senior managers were committed to, and demonstrated, the organisational values in their day to day work.
- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff leads attended governance meetings and committees. Staff received feedback from hospital-wide meetings in emails and through team meetings and minutes.
- Quality and safety of care was regularly discussed in senior management team meetings, and in other relevant meetings below that level. The Spire Healthcare Clinical Scorecard, covered a range of quality and safety information for hospitals across the organisation. This was used by the hospital as a focus for local improvement and benchmarking against other hospitals. The hospital was investing in training for the newly appointed governance lead and was committed to improving root cause analysis and learning from incidents
- There was a hospital-wide risk register which incorporated departmental risks which may affect staff, patients and visitors. Staff were able to escalate concerns and the risk registers reflected the actions to be taken to mitigate risks.
- The Medical Advisory Committee (MAC) met quarterly. The MAC had standing agenda items, which included a quarterly clinical governance report, incidents and complaints, quality assurance, practicing privileges and proposed new clinical services and techniques.
- All policies were approved at corporate and local level. Staff had access to policies in hard copy and on the intranet.
- Staff enjoyed working at the hospital. They described an open culture and felt supported by their management. They were extremely complimentary about their managers and positive about the recent changes in management at the hospital. They told us the leadership team were visible, accessible and approachable. They felt concerns were listened to and where possible acted upon.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. During 2015 the hospital reported consistently high levels (between 98% and 100%) of patients would recommend the hospital to their friends and families. The hospital patient satisfaction survey results showed improvement although overall just below target in net scores for 2015, there were clear action plans for further improvements based on patient feedback.

There were areas where the provider needs to make improvements.

# Summary of findings

Importantly, the provider must ensure:

- The door from theatre 1 and theatre 2 into the shared preparation room cannot be opened at the same time.
- Assessments of all risks associated with practices in theatres are carried out in a timely manner and actions to mitigate any identified risks are recorded, monitored and regularly reviewed.

In addition the provider should ensure:

- Action taken to mitigate any identified risks in theatre practices should take into consideration national guidance and recommendations.
- Incidents should be appropriately graded and investigations should follow best practice in root cause analysis.
- The hospital should ensure continued progress of action plan to achieve Joint Advisory Guidance accreditation in gastrointestinal endoscopy.
- There should be continued work to have a copy of oncology patients MDT notes 100% of the time.
- The hospital should ensure compliance with all mandatory training to meet hospital target of 95%.
- All staff should receive feedback on complaints from patients.
- There should be more monitoring of outpatient clinics to identify any improvements.

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

# Summary of findings

## Our judgements about each of the main services

### Service

#### Medical care

### Rating Summary of each main service

Good



Endoscopy, oncology and the ward areas were visibly clean and there were good infection prevention and control practices to reduce the risk of infection. Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure and chemotherapy at the hospital. Staff reviewed patient risks, and patient risks were appropriately monitored during their stay. Staff had an awareness of safeguarding, and steps to take to prevent abuse from occurring. Mandatory training compliance ranged from 76% to 95%.

Staff were supported in their role through appraisals, and there was 100% compliance. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Medical staff obtained informed consent from patients prior to endoscopy procedures and chemotherapy.

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. The endoscopy lead following risk assessment, had put current decontamination workflow practises in place, to prevent any adverse impact to patients. During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Patients commented positively about the care provided from all of the endoscopy, oncology, and ward staff. Patients were treated courteously and respectfully. Patients felt well informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a chemotherapy treatment in oncology and on the ward. 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. For example,

# Summary of findings

patients attending the oncology department were asked if they had any special needs, in case these could affect their treatment options or care preferences.

Staff in endoscopy and oncology were clear about the vision and strategy for their services, 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 the endoscopy and oncology leads to report to for concerns/ issues to be discussed.

## Surgery

We rated surgical services as requires improvement for safe and good for effective, caring, responsive and well-led.

Staff understood their responsibilities to raise concerns and report incidents, and there was evidence learning occurred as a result. Nurse staffing levels were based on an assessment of patient needs and there was a low level of agency usage across the department. Consultants and the Resident Medical Officer (RMO) provided 24 hour medical cover to respond to any clinical issues.

Nursing and medical staff were caring, compassionate and patient centred in their approach. We observed staff maintained patient's respect and dignity at all times. Patients felt they received enough information about their treatment and were involved in decisions about their care.

Good



The hospital took part in national audits to measure outcomes for NHS patients undergoing joint replacement surgery. The hospital and processes that staff followed to assess and respond to patient risk that included using the five steps to safer surgery WHO checklist, using the national early warning scale (NEWS) to identify any deterioration in a patient's condition. There was a one bedded enhanced recovery area on the ward and the hospital had a service level agreement with a local acute hospital for emergency transfers to critical care facilities.

Staff worked effectively across different disciplines and had good links with staff at other Spire hospitals and local NHS services. Nursing and medical competence was good, with trained professionals



# Summary of findings

taking pride in their work. There was a strong sense of loyalty and teamwork among staff. Staff valued the support from their leaders and liked working in the service.

We found some practices in the operating theatre department did not fully protect patients from the risk of hospital acquired infections. Two theatres shared a preparation room. There was no mechanism to ensure only one theatre door into the preparation room was open at a time. We observed both door from the theatres opening into the preparation room at the same time. This had the potential to reduce effectiveness of over pressurisation and therefore increase risk of cross infection.

There was no assessment of risks associated with preparing for two surgical procedures at the same time in the same preparation room. The hospital did not follow national guidance recommendations that for surgery carried out under Ultra Clean Ventilation (UCV) systems, the equipment should be prepared under the same conditions. There was no assessment completed to identify any risks this practice may pose to patients.

## Outpatients and diagnostic imaging

Outpatient areas were clean and that equipment was well maintained. Staffing levels were as planned for safe care. Patient records were available for appointments, and the department had timely access to test results.

There was good multidisciplinary team working. Staff told us there was good support in their role, with appropriate opportunities to develop their skills further.

We observed that staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care.

Hospital staff, together with consultant private secretaries, managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities.

There were effective governance processes in place. Staff worked well together in teams, and were positive about the leadership of the service at both local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. The hospital used different methods to gather feedback from patients about their experience.

Good



## Summary of findings

Although there were appropriate systems in place to keep patients safe and medicines were generally managed safely. In diagnostic imaging a member of staff who was not an authorised health professional was authorised by the hospital to administer contrast media products. When we brought this to the attention of the radiology manager, this practice was ceased immediately.

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# Summary of findings

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Good 

# Spire Portsmouth Hospital

## Services we looked at

Medical care; Surgery; Outpatients and diagnostic imaging.

# Summary of this inspection

## Background to Spire Portsmouth Hospital

Spire Portsmouth Hospital is purpose built and opened in 1984, it is currently provided by Spire Healthcare Limited. The hospital is situated midway between Portsmouth and Chichester, in its own grounds with parking.

The hospital currently operates 50 beds, used flexibly for inpatients and day care, across two wards. The ground floor ward has 24 beds in single rooms and a single bedded room can be equipped for enhanced monitoring. There is no critical care facility or emergency department at the hospital. The first floor ward has 20 beds plus four oncology day care pods and a treatment room, for day case chemotherapy.

The on-site facilities include an endoscopy suite, three operating theatres (two with laminar airflow). The outpatient department has two procedure rooms, two treatment rooms, and 12 consulting rooms. The diagnostic imaging department offers plain X-ray, ultrasound, mammography, MRI and CT scans. Physiotherapy treatment is offered as an inpatient and outpatient service in its own physiotherapy suite of gym and treatment areas. There is an accredited sterile services department and pathology laboratory on site.

The hospital provides a range of services to patients aged 18 years and over, who are self-pay or use private medical insurance. Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Orthopaedic services are available to NHS patients through Choose and Book.

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

The registered manager, Mrs Heather Dob, registered on 11 August 2015.

The nominated individual from Spire Healthcare Limited Mr Jean Jaques De Gorter, registered on 1 October 2010.

## Our inspection team

Our inspection team was led by:

**Inspection Lead:** Anne Davis, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists: consultant surgeon, theatre manager, medical nurse, oncology nurse, radiotherapist, and governance lead.

## Why we carried out this inspection

We undertook a comprehensive inspection of the hospital as part of our planned inspection programme of independent acute hospitals.

## How we carried out this inspection

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

- Is it safe?
- Is it effective?

# Summary of this inspection

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

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We carried out an announced inspection visit between 13 -14 April 2016, and a routine unannounced inspection 28 April 2016.

We held focus groups for staff in the hospital. We also spoke with staff and managers individually. We talked

with patients and staff from the ward, oncology day unit, physiotherapy department, operating department, X-Ray, endoscopy unit, and outpatient services. We observed care and treatment, talked with patients, and reviewed patients' records of care and treatment.

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

## Information about Spire Portsmouth Hospital

### Key facts and figures

The hospital provides a range of services to patients aged 18 years and over, who are self-pay or use private medical insurance. Services offered include general surgery, orthopaedics, cosmetic surgery, refractive eye surgery, gynaecology, ophthalmology, oral & maxillofacial surgery, general medicine, oncology, dermatology, physiotherapy, endoscopy and diagnostic imaging. Orthopaedic services are available to NHS patients through Choose and Book. .

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

4,574 day-case inpatients;

2,095 overnight inpatients;

5,516 visits to theatre;

24,832 outpatients (first attendees).

26,924 outpatient follow ups

The most common surgical procedures were :

- 391 arthroscopic operation on knee
- 325 injections into joints
- 262 Phacoemulsification of lens with implant procedures
- 159 Total knee replacement procedures.
- 141 breast augmentation

The most common medical procedures were :

- 532 Endoscopic laryngopharyngoscopy
- 262 Diagnostic oesophago-gastroduodenoscopy
- 243 Diagnostic flexible sigmoidoscopy
- 188 Colonoscopy

The accountable officer for controlled drugs is, Heather Dob registered manager

# 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?**

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

Requires improvement



- We had concerns that the layout and some practices in the operating theatre department did not fully protect patients from the risk of hospital acquired infections. At the time of the inspection the hospital did not follow national guidance recommendations that for surgery carried out under Ultra Clean Ventilation (UCV) systems, the equipment should be prepared under the same conditions.
- In diagnostic imaging a member of staff who was not an authorised health professional under the legislation relating to Patient Group Directions (PGD), had been permitted to issue two contrast media products via PGD. When we brought this to the attention of the radiology manager, this practice was ceased immediately.
- In all other respects medicines were stored securely and managed safely. Pharmacy staff were actively involved in the pre-admission, admission, inpatient and discharge processes.
- Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed and staff clearly demonstrated examples of learning from these. Senior management understood and adhered to the Duty of Candour appropriately
- Clinical areas were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staff received appropriate training to perform their role safely, were supported to keep their skills up-to-date. The hospital set a target of 95% compliance with mandatory training. The compliance rate overall for 2015 was at 84% with some training such as information governance on target at 95%.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Equipment was safety tested and well maintained, in line with manufacturer's guidance. The estates and engineering department had excellent systems, processes and procedures for ensuring appropriate monitoring and maintenance, and decontamination, of equipment across the hospital.

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- Records were managed safely, securely stored on site and available when needed. Processes were in place to reduce risks to private patient records taken off site by consultant secretaries.
- Staff routinely assessed and monitored risks to patients. There were appropriate transfer arrangements to transfer patients to a local NHS hospital if required.
- Staffing levels and skills mix were planned, implemented and reviewed to keep patient's safe at all times.
- Plans and arrangements were in place to respond to emergency situations.

## Are services effective?

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

- Patients care and treatment was planned and delivered in line with current evidence based guidance, best practice and legislation.
- Endoscopy staff took account of National Institute for Health and Care Excellence (NICE) guidance, but work was ongoing to achieve Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation.
- Patient outcome data was reported for comparative analysis for surgical services, but outcomes following endoscopy procedures were not monitored at the hospital. The hospital was introducing an electronic system April 2016, to capture outcome data following a procedure.
- The hospital took part, and performed in line with England average, in national audits to measure outcomes for NHS patients undergoing joint replacement surgery.
- Oncology patient outcomes were monitored at cancer multi-disciplinary (MDT) meetings and work was ongoing to ensure 100% of notes of MDT meetings were available at the hospital
- Staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.
- Staff were supported in their role through appraisals. All staff were appraised or had appraisals booked with their managers. Staff were encouraged to participate in training and development to support them to deliver good quality care.
- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. The

Good





# Summary of this inspection

medical advisory committee (MAC) reviewed patient outcomes and the renewal of practising privileges of individual consultants. It also reviewed policies and guidance and advised on effective care and treatments.

- Communication between Medical Advisory Committee (MAC) Chair and the local trust medical directors was maintained to ensure a coordinated approach to consultant engagement. Consultant concerns were discussed by the hospital management team with the MAC Chair, and if considered serious enough, with the Spire Medical Director.
- Radiology staff were aware of competencies of consultants for procedures and use of equipment. Senior staff in outpatient department (OPD) were not formally aware of the competencies or any restrictions on practice for individual consultants
- Patients' pain needs were met appropriately during and following a procedure or investigation.
- The consent process for patients was well structured and included consent for anaesthesia. Although rarely used in practice, staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- The hospital offered a choice of meals and drinks and the chef catered for patients requiring special diets. The Patient Led Assessment of the Care Environment (PLACE) in 2015 rated the quality of ward food as 100%, higher than the England average 94%.

## Are services caring?

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

- During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Staff maintained patients' dignity and respect at all times.
- Patients commented positively about the care provided by all staff and said they were treated courteously and respectfully.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.
- The hospital patient satisfaction survey showed a rating of 93% against the average provider group score of 92% for 'discussing patient care and treatment plans.'
- Staff supported patients emotionally with their care and treatment as needed.
- Hospital performance data January 2016 to March 2016 showed care and attention from the nurses score as 99%.

Good



# Summary of this inspection

## Are services responsive?

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

- Services were planned and delivered in way which met the needs of the local population. Patients told us that there was good access to appointments and at times which suited their needs.
- Facilities and premises were appropriate for the services being delivered.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Physiotherapy and diagnostic imaging appointments were on time and patients were generally kept informed of any delays in outpatient clinics
- The hospital met the referral to treatment time targets for NHS patients.
- Staff assessed patient's needs before admission, and the hospital was able to take the needs of different people into account when planning and delivering services. For example, suitably trained staff ensured the hospital met the needs of patients living with dementia or a learning disability.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 88% for dementia which was higher than the England average of 81%.
- Staff took account of individual patient's spiritual, religious and emotional needs when delivering care and treatment.
- There was patient information on specific procedures, conditions and hospital charges. This was in English with other languages or formats, such as braille, available on request. The hospital reported that they had minimal numbers of patients who could not understand English. For those patients, they had good access to translation service, when needed.
- The hospital dealt with complaints and concerns promptly, and there was evidence that the hospital used learning from complaints to improve the quality of care.

Good



## Are services well-led?

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

- There was a clear statement of goals and a local strategy with a strong focus on continuous learning and improvement across the hospital. This aligned with the corporate vision and mission for excellence and highest quality patient care.

Good



# Summary of this inspection

- Staff knew and understood the hospital vision and strategic goals and how that aligned with their services. Staff and senior managers were committed to, and demonstrated, the organisational values in their day to day work.
- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff leads attended governance meetings and committees. Staff received feedback from hospital-wide meetings in emails and through team meetings and minutes.
- Quality and safety of care was regularly discussed in senior management team meetings, and in other relevant meetings below that level. The Spire Healthcare Clinical Scorecard, covered a range of quality and safety information for hospitals across the organisation. This was used by the hospital as a focus for local improvement and benchmarking against other hospitals. The hospital was investing in training for the newly appointed governance lead and was committed to improving root cause analysis and learning from incidents
- There was a hospital- wide risk register which incorporated departmental risks which may affect staff, patients and visitors. Staff were able to escalate concerns and the risk registers reflected the actions to be taken to mitigate risks.
- The Medical Advisory Committee (MAC) met quarterly. The MAC had standing agenda items, which included a quarterly clinical governance report, incidents and complaints, quality assurance, practicing privileges and proposed new clinical services and techniques.
- All policies were approved at corporate and local level. Staff had access to policies in hard copy and on the intranet.
- Staff enjoyed working at the hospital. They described an open culture and felt supported by their management. They were extremely complimentary about their managers and positive about the recent changes in management at the hospital. They told us the leadership team were visible, accessible and approachable. They felt concerns were listened to and where possible acted upon.
- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. During 2015 the hospital reported consistently high levels (between 98% and 100%) of patients would recommend the hospital to

## Summary of this inspection

their friends and families. The hospital patient satisfaction survey results showed improvement although overall just below target in net scores for 2015, there were clear action plans for further improvements based on patient feedback.

# Detailed findings from this inspection

## Overview of ratings






Our ratings for this location are:

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

### Notes

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

# Medical care

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

## Information about the service

Spire Hospital Portsmouth provides medical services to patients who pay for themselves, are insured, or are NHS patients. Medical services include those services that involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Endoscopy or chemotherapy services undertaken as a day case are also included within medical care. During the period January 2015 to December 2015, there were five overnight gastrointestinal patients and two oncology patients.

There were 693 elective gastrointestinal endoscopies performed by consultants between January 2015 and December 2015. There were also 532 elective endoscopic laryngoscopies and 74 other specified diagnostic endoscopic procedures during this period.

The endoscopy operating theatre was situated in the main theatre suite. There was also a flexible scope-washer room with clean and dirty processing areas, and a four bayed recovery area shared with main theatres.

The oncology suite consisted of four patient treatment rooms, and five ensuite single rooms. There was also a consulting room, treatment room and waiting area. The oncology service was for treating day case patients only.

We spoke with a consultant, endoscopy, oncology and outpatient lead nurses, theatre manager, pre-operative nurse team leader, theatre practitioner, breast care specialist nurse, three registered nurses, five patients, two relatives, and a member of administrative staff. Before, during and after our inspection we reviewed the provider's performance and quality information.

## Summary of findings

**We found that medical care was 'good' for safe, effective, caring, responsive and well led.**

Endoscopy, oncology and the ward areas were visibly clean and there were good infection prevention and control practices to reduce the risk of infection. Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure and chemotherapy at the hospital. Staff reviewed patient risks, and patient risks were appropriately monitored during their stay.

Staff had an awareness of safeguarding, and steps to take to prevent abuse from occurring.

Mandatory training compliance ranged from 76% to 95%.

Staff were supported in their role through appraisals, and there was 100% compliance. Staff were encouraged and supported to participate in training and development to enable them to deliver good quality care. Medical staff obtained informed consent from patients prior to endoscopy procedures and chemotherapy.

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. The endoscopy lead following risk assessment, had put current decontamination workflow practises in place, to prevent any adverse impact to patients.

# Medical care

During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Patients commented positively about the care provided from all of the endoscopy, oncology, and ward staff. Patients were treated courteously and respectfully. Patients felt well informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a chemotherapy treatment in oncology and on the ward.

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. For example, patients attending the oncology department were asked if they had any special needs, in case these could affect their treatment options or care preferences.

Staff in endoscopy and oncology were clear about the vision and strategy for their services, 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 the endoscopy and oncology leads to report to for concerns/ issues to be discussed.

## Are medical care services safe?

Good 

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

### We rated safe as 'good' because;

- Staff followed processes and procedures to report incidents, and share lessons learnt.
- Endoscopy, oncology and the ward areas were visibly clean and there were good infection prevention and control practices to reduce the risk of infection.
- Patients were risk assessed to make sure only those that were suitable underwent an endoscopy procedure and received chemotherapy at the hospital. Staff reviewed patient risks and appropriately monitored a patient's risks during their stay.
- Clinical staff compliance with face-to-face advanced life support training exceeded the standard set by the provider.
- Equipment was well maintained and tested in line with manufacturer's guidance. Medicines were stored and handled correctly.
- Medical staff undertook the endoscopy procedures. The service adopted a flexible approach to rostering in response to scheduling of lists.
- Staff had an awareness of safeguarding and steps to take to prevent abuse from occurring.
- The nursing and medical staffing was as planned to provide safe medical care.

### However:

- Mandatory training undertaken by e learning was at 84% against a target of 95% for the period January to December 2015. However, information governance was at 95%.
- Compliance of clinical staff with face-to-face basic life support training and immediate life support training combined was at 76%.

### Incidents

## Medical care

- The hospital had reported 373 clinical incidents in the period January 2015 to December 2015. The overall rate of incidents reported during that period had risen slightly in the reporting period; this demonstrates a good reporting culture.
  - Staff in the endoscopy and oncology services were aware of their responsibility to report incidents. Staff in endoscopy had reported 16 incidents, and staff had reported six in oncology, during the period January 2015 to December 2015. Staff we spoke with were confident to report incidents and challenge poor behaviour by staff at any level, medical or nursing, if they were concerned about poor practice that could harm a person.
  - Within the endoscopy and oncology units, there were no serious incidents (January 2015 to December 2015).
  - The leads understood the importance of learning from incidents. The lead in endoscopy following when there was missing/incorrect details on a specimen pot, introduced a new work instruction for staff working in endoscopy. The lead in oncology, following a patient having an adverse reaction to a medication, asked staff to ensure that new patients were always placed close to where nursing staff are located, to enable increased observation of a patient.
  - The hospital held a multidisciplinary weekly incident meeting, attended by heads of department or deputy, which all staff found very helpful for sharing learning. The oncology lead discussed how recently there had been incidences of slips, trips and falls, and that the multidisciplinary approach was key to helping to prevent this type of incident.
  - Staff in endoscopy and oncology 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 an incident occurred in oncology or endoscopy, nursing staff, were open and honest to talking with patients following incidents.
  - No never events had been reported in the endoscopy or oncology service. Never events are serious incidents that should not occur if the preventable safety measures have been put in place.
- Safety thermometer or equivalent (how does the service monitor safety and use results)**
- The hospital displayed clinical performance data for the whole hospital in the oncology reception, and near the entrance to the main ward where endoscopy patients were cared for before and after their procedures. The data included details for the period January to March 2016 about hospital infection rate (0.4% per inpatient admission calculated on three months inpatient activity and number of serious incidents (4).
- Cleanliness, infection control and hygiene**
- The hospital had policies and procedures in place to manage infection prevention and control. Staff were able to access the policies and procedures. We saw policies and processes for the management of waste and decontamination.
  - All areas were visibly clean.
  - 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 and administering chemotherapy.
  - In oncology, an asepsis audit undertaken in December 2015, which involved observing practice and commenting on compliance. A member of staff had opened an aseptic pack, and then left it covered ready to use. The auditor advised the member of staff this was not best practice, and a nurse should not open a sterile pack until immediately required.
  - Staff adhered to the 'bare below the elbow' policy when providing care and treatment. Compliance with good hand hygiene practice was checked through quarterly audits and checks on usage of hand gel.
  - The hospital scored 100% for cleanliness, compared to the national average of 98% for the patient-led assessment of the care environment (PLACE) audit in 2015.



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- The hospital had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA) or
- Staff followed a cleaning schedule and maintained a record providing assurance of cleanliness.
- Staff took weekly samples of the water in endoscopy to check for contaminants. The endoscopy lead and estates department ensured that when the results were borderline, appropriate action was taken.
- 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 had risk assessed the decontamination process, and work instructions were in place to reduce the risk of cross contamination. There was a drying cupboard for the endoscopes. Endoscopy staff kept flexible endoscope tracking and traceability records of the decontamination process tracing the serial number of the equipment used to each individual patient.
- The clinical effectiveness lead undertook an audit of the decontamination processes in the endoscopy environment in January 2015 and developed an action plan to address areas where non compliant with Joint Advisory Guidance in gastrointestinal endoscopy. The actions were for example new work instructions needed completion. Where major work needed, for example building work, this was scheduled for completion during 2016.
- Staff undertook an audit of the endoscopy environment in April 2015. This showed compliance with 10 of 11 audit questions. The noncompliance was regarding evidence of previous audits of the endoscopy environment.

### Environment and equipment

- The number of endoscopes and size of scopes enabled scheduled lists to run uninterrupted, which meets the standard set by the Joint Advisory Guidance on gastrointestinal endoscopy. There were also a sufficient number of monitors, cameras and printers.
- Medical equipment used in oncology and endoscopy was tested as part of annual servicing. The asset register and equipment maintenance schedule for the hospital showed that 98% of equipment maintenance was in date.
- The hospital had placed a resuscitation trolley just outside of oncology. Records showed that nursing staff in February, March and for part of April 2016 that the trolley was checked daily to ensure the contents were complete and in date, except for one day in February 2016. The trolley had tamper evident tags to prevent access by unauthorised personnel.
- The theatres had mobile resuscitation trolleys for use if a patient had a cardiac arrest. Records showed that staff checked the trolleys daily in line with professional guidance to ensure equipment was available and in date. All trolleys had a tamper proof tag to prevent access by unauthorised personnel.
- Staff in endoscopy and oncology services were following good practice with the management of waste and sharps. Sharps bins were at the point of use, and used appropriately. Sharps injury instructions were highly visible and available in designated locations.

### Medicines

- Patients attending the oncology day unit received intravenous chemotherapy, for which safe systems had been put in place.
- Medical staff were responsible for prescribing chemotherapy.
- The hospital pharmacist checked the chemotherapy products, which was supplied by an outside pharmacy, before delivery to the ward. The hospital had made a decision to stop reconstituting chemotherapy on site, which was explained to the consultants in February 2016. This decision minimised risks for patients.
- Two nurses trained in the administration of chemotherapy checked the medication before administering to a patient in the treatment room.
- Two nurses trained in the administration of chemotherapy then checked the patient details and name band in a patient's room against the prescription and chemotherapy product. The administration rate checked and chemotherapy infusion commenced.
- Nursing staff trained in the administration of chemotherapy administered the chemotherapy agent using a venous access device inserted into the patient.
- In the oncology unit, emergency medicines, including extravasation kits were available for use. An

## Medical care

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 found to be in date. Staff were aware of the procedure for managing extravasation and the procedure to follow if the situation occurred.

- An anaphylaxis kit, for treating anaphylactic shock, was present on the unit with the content clearly marked. The anaphylaxis kit was in date.
- Chemotherapy spillage kits were available.
- A patient having an endoscopy may have the procedure under sedation. Endoscopy staff ensured a medication was available in case a patient reacted adversely to the medication used for sedation.
- We reviewed the storage of controlled drugs (prescription medicines that are controlled under Misuse of Drugs legislation). Controlled drugs were transported, stored securely, administered and records kept according to legislative requirements.

### Records

- We reviewed six records, three in endoscopy and three in oncology.
- The patients undergoing endoscopy completed the 'assessing you for admission form', which the nurse then reviewed. Nursing staff completed the gastrointestinal pathway for a patient undergoing an endoscopy.
- The medical and nursing staff in endoscopy had completed a safer surgery checklist (World Health Organisation) in endoscopy.
- Nursing staff completed the administration care pathway for a patient having systemic anti-cancer therapy.
- Nursing and medical staff had completed accurately, legible records, which were up to date and stored securely.

### Safeguarding

- Nursing staff in endoscopy and oncology were alert to signs of abuse, and could explain how they would respond if they witnessed or suspected abuse. Nurses in the endoscopy and oncology departments confirmed there had been no safeguarding incidents in the last year.

- Staff working in endoscopy and oncology were aware of the corporate safeguarding vulnerable adults' policy and the safeguarding leads for the hospital. All hospital staff received child protection training.
- Staff working in endoscopy and oncology were 98% compliant with level 1 and level 2 safeguarding training, against the hospital target of 95%, for the period January 2015 to December 2015.

### Mandatory training

- The hospital overall for the period January 2015 to December 2015 were 84% mandatory training undertaken as e learning against a target of 95%. This did not include the data for information governance, which was 95%, against a target of 95%.
- Compliance of clinical staff with face-to-face basic life support training and immediate life support training combined was at 76%.
- Compliance with advanced life support training exceeded the standard set by the provider.
- The hospital also provided face-to-face training for fire prevention, infection prevention and control and manual handling. For fire prevention, all staff compliance was at 89%, for clinical staff infection control and manual handling training at 94%, and for non clinical staff infection control compliance at 82%. The hospital clarified after the inspection the additional face-to-face training was designed to reinforce the learning provided in the provider's mandatory e learning programme (fire, manual handling and infection control).
- Bank staff working within oncology and endoscopy services were included in the above compliance figures. The ward manager confirmed that agency staff were not used in oncology or the theatre departments.

### Assessing and responding to patient risk

- Patients were asked to complete a postal pre-assessment health check questionnaire. A registered nurse checked the returned questionnaires prior to the procedure to assess a patient's suitability and fitness for endoscopy. The pre-operative assessment nurse would advise the consultant's secretary, if there were any medical risk factors that the consultant needed to be made aware of.

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- The endoscopy list order took account of a patient's health risks. For example, if a patient had diabetes, the patient was listed first to prevent the possibility of low blood sugar in pre-operative starvation period. Patients were advised to bring any tablets or insulin to control their diabetes with them. A patient could take their medication after the procedure.
- The endoscopy service used a modified five steps to safer surgery checklist (World Health Organisation) to fit with their service. For the three records we checked, the list had been fully completed. At the clinical audit and effectiveness committee in April 2015, it had been noted that compliance with the safety surgery checklist needed improvement. This had been followed up by the head of clinical services.
- The national early warning system (NEWS) is a scoring system that identifies patients at risk of deterioration, or needing urgent review. This included observations of vital signs and the patient's wellbeing to identify whether they were at risk of deteriorating. This system was in use for patients undergoing endoscopy. Medical and nursing staff were aware of the appropriate action if a patient scored higher than expected.
- If staff in the endoscopy operating theatre required extra assistance urgently, there was an emergency call button to alert the staff member in an adjoining room designated to decontaminate the endoscopes.
- The nurses completed an oncology nursing assessment, as part of a specifically designed care pathway, for oncology patients on admission. The patient's assessment included information about the risks of chemotherapy, and how these risks could be 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.
- The hospital had a transfer agreement with a nearby trust and a policy in place for a patient who became unwell. A patient from endoscopy had required urgent transfer, and the process in place had worked well.

## Nursing staffing

- There were three staff specifically dedicated to supporting the performance of gastrointestinal endoscopy procedures. Other staff working in theatres with competencies in gastrointestinal endoscopy also

supported the scheduled endoscopy lists. The endoscopy lead confirmed the staffing skill mix and competencies were appropriate and were as planned for the endoscopy procedure lists that were scheduled at the hospital. No gastrointestinal endoscopy lists had been cancelled due to not having sufficient appropriately skilled staff.

- Staff from the endoscopy suite worked in main theatres, when there was not an endoscopy list taking place.
- Three registered nurses and a healthcare support worker formed the oncology team. Two chemotherapy-trained nurses were always on a duty when a patient was booked for a chemotherapy treatment. The oncology lead confirmed the skill mix and competencies of staff enabled the needs of oncology patients attending the unit to be met effectively.

## Medical staffing

- The medical staff, who undertook endoscopies, also regularly performed gastrointestinal endoscopy procedures within the NHS.
- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The consultants in oncology also worked in the NHS as oncologists.
- A Resident Medical Officer (RMO) provided 24 hour, seven day a week cover at the hospital. The RMO cover was supplied through an agency who also checked their competency. This included ensuring the RMO was trained in advanced life support.
- The endoscopist saw patients on the ward after the procedure, to feedback findings and ongoing plan of care. If an oncologist had left the hospital before a patient's chemotherapy treatment had completed, nursing staff would care for the patient. The leads reported timely access to the consultants if a patient's needs changed, and that there was a formal arrangement that the consultants provided cover for each other's patients if required. For example, a patient

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experienced a complication following an endoscopy carried out at the hospital. The consultant undertook some further treatment to manage the complication, and went with the patient to a local NHS trust hospital.

## Major incident awareness and training

- Facilities staff tested the electricity generator each month to ensure it was safe to use in case of power failure, and there was a yearly full load test. The estates manager advised the generator could provide a minimum of three days power supply.
- The hospital held regular unannounced fire drills, and a table top exercise with night staff and theatre staff. We observed fully equipped fireboxes, which included a call sheet and an updated contact sheet.

## Are medical care services effective?

Good 

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

## We rated effective as 'good' because;

- People's care and treatment took account of current evidence based guidance, standards and legislation in oncology.
- Endoscopy staff took account of National Institute for Health and Care Excellence (NICE) guidance, but did not have Joint Advisory Group (JAG) on gastrointestinal endoscopy accreditation.
- The leads supported staff in their role through undertaking appraisals. There was 100% compliance with staff appraisals. Staff were encouraged to participate in training and development to enable them to deliver good quality care.
- The consultants obtained informed consent from patients prior to endoscopy and chemotherapy procedures.
- Staff monitored a patient for any pain, and responded promptly if pain relief required.

## However;

- People's care and treatment outcomes following endoscopy procedures were not monitored at the hospital. The hospital was introducing an electronic system April 2016, to enable the endoscopist to input outcome data following a procedure.

## Evidence-based care and treatment

- The oncology unit had been awarded the Macmillan Quality Environment Mark (MQEM), a detailed quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer.
- The endoscopy service were actively working towards JAG accreditation. The service had self assessed themselves against the Joint Advisory Group (JAG) global rating scale (GRS). The GRS is a quality improvement system designed to provide a framework for continuous improvement for endoscopy services to achieve and maintain accreditation. The service had then produced an action plan to support them in achieving JAG accreditation. For example a protocol had been developed in relation to diabetes, anticoagulation therapy and an initial patient consent audit completed.
- Endoscopy staff booked procedures in line with British Society of Gastroenterology (BSG) guidance. This meant that sufficient time was given for procedures not to be rushed that could cause endoscopy staff to fail to detect abnormalities.
- The oncology unit followed best practice guidance in the care of their patients using NICE guidance sources.
- Policies, pathways and audits were discussed at quarterly clinical audit and effectiveness meetings. For example, an updated transfer policy discussed at the meeting in June 2016.
- Staff adhered to local policies and procedures. The oncology lead had placed a list with the oncology policies for staff to sign, to evidence when staff had read them.

## Pain relief

- Staff offered patients undergoing gastroscopy a throat spray to reduce discomfort, and/ or intravenous sedation, to minimise their discomfort and pain.

## Medical care

- Medical staff performed colonoscopies under intravenous sedation, to ensure a person was relaxed and comfortable during the procedure.
- Nurses monitored a patient's pain using a pain scale. The three patient records we reviewed and our observations confirmed that staff gave patients pain relief when appropriate.

### Nutrition and hydration

- Patients having a gastroscopy were advised not to eat or drink anything for at least six hours prior to appointment time, to enable good views of the stomach.
- Patients due to attend for a colonoscopy, was given detailed advice on how to prepare for the procedure that included administering a laxative and advice regarding dietary and fluid intake.
- Following a gastroscopy or a colonoscopy, patients were offered 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 was supportive, and would visit a patient in oncology to discuss their dietary needs if required.
- The Patient Led Assessment of the Care Environment (PLACE) in 2015 rated the quality of ward food as 100%, the England average was 94%.

### Patient outcomes

- The endoscopy service self assessment, using the GRS, found development was needed in clinical quality, safety, comfort, quality, appropriateness, results, aftercare and workforce. Progress to address these issues, for JAG accreditation, was being made with the support of a staff endoscopy user group.
- The endoscopy lead advised us there was no system used for the monitoring and review of clinical performance data, for endoscopy procedures performed at the hospital. The lead advised us that during April 2016, an electronic system was to be introduced to enable the outcome of gastrointestinal procedures to be recorded, as required for JAG accreditation.
- 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, recorded in patient medical notes.

- The oncology service undertook a gap analysis against the 19 cancer standards in May 2015. In April 2016 the service was compliant with 17 of the standards, and rated themselves at 'amber' with two of the standards. One of these standards was in relation to obtaining a patient's NHS multidisciplinary meeting notes. The lead advised compliance had improved to 75% patients with notes on site and was hoping to achieve 100% through further liaison with the local NHS trusts. There was a separate medicines management audit schedule including medicine reconciliation, controlled drugs (CDs) and missed doses. Results for 2015 showed that for nine of the 12 month period there was 100% compliance with medicine reconciliation.
- There was a provider audit schedule for 2016 supported by an audit calendar. This schedule consisted of procedural audits of processes and procedures undertaken in endoscopy and oncology.
- The head of clinical services informed us that the provider was working with the private healthcare information network (PHIN), in relation to the collection and publication of clinical outcomes.

### Competent staff

- The leads in oncology and endoscopy advised us that all staff appraisals were up to date.
- Medical staff performed endoscopy procedures, supported by nurses with specific endoscopy skills.
- The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff. We reviewed three electronic records which demonstrated there was a process in place to ensure consultants documentation, including, general medical council registration/ relevant speciality and scope of practice, appraisal and disclosure and barring service check up to date. The system sent a reminder if any documents overdue. The Hospital Director (registered manager) had suspended a consultant practising privileges when they did not produce an appraisal.

# Medical care

- Nursing staff in oncology had received training and were competent in the use of vascular access devices.
- Nurses in oncology were able to describe how to respond if a chemotherapy medication leaked from a vein into the surrounding tissues.
- The oncology nurses were competent to manage intravenous catheters used in a patient's vein to deliver chemotherapy medication.
- Nursing staff in oncology had also undertaken some specific communication training called 'Sage and Thyme'. The model provides structure to psychological support by encouraging the health worker to hold back with advice and prompting the concerned person to consider their own solutions.
- 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.
- The RMO completed training and appraisals through their employing locum agency. They also had a Spire consultant mentor who they met with every three months to discuss and monitor progress with their development goals for the year.

## Multidisciplinary working ( in relation to this core service)

- The oncology lead had developed good working relationships with local NHS trust, this included sending patients NHS cancer multidisciplinary notes at the hospital.
- Consultants were involved in cancer MDT meetings at the NHS trusts and these were sometimes attended by the oncology lead.
- The breast care nurse specialist worked closely with the oncology nurses and doctors to ensure effective support for patients.
- There was effective multidisciplinary working in the oncology and the endoscopy unit. During our inspection, the administrative, pre-assessment, endoscopy, oncology, medical and ward 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 support might be required.
- We observed there was effective team working between all staff groups. A daily morning bed meeting facilitated this, where a representative of each department was present. The meeting enabled staff to communicate their team's priorities and issues with other departments and share workload if necessary.

## Seven-day services

- The endoscopy procedures were planned interventions, and endoscopy theatre operating sessions were available from 8:30am to 12:30pm, 1.30pm to 5.30pm and 5.30pm to 8.30pm Monday to Friday with occasional Saturday lists.
- The oncology service was available Monday to Thursday 8.30am to 4.30pm. Staff administered chemotherapy treatments Monday to Thursday. For patients who were receiving chemotherapy there was seven day support available through an out of hours contact number, if any adverse side effects.
- Pharmacy was open Monday to Friday. The hospital pharmacist advised there was also an on call rota for pharmacy advice out of hours, which was part of the hospital on call list.
- The hospital operated an on-call system for senior managers seven days a week.

## Access to information

- Endoscopy patients, on discharge, received a letter that included the reason for the procedure, findings, medication and any changes, potential concerns and what to do and details of any follow up. The nurse sent a copy of this letter to the GP and placed a copy in the patient's medical records at the hospital.
- Nursing staff in oncology sent a letter to the patient's GP detailing chemotherapy treatment administered, and symptoms the patient may report, when the oncology out of hours number should be contacted. The lead in oncology explained that if blood tests were needed urgently to assess a patient's response following chemotherapy, the GP surgery was contacted by telephone.

## Medical care

- The oncology lead also sent treatment details to the two local NHS trusts so they were aware of patients, in case patients contacted those oncology departments urgently out of hours.
- Staff provided oncology patients with information that included a contact number for the hospital in case they needed support with any symptoms and/or side effects. For example, a leaflet was given 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 very helpful.
- The hospital kept records on site for three months after admission (aiming for six months as there was room at the hospital), after which they were sent to an offsite national distribution centre. Staff could access paper records stored offsite within 24 hours. This meant staff could access past clinical information about patients previously treated at this hospital.
- An oncology consultant assessed a patient's understanding prior to obtaining consent using specifically designed consent forms for systemic anti-cancer therapy. This included a discussion of the benefits and risks.
- The hospital provided Mental Capacity Act (2005) training was part of the mandatory training programme. Staff we spoke with had not had to use knowledge and skills from this training in their practise at the hospital.

### Are medical care services caring?

Good 

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

**We rated caring as 'good' because;**

- During the inspection, we saw that staff were caring, sensitive to the needs of patients, and compassionate. Patients commented positively about the care provided by all of the endoscopy, oncology, and ward staff and said they were treated courteously and respectfully.
- Patients felt informed and involved in their procedures and care. This included their care after discharge from an endoscopy procedure, a chemotherapy treatment in oncology and on the ward.
- Staff supported patients emotionally with their care and treatment as needed.

#### Compassionate care

- Staff treated patients with dignity and respect, and maintained a patients' privacy.
- Patients in oncology and endoscopy found staff to be compassionate and caring. A patient in oncology said 'they are so friendly and caring and cannot do enough to ensure what is a stressful time, is as pleasant experience as it can be'. A patient in endoscopy described the experience as 'perfect'.
- In the Patient Led Assessments of the Care Environment (PLACE) in April 2015 privacy, dignity, and wellbeing scored 91% compared to an England average of 87%.

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

- Patients received information prior to their endoscopy procedure. This allowed patients to read the information and, if understood, give informed consent when they came for their procedure. Consent forms, we reviewed, were appropriately completed and signed and detailed the risks and benefits to the procedures.
- Best practice from the British society of gastroenterology (BSG) states that patients should be consented prior to the day of procedure and allowed a 'cooling off period' after consultation. This was reflected in the corporate consent policy published in January 2016, and was the practice advocated by the hospital. The endoscopy lead, as part of achieving JAG accreditation had designed an audit of the location where and when the consultant obtained consent for endoscopy procedures. The initial results demonstrated that about third of patients were being consented on the day, rather than during prior consultation with the consultant. The lead explained for this first audit, not all the patients had received the questionnaire so were not accurate results. The lead recently re launched the questionnaire and planned to discuss the findings and determine progress actions through the endoscopy user group.

## Medical care

- Hospital clinical performance data displayed for the quarter January 2016 to March 2016 showed care and attention from the nurses score which was 99%, and Friends and Family test score which was 97%.

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

- Patients' undergoing an endoscopy 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 in any decision-making, and listened to them.
- The hospital patient satisfaction survey showed a rating of 93% against the average provider group score of 92% for 'discussing patient care and treatment plans.' One patient admitted for a colonoscopy of the three we spoke with, was concerned a staff member had not updated him about a delay to the performance of his procedure.
- Patients in oncology and endoscopy found medical and nursing staff caring in their approach explaining clearly ongoing plans. For example, following an endoscopy procedure the consultant visited the patient and provided feedback on findings and ongoing plan of care.
- Patients from oncology and endoscopy we spoke with found the information provided, before, during and after treatment, was very helpful and reassuring.
- Patients also involved their close relatives, as they wanted to. The relatives we spoke with also felt well informed and cared for by staff, and able to support their loved ones.

### Emotional support

- Patients were able to have emotional support from family and friends at any time, as there were no restrictions to visiting times.
- A breast care nurse specialist was available Monday to Thursday for practical and emotional support for oncology patients. The oncology lead contacted other

clinical nurse specialists as required, to provide support for patients. An oncology patient reported how the support and kindness of staff had helped her get past her illness, 'I cannot speak highly enough'.

- The nurse lead in oncology explained a therapist from the Wessex Cancer Trust was now coming to the hospital one day a week to provide counselling and acupuncture.
- The oncology lead described how support groups for patients were being developed to provide emotional and practical support. The first breast care support group had run in December 2015. The first prostate support group in February 2016, and a gynaecology support group was due to commence in June 2016. The oncology lead explained there was a plan in the future to develop both male and female support groups.
- Nursing staff also provided a patient with information from the range of Macmillan leaflets, which contained details of support groups for emotional support.
- A chaplain came to the hospital one day a week, the chaplain provided support to any patient who wanted their support.

### Are medical care services responsive?

Good 

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

#### We rated responsive as 'good' because;

- The medical service met national waiting times for patients 92% should wait no longer than 18 weeks for treatment after referral for a gastrointestinal endoscopy procedure. 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.
- There were no waiting lists for oncology services at this hospital.



# Medical care

- The needs of different people were taken into account when planning and delivering services. Staff took account of individual patient's spiritual, religious and emotional needs when delivering care and treatment.
- Staff always listened to complaints, concerns, and communicated lessons learnt.

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

- The oncologists treated insured and self pay patients at the hospital on a planned outpatient based service. The oncology lead advised us, the four patient treatment rooms and five ensuite bedrooms were designed to meet the needs of patients.
- The lead in oncology advised the oncology unit was awarded the Macmillan environment quality mark in December 2015. This is a detailed quality framework, used for assessing whether cancer care environments meet the standards required for people living with cancer. Patients we spoke with were happy with the cleanliness and facilities in the environment, and felt comfortable.
- The oncology service had benchmarked themselves against the cancer standards to check compliance. The service was compliant in 17 out of 19 standards. The areas with ongoing work were obtaining 100% of patients' multidisciplinary notes and ensuring all patients who have a cancer diagnosis have comprehensive support.
- Patients were cared for in single rooms, offering privacy, pre and post endoscopy
- The endoscopy suite did have limitations due to the physical environment. The endoscopy lead following risk assessment, had put decontamination workflow practises in place, to prevent any adverse impact to patients.
- The head of clinical services advised us the senior team met with the clinical commissioning group to support effective planning of services at the hospital.

## Access and flow

- Consultants saw patients who were referred by their GP as an outpatient before an endoscopy procedure, to check the patient met the admission criteria, assess the patient and discuss a plan of treatment. This meant staff could plan for the flow of patients.
- Consultants undertook endoscopy procedures within two to four weeks of referral to the hospital, which was within national waiting times for NHS patients.
- NHS consultants referred oncology patients to the hospital following diagnosis at an NHS hospital. A patient could have chemotherapy treatment Monday to Thursday. There was not a waiting list for this treatment. The oncology lead advised they saw five to 16 patients a day. The lead also said depending on the needs of patients, treatments could take 15 minutes to several hours.

## 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 it could be performed, the examination process and after care. For a colonoscopy, the information included guidance on preparation, arrival time, the procedure and aftercare.
- Patients day surgery pre admission questionnaire included an assessment of people's individual daily living needs, which included a question to check if any additional support needed, to support effective communication and understanding.
- 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.
- The lead in oncology explained the department also had a 'concerns checklist' that a patient could complete. The checklist included physical, practical, family/relationship, emotional, spiritual or religious and lifestyle concerns. A patient could score these concerns, and there was then guidance on how staff could support a patient. The lead advised patients did not always complete these checklists, but the information was helpful when completed to ensure a patient's individual needs were met.
- Staff told us that an interpreting service was available at the hospital if required.

## Medical care

- The oncology unit had a well stocked supply of leaflets and patients could access those that suited their individual needs.
- Oncology nurses provided patients with information on discharge, should they have any concerns when not attending for treatment. They gave them information about the signs and symptoms to look out for following chemotherapy, and what they could do to relieve them. They also gave them in and out of hours contact details in case of advice or concerns.

### Learning from complaints and concerns

- The provider had produced a leaflet for the hospitals within the group entitled 'Please talk to us', which was available in the patient bedrooms in endoscopy and oncology. The leaflet provided information about how to raise a concern or make a complaint.
- The hospital had received 102 complaints during the period January 2015 to December 2015. One of these complaints related to oncology, in relation to communication. The ward manager with the nurse, to prevent reoccurrence, addressed this. The head of clinical services advised were no complaints relating to endoscopy between January 2015 and December 2015.
- The leads advised that complaints were discussed at the weekly incidents meeting, and monthly clinical governance meetings to ensure any lessons learned shared promptly with staff.
- The hospital also included learning from complaints on within their displayed clinical performance data, as 'you said, we did'. One comment was 'we did not have enough signs' and the hospital had responded 'we have increased the number of signs and we have made them more visible'.

### Are medical care services well-led?

Good 

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

### We rated well led as 'good' because;

- The leads were able to outline their vision for their services, and steps being taken to deliver 'highest quality patient care', in line with the provider mission statement.
- There was a strategy for improvement in endoscopy and oncology. This included improvement priorities for oncology and joint advisory group (JAG) accreditation for gastrointestinal endoscopy.
- Governance arrangements ensured that incidents, complaints, audit results and policy development were reviewed and learning shared appropriately.
- The staff we spoke with described an open culture and leaders to be visible and approachable.
- There was a strong focus on continuous learning and improvement within the organisation and the service.

### Vision and strategy for this this core service

- Staff spoke passionately about the service they provided and the care they offered to patients.
- Staff had a clear ambition for the service and were aware of the vision for the department. This was in line with the provider mission statement, which was 'to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care'.
- The corporate provider strategy was for all hospitals in the group to be JAG accredited. The matron at another hospital within the Spire group, with JAG accreditation, was providing leadership towards achieving this objective. There was an action plan in place, which the endoscopy lead was working through with the support of the theatre manager and head of clinical services.
- There was a corporate and hospital wide strategy for improvement in cancer services. This included meeting cancer standards and having a 100% compliance of evidence of NHS cancer patients multidisciplinary team discussions in patients' medical notes.
- The oncology lead also told us of plans to develop the team so nurses were able to support consultants in their clinics as nurse specialists. Nurses within the oncology

# Medical care

team would develop specialist knowledge in a particular area, joining patients who were having a new cancer diagnosis to facilitate joint discussion of patient treatment plans.

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

- There was a hospital wide risk register, with specific sections for the oncology department and endoscopy service.
- The register detailed nine oncology risks, which the oncology lead was appropriately managing. The oncology lead, for example, explained that obtaining multidisciplinary reports for patients had improved with actions undertaken.
- The endoscopy service risk, not having JAG accreditation, was detailed within the theatre department risk register. The endoscopy lead was managing this risk through an action plan. An endoscopy user group was in place, which included the attendance of the head of clinical services and theatre manager enabling actions to be driven forward.
- The endoscopy lead explained a group email had been developed with other hospitals in the provider group, enabling them to support each other with queries and work through issues and challenges. The lead said for example, Spire Portsmouth Hospital now used the same endoscopy safety checklist used by the consultants in the local NHS trust, as the consultants were familiar with this checklist.
- The oncology lead attended the clinical governance meeting along with the heads of department enabling cascade of information up and down between staff and senior managers. The theatre manager at the clinical governance meeting represented the endoscopy lead.
- The hospital had other committees feeding into the clinical governance committee including medicines management, clinical audit and effectiveness, and infection control.
- The Medical Advisory Committee (MAC) included medical representation from endoscopy and oncology. The MAC had quarterly meetings. The MAC meeting minutes included an update from the clinical governance meeting and practising privileges.

## Leadership and culture of service

- Front line staff were very positive about the leadership at departmental and senior management level. The leadership team was visible and approachable.
- The theatre manager oversaw the endoscopy service and worked with the endoscopy lead nurse.
- The oncology lead was supported by her line manager, the clinical nurse manager, who she saw often daily and they met formally monthly.
- Staff felt supported and worked in collaborative teams. All staff said they felt their role was valued.
- The Hospital Director (HD), registered manager, ensured consultants were informed of any changes. The HD recently held a meeting with the oncology consultants to ensure they were up to date with the introduction of prepared chemotherapy and outlined concerns with regard to evidence of compliance with multidisciplinary discussions.

## Public and staff engagement






- The consultants were positively involved in developments at the hospital and quality of care provided. In the annual consultant survey 2015 8% more consultants rated the hospital as excellent/ very good than in 2014. 97% recommended the hospital to their family and friends.
- The oncology lead took part in an abseil in March 2016 to raise money for the Wessex Cancer Trust. At 18 April 2016, £2,250 had been raised. The event was to raise awareness of the support the Wessex cancer trust can give to patients and their families, and to mark the beginning of a partnership between Wessex cancer trust and the hospital.
- The oncology lead advised the department had taken part in a Macmillan survey as part of working towards the Macmillan quality environment mark awarded in December 2015. Approximately 30 patients responded in a mostly positive way about their experience of being treated in the oncology unit. One of the respondents had suggested a hot drinks machine would be helpful, which the hospital has subsequently put in place.

## Innovation, improvement and sustainability

## Medical care

- The endoscopy lead was working through an endoscopy action plan towards the achievement of JAG accreditation. The hospital had set a target of December 2016.
- The head of cancer services for the provider was aiming to put e prescribing in place within oncology.
- A bi-annual Macmillan patient experience survey was completed in 2015 and will be repeated in 2017.
- The oncology lead was exploring the way forward with their on call service, and considering linking with Southampton Spire, to support sustainability.

# Surgery

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

## Information about the service

Spire Portsmouth Hospital provides elective surgery to patients who pay for themselves, are insured or are NHS funded patients. Between January 2015 and December 2015, there were 5,516 visits to theatre. Surgical operations included orthopaedics, ophthalmology, general surgery, ear, nose and throat (ENT), gynaecology, upper gastro intestinal (GI), lower GI, oral and maxillofacial surgery, cosmetic surgery, upper limb surgery, urology, vascular surgery, spinal surgery, pain management and breast surgery.

The hospital has four operating theatres. One of the theatres is dedicated to endoscopic procedures, this is reported on in the medicine section of this report. Of the three theatres dedicated to surgical work, two have ultra clean ventilation (UCV) systems (a system of circulating filtered air to reduce the risk of airborne contamination). The hospital manager told us the third theatre was going to be fitted with UCV system in August 2016. There is a dedicated recovery area within the main theatre complex. The hospital has 50 beds in use on two wards, which are used flexibly for inpatients and day case patients. There are no facilities to provide ongoing critical care treatment. There is a one bedded enhanced recovery area to provide care and treatment for patients requiring more intensive care and treatment for a short period of time post operatively or for stabilisation of their condition before transfer to critical care facilities at a local acute NHS hospital

Between January and December 2015 there were 4,547 day case treatments and 2,095 inpatient treatments. The NHS funded approximately 11% of day case and inpatient treatments. The surgical operations most commonly

performed were multiple arthroscopic operation on knees, injections and aspiration into joints with or without image guidance, phacoemulsification of lens with implant and biopsy of skin or subcutaneous tissue.

The inspection included a review of all the areas where surgical patients receive care and treatment. We visited the pre-assessment clinic, the surgical ward, anaesthetic rooms, theatres and recovery area. We spoke with 12 patients and reviewed nine patient records. During the inspection we spoke with 30 members of staff, including managers, medical staff, registered nurses, health care assistants, operating department assistants, allied health professionals and administrative staff. Before, during and after our inspection we reviewed the hospital's performance and quality information.

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## Summary of findings

We rated surgical services as requires improvement for safe and good for effective, caring, responsive and well-led.

Staff understood their responsibilities to raise concerns and report incidents, and there was evidence learning occurred as a result. Nurse staffing levels were based on an assessment of patient needs and there was a low level of agency usage across the department. Consultants and the Resident Medical Officer (RMO) provided 24 hour medical cover to respond to any clinical issues.

Nursing and medical staff were caring, compassionate and patient centred in their approach. We observed staff maintained patient's respect and dignity at all times. Patients felt they received enough information about their treatment and were involved in decisions about their care.

The hospital took part in national audits to measure outcomes for NHS patients undergoing joint replacement surgery. The hospital and processes that staff followed to assess and respond to patient risk that included using the five steps to safer surgery WHO checklist, using the national early warning scale (NEWS) to identify any deterioration in a patient's condition. There was a one bedded enhanced recovery area on the ward and the hospital had a service level agreement with a local acute hospital for emergency transfers to critical care facilities.

Staff worked effectively across different disciplines and had good links with staff at other Spire hospitals and local NHS services. Nursing and medical competence was good, with trained professionals taking pride in their work. There was a strong sense of loyalty and teamwork among staff. Staff valued the support from their leaders and liked working in the service.

We found some practices in the operating theatre department did not fully protect patients from the risk of hospital acquired infections. Two theatres shared a preparation room. There was no mechanism to ensure only one theatre door into the preparation room was open at a time. We observed both door from the

theatres opening into the preparation room at the same time. This had the potential to reduce effectiveness of over pressurisation and therefore increase risk of cross infection.

There was no assessment of risks associated with preparing for two surgical procedures at the same time in the same preparation room. The hospital did not follow national guidance recommendations that for surgery carried out under Ultra Clean Ventilation (UCV) systems, the equipment should be prepared under the same conditions. There was no assessment completed to identify any risks this practice may pose to patients.

# Surgery

## Are surgery services safe?

Requires improvement 

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

We rated safe as requires improvement because:

- Two theatres shared a preparation room. There was no mechanism to ensure only one theatre door into the preparation room was open at a time. We observed both doors from the theatres opening into the preparation room at the same time. This had the potential to reduce effectiveness of over pressurisation and increase risk of cross infection. There was no assessment of risks associated with preparing for two surgical procedures at the same time in the same preparation room.
- The hospital did not follow national guidance recommendations for surgery carried out under Ultra Clean Ventilation (UCV) systems, that equipment should be prepared under the same conditions. There was no assessment completed to identify any risk this practice may pose to patients.
- The investigation of incidents was not always in line with best practice in root cause analysis.

However,

- Staff understood their responsibilities to raise concerns and report incidents, and there was evidence learning occurred as a result.
- All clinical areas were visibly clean and appropriately equipped to provide safe care and treatment.
- Infection prevention and control practice on the wards was good. Infection prevention and control link staff in all departments provided advice and guidance for staff.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Staffing was at planned levels, following assessment of patient needs and guidance for safe care.

- Staff routinely assessed and monitored risks to patients. They used the national early warning score to identify patients whose condition might deteriorate. There were appropriate transfer arrangements to transfer patients to a local NHS hospital if required.

## Incidents

- There was a good culture of incident reporting. Staff at all levels and disciplines knew what incidents they needed to report and how to report them. Staff said they were confident with using the hospital's electronic incident reporting system. Staff confirmed they received feedback about incidents reported.
- There were no serious incidents reported between January 2015 and December 2015. However, on inspection we found three incidents that had been recorded as low grade but had been investigated using root cause analysis as they were serious events, however the grading had not been changed. The registered manager, recognising the need to improve learning from incidents, had appointed a part time clinical governance lead and instigated weekly incident discussion meetings. The root cause analysis investigations reviewed on inspection did not follow best practice and were not fully completed. The registered manager confirmed the governance lead was booked to attend accredited root cause analysis training in May 2016.
- There was a structured process for feedback and learning from incidents. Weekly and monthly meetings for head of departments supported discussion and learning from incidents across the hospital. Department meetings, newsletters, and hand over sessions provided opportunities for all staff to share feedback and learning from incidents. Members of staff told us about changes in practices that had come about as a result of learning from incidents. These included ensuring beds were set to low heights to reduce risk of patients falling when getting out of bed.
- There was evidence learning from incidents across the Spire hospital group was shared. A monthly bulletin detailed incidents and learning from incidents which had happened in other Spire Hospitals.
- Cosmetic governance meeting records showed learning from incidents happened across cosmetic surgery services, both in the independent and the NHS sector.

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- Staff had an awareness of the duty of candour legislation. Senior staff were following the legislation and gave an example of when they had followed the duty of candour process. The head of clinical services told us that incidents were reviewed at corporate level and checked for correct grading and application of duty of candour.

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

- The NHS Safety Thermometer is a local improvement tool that is used to measuring and monitoring patient harms and 'harm free' care. The latest monthly results from the safety thermometer were displayed at the hospital. Full year results for 2015 showed there had been no episodes of harm (venous thromboembolism pressure ulcers, falls, and hospital acquired urinary infection) for NHS patients treated at the hospital in 2015. The information displayed for patients clearly stated the data referred to NHS patients on a specific date in a month.
- The hospital did not have an equivalent process for gathering the same information for self-paying patients or those funded by health insurance policies. This meant the detail of harm free care for patients displayed during the year 2015 may not have accurately described the situation for all patients treated at the hospital.

## Cleanliness, infection control and hygiene

- National guidance (Department of Health: heating and ventilation systems Health Technical Memorandum 03-01 (HTM03-01)) 2007 specifies how theatre departments should be designed and built to reduce risks of cross infection and hospital acquired infections. The theatre department at Spire Portsmouth hospital was built prior to this guidance being published. This meant the hospital did not have to adhere to the guidance in this publication. However, the hospital should be mindful of the guidance in their practices and management of the operating theatre department. During the inspection we observed some practices in the operating theatre department that did not fully protect patients from risks of hospital acquired infections and indicated they were not constantly mindful of the HTM03-01 guidance.
- There were three theatres used for surgical procedures. Theatre 1 and 2 shared a preparation room. The

preparation room was accessed from the theatre corridor and from both theatres. The HTM03-01 details that where shared preparation rooms are used the air pressure in the preparation rooms should be higher than that in either of the theatres and the doors to the two theatres should be interlocked to prevent them being open at the same time. This is to maintain effective over-pressurisation and reduce the risk of cross-infection. We saw that the air pressure in the preparation rooms were checked regularly and met national guidelines. However, at both the announced and unannounced inspections, we saw the doors were opened to both theatres at the same time. This had the potential to reduce effectiveness of over-pressurisation and therefore increase risk of cross infection.

- On 14 April 2016, we saw the door from theatre 2 to the preparation room had a wedge to keep it open whilst ophthalmic instruments were being prepared for the start of surgery. Staff confirmed this was common practice and also that the door would then remain open during surgery. In addition, the door from theatre 2 into the anaesthetic room (used as storage and not for induction of anaesthesia) did not close completely. Following the inspection the Hospital Director (registered manager) told us action had been taken and the door from theatre 2 into the anaesthetic room now closed completely.
- On 28 April, at the unannounced inspection, we saw staff entering the preparation room from both theatre 1 and 2. We saw that the doors from both theatres into the preparation room were open at the same time as staff came in and out of the rooms.
- At the time of the inspection, there was no interlocking system to remove the risk of the doors from the preparation room being opened to both theatres at the same time.
- We asked if the hospital had completed an assessment of risks the practice of having both theatre doors open to the preparation room. We were told an assessment was not needed because there was no risk to patients. However, there was no record of how this decision was made, or who was involved in the decision process.



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- The registered manager told us refurbishment of the theatre department planned for August 2016 included the provision of interlocking doors from the preparation room to theatres 1 and 2.
- Staff confirmed staff from theatre 1 and 2 laid up for surgery at the same time in the preparation room. There was no consideration of the risks of contaminating the sterility of equipment due to several members of staff working in a confined space.
- Of the three theatres used for surgery, only theatres 1 and 3 had ultraclean theatre ventilation (UCV) system. National guidance recommends, that to reduce risks of surgical site infections, joint surgery is carried out in theatres that have a UCV system. The hospital manager confirmed joint surgery was carried out in all three theatres, which meant some joint surgery was carried out in the theatre that did not have a UCV system. The hospital director (registered manager) told us refurbishment of the theatre department planned for August 2016 included a UCV system for theatre 2.
- Preparation rooms do not have UCV systems. The HTM03-01 guidance states for operations taking place in UCV conditions “Laying up in the clean zone is preferable for infection control reasons,” which in practical terms meant laying up (preparing the surgical equipment) in the theatre that had UCV systems. However, the hospital laid up for all operations in the preparation room, including for those operations taking place in theatres with UCV systems. This meant equipment was prepared in a potentially less clean environment and then used to operate on a patient in a cleaner environment, thus reducing the effectiveness of operating under UCV systems. There was no documented assessment to identify any risks this practice posed to patients.
- Theatre 3 was also used for day case eye surgery. We observed patients entering the theatre in their own clothes and outdoor shoes. Staff told us this practice was followed to improve patient flow through theatres. The registered manager told us, to reduce risk of cross infection, there was a minimum of 30 minutes down time at the end of day case eye surgery lists to allow for thorough cleaning of the theatre.
- The hospital monitored the rate of surgical site infections, (SSI). Data for all primary hip and knee replacement surgery undertaken in all theatres, showed a rate of 0.17% SSIs for the period 2014 to 2015. However, data provided by the hospital showed that none of these infections occurred in patients who had undergone surgery in theatre 2.
- Ward and theatre areas were visibly clean at the time of inspection. General cleaning of the hospital was carried out by housekeeping staff employed by the hospital. Daily cleaning and bi annual deep clean of theatres was outsourced to another provider. The infection control link nurse and the theatre manager monitored the quality of cleaning.
- All departments had an infection control and prevention link member of staff who attended regular training and meetings chaired by the Infection and Prevention Lead for the hospital.
- There had been no reported cases of MRSA or Clostridium Dificile January 2015 to December 2015.

## Environment and equipment

- All surgical areas were tidy, well organised and equipment stored appropriately.
- Medical equipment was tested as part of annual servicing. The asset register and equipment maintenance schedule for the hospital showed that 98% of equipment maintenance was in date.
- The wards and theatres had mobile resuscitation trolleys for use if a patient had a cardiac arrest. Records showed that staff checked the trolleys daily in line with professional guidance to ensure equipment was available and in date. All trolleys had a tamper proof tag to prevent access by unauthorised personnel.
- Staff checked the difficult intubation trolley monthly to ensure equipment was available and in working order in the event of difficulties intubating a patient.
- Staff checked essential equipment regularly to ensure all equipment was available and in working order. Staff checked anaesthetic machines in theatres and anaesthetic rooms on each day that theatre was operating. We saw record books to confirm that this occurred on most days.
- There were three operating theatres in the theatre suite used for surgical procedures. Staff prepared equipment

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in advance for the next procedure in a separate preparation rooms, one that was shared between theatre 1 and 2 with theatre 3 having its own preparation room.

- There was a recovery area with facilities to care for patients in the immediate post-operative period before they returned to the ward.
- Theatre staff planned surgical equipment for operations in advance. Surgeons completed an equipment requirement form at patient booking, and no less than five days prior to surgery, to ensure the correct equipment and staffing for a procedure. Additional packed instruments were available quickly if required. The hospital could meet additional requests for equipment by outsourcing to external companies.
- Staff had access to the use of a hoist if needed to transfer patients with restricted mobility. We saw slings available for training as well as disposable slings for individual use.

## Medicines

- Staff followed the hospital's medicine management procedures and policies. We observed medicine administration in the recovery area, which showed staff followed the hospital's procedure for administering medicines.
- On the ward and in theatre, medicines including controlled drugs, and intravenous fluids were stored securely in locked cupboards and rooms. Staff on the wards kept medicine trolleys locked and secured to the wall when not in use. Private prescription pads were stored securely.
- Medicines were stored at safe temperatures. Staff monitored fridge and room temperatures and took appropriate action when temperatures were outside the recommended range. We saw records that evidenced staff monitored the temperatures.
- Pharmacy and nursing staff monitored and managed stock levels of medicines and controlled drugs appropriately. Staff completed the controlled drugs registers correctly. Three monthly audits were undertaken of controlled drugs held by wards and departments. Pharmacists supported the ward and

theatre staff. Pharmacist reviewed all prescription charts and carried out medicine reconciliation (MedRec) for all patients to ensure they continued to have their routinely prescribed medicines.

- There were piped medical gases in the theatre suite and ward. Portable oxygen cylinders were available for transfer of patients from theatre to the ward, and for use in patients' rooms.
- Regular small scale prepacking of To Take Out medicines was undertaken within Pharmacy. The prepacking records kept were not reflective of best practice. The pharmacy department did not keep copies of the labels attached to the TTO packages. We discussed this issue with the pharmacist manager. They told us they would change pharmacy practices to ensure copies of labels attached to dispensed TTOs were kept in the pharmacy department.

## Records

- Ward staff kept patient records in paper format and stored them securely in the ward office.
- We reviewed 12 sets of patient records and saw entries were legible, signed and dated by the member of staff who completed the record.
- The hospital had identified concerns with some consultants holding their own private patient records, which meant the hospital did not always have a full record of the patient's assessments, care and treatment. To ensure full patient records were available at the hospital, the hospital was working towards a single patient record of inpatient and outpatient activity which would include the consultant's notes.
- Patient notes were held on site for an average of three months following discharge. After two months they were stored off site in the secure Spire national distribution centre. Patient notes could be recalled within in 24 hours, or if needed in an emergency could be faxed securely to the hospital. This meant staff had access to patient's records in a timely manner.
- Patient's care records contained pre-operative assessments, records from the surgical procedure and anaesthetic, recovery observations, nursing and medical staff notes, and discharge checklists and

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assessments. The records also included multidisciplinary clinical notes, including those from physiotherapists and occupational therapists, to support safe care and treatment.

- The theatre administrator maintained a comprehensive log of implants and prosthetics on their prosthetics register.
- The hospital was working to resolve some IT problems that had caused delays with discharge information being sent to some patient's GPs. However, all patients were given a copy of their discharge information to hand in to their GP practice.
- The hospital had an innovative and simple way to alert staff that theatre lists had changed. Initial theatre lists were printed on white paper. They were then printed on yellow paper if there had been a change and on red paper if there had been a second change.
- Patient's records were held in the ward office securely. A board that detailed patients on the ward and patients coming in that day was located in the ward office. The door was kept shut for confidentiality and detail on the board could not be read from the ward corridor.

## Safeguarding

- The head of clinical services and the ward sister were the safeguarding leads for the hospital. They were level three trained which meant they were able to investigate safeguarding issues if required.
- Safeguarding was part of mandatory training for all staff. The hospital provided training for clinical staff to level 2, 99% had completed this training. Staff we spoke with knew what the term safeguarding meant and how to recognise signs of abuse. They could explain the reporting process, and how to seek support if they needed to.

## Mandatory training

- A role-specific mandatory training plan was assigned to each staff member. Staff completed most training electronically but this was supplemented by practical training where appropriate.
- Individual training records were kept in the ward and theatre offices, and staff could access this information on line. Senior staff regularly monitored and organised completion of mandatory training.

- Mandatory training that all staff had to complete included fire safety, health and safety, infection control and prevention, compassionate care and safeguarding adults levels 1 (or level 2 for all clinical staff), and moving and handling.
- Data provided by the hospital, showed in 2015 most staff had completed all mandatory training. The lowest number was for staff completing moving and handling training at 90%, and the highest was for members of staff completing safeguarding adults levels 1 and 2 training at 99%.
- Staff said they had time and opportunity to access mandatory training. Nursing staff told us their role specific mandatory training included blood transfusion and basic life support training.
- Bank staff told us they were required to, and were supported by the hospital, to complete the hospital's mandatory training programme.
- Medical staff completed mandatory training at the hospital they carried out the majority of their work through their substantive employer, and this was checked through the practise privileges renewal process. Resident medical officer (RMO) mandatory training was provided by their employing agency, this included advanced life support training.

## Assessing and responding to patient risk

- Patients completed a health questionnaire which nursing staff reviewed at pre-assessment to assess the suitability of patients for surgery at the Spire Portsmouth hospital. Staff confirmed that if the pre-assessment raised concerns they would escalate the issue to the surgeon or anaesthetist by telephone or email for further assessment. Patients had to meet certain criteria before the hospital accepted them for surgery.
- The anaesthetist could request an enhanced recovery bed on the ward in advance of surgery if they identified a patient as high risk and required level 1 care post operatively for a short period of time such as 24 hours. (Level 1 care includes patients at risk of their condition deteriorating, whose needs can be met on an acute ward with additional advice and support from a critical care team.) This was to ensure a bed and appropriate staffing levels were available to care for their needs. If

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needed, the hospital sought advice from the local acute NHS critical care service. The hospital did not admit patients who required level 2 or 3 postoperatively. However, they were able to provide short term level 2 care until patients could be transferred to the local acute NHS critical care service.

- Staff completed risk assessments appropriate to the length of patient stay. These included risks related to mobility, cognitive understanding, skin damage and venous thromboembolism (VTE). This provided a baseline measure and meant they could quickly identify signs that a patient's condition may be worsening
- Theatre staff used the 'five steps to safer surgery' WHO checklist. This is a nationally recognised system of checks before, during and after surgery, designed to prevent avoidable harm and mistakes during surgical procedures. We observed staff performing the checklist correctly and consistently during our visit. There was a programme of audits of compliance with the checklist, but the hospital did not supply the detailed result. The clinical audit and effectiveness committee minutes, April 2015, noted that compliance with the safety surgery checklist needed improvement. This had been followed up by the head of clinical services,
- Procedures were in place to monitor patients for any deterioration in their health. The hospital used the national early warning system (NEWS) after surgery to record patient observations, and a standard scoring system was in place across all patient pathways. Staff initiated the NEWS scoring in recovery and continued it on the ward. Staff we spoke to knew how to escalate concerns if a patient's observations deviated from expected ranges.
- There was an emergency transfer arrangement with a local acute NHS hospital for patients who deteriorated and needed critical care. The hospital policy and procedure for unplanned transfer of deteriorating patients was available on the intranet. Staff explained the procedure clearly and described how they had dealt safely with recent cases.
- All necessary equipment for the safe stabilisation and management of patients until transfer to the local acute NHS critical care services was available in the enhanced recovery area. This enabled the trust to provide short term level 2 care and treatment. The hospital's

agreement with the local NHS acute trust meant all equipment to provide care and treatment to patients during transfer was provided by the retrieval team from the acute NHS trust..

- There were 17 emergency transfers to the acute NHS hospital between January 2015 and December 2015. This meant that 0.26% of all patients treated during that period at the hospital required emergency transfer to an acute NHS hospital.
- The hospital had an emergency blood transfusion procedure. All clinical staff received training to equip them with the skills and competencies to transfuse blood. Two units of blood suitable to use for all patients in an emergency were stored in the blood fridge. Staff took part in scenarios held annually on what to do if a patient had a major haemorrhage.

## Nursing staffing

- The hospital used a modified version of the NICE approved safer nursing tool to plan the skill mix of staff, with continuous review on a daily basis. Ward staff told us staffing levels were adapted to meet the needs of the patients and the type of surgery they had received. For example, the hospital arranged extra suitably trained staff for enhanced recovery patients or other patients needing more close observation. Staff we spoke with said they did not experience problems in getting additional staff. Regular bank staff were called to cover additional shifts and permanent staff were often happy to work extra hours as they were paid to do so.
- There were always two registered nurses on duty on the ward, including nights and weekends, to enable staff to respond to emergencies. The use of bank and agency staff across the hospital from January to December 2015 was less than 20%.
- Staff working in the recovery area told us there were always two members of staff on duty. Extra staff, bank or permanent staff doing extra hours, were arranged to work during periods of increased activity.
- Student nurses worked on the wards in a supernumerary role. They were not counted in the shift numbers.
- The occasional use of bank staff meant theatre staffing ratios met the guidelines from the Association for Perioperative Practice (AfPP). Each theatre was staffed

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by an operating department assistant, a first assistant, two scrub nurses and a healthcare assistant (HCA) with no dual working by the scrub nurse. The theatre manager oversaw both theatres and the recovery area.

- The hospital told us and staff confirmed there was always a senior nurse on call cover out of hours, with support of a duty manager at all times.

## Surgical staffing

- Over 190 doctors, surgeons, anaesthetists and dentists had practising privileges at the hospital. They were competency assured as they undertook similar work regularly in the NHS. The medical advisory committee (MAC) reviewed their practising privileges every two years to check they continued to be suitable to work at the hospital.
- Consultants 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. The Resident Medical Officer (RMO) and nursing staff said consultants were always available out of hours for telephone advice and support. Staff told us consultants returned to the hospital to reassess their patients within 30 minutes if required. There had been one reported incident in 2015 where a consultant had not been contactable when needed. This had not affected the care and safety of the patient. As a result, processes were reviewed to ensure consultants were contactable. This included identifying if mobile coverage was available at the consultants home address or whether staff needed to contact the consultant by landline.
- The hospital employed two RMOs who worked opposite each other in weekly blocks. They were resident on site and available 24 hours a day, seven days a week. Their role was to review patients when required, prescribe additional medicines and liaise with consultants responsible for individual patient's care.
- The RMO we spoke with said consultants were on call for their patients 24 hours a day and they had no problems contacting them. There was always an anaesthetist on call to review patients if needed. The RMO told us ward staff did not call them frequently at night, and they achieved enough rest time to work effectively. There were two standby RMOs to cover sickness or emergencies.

## Major incident awareness and training

- The hospital had local and corporate business continuity plans for use in events such as internet or electricity failure. Staff knew how to access the plans.
- A generator was available for use in case of power failure and records showed staff tested this monthly.
- The provider held regular fire drills and there was a fire evacuation procedure on laminated card in each patient room.

## Are surgery services effective?

Good 

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

We rated effective as good because:

- Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards.
- Patients reported staff managed their pain effectively and they had access to a variety of methods for pain relief.
- The hospital offered a choice of meals and drinks and the chef catered for patients requiring special diets.
- The hospital took part in national audits to measure outcomes for NHS patients undergoing joint replacement surgery.
- Staff had good access to training and there were opportunities for staff to attend additional courses to extend their skills.
- Staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.
- Staff understood their responsibilities to the Mental Capacity Act 2005 and there was appropriate guidance to assess a patient's mental capacity.
- Informed consent was obtained prior to procedures and surgery being carried out. Some anaesthetists gained written consent from patients prior to anaesthetising

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them. This meant they were assured patients fully understood the anaesthetic process, the risks associated with anaesthesia and that the patient consented to have the anaesthetic.

## Evidence-based care and treatment

- Staff provided care to people based on national guidance, such as the National Institute for Health and Care Excellence (NICE) guidelines, and were aware of recent changes in guidance. We saw evidence of discussion of NICE guidelines in meetings and on clinical governance bulletins.
- There was a local and corporate annual audit programme. This included audits such as records, consent, Five Steps to safer surgical checklist, theatre, infection, prevention and control (IPC), VTE assessment and resuscitation. Staff discussed results at clinical governance meetings, appropriate sub-committees and senior nurse group meetings at corporate level.
- There were different care pathways for staff to follow dependent on the type of surgical procedure. The care pathways covered day procedures and inpatient procedures. There were dedicated care pathways for hip and knee joint replacement surgery.
- Staff assessed patients for VTE risk and took steps to minimise the risk where appropriate in line with the NICE guidelines. Some consultants chose not to follow NICE guidelines about VTE prophylactic medicines. In these incidents, the consultant was required to complete a document detailing the reason why the recommended prophylactic medicine was not prescribed, that the reason had been explained to the patient. We saw these forms in patient notes evidencing consultants' completed, dated and signed them detailing the reason why the recommended prophylactic treatment was not prescribed and the explanation given to the patient. We observed the use of mechanical VTE prophylaxis, such as special boots and stockings, in theatre and on the ward during our visit.

## Pain relief

- All patients spoken with said they got pain relief as and when needed.
- Nurses discussed post-operative pain relief with patients at pre-assessment, and gave them information leaflets about pain control and anaesthesia. This

included information about different types of pain relief and pain scoring. We also observed anaesthetic consultants and nursing staff discussing post-operative pain relief with patients in the recovery area.

- Staff recorded pain scores on a scale of 0-4 on the NEWS observation chart in the recovery area and on the ward.
- Staff were proactive in managing pain. They encouraged patients to ask for pain relief early on to allow them to mobilise after their surgery. We observed staff providing pain relief to patients before physiotherapy treatment.
- Nursing staff responded promptly to a patient in discomfort, including asking the anaesthetist to review the patient's pain management. Anaesthetic staff were on call 24 hours a day for post-operative pain management and ward staff reported that they were obliging, helpful and accessible.

## 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 reduce the risk of post-operative nausea and vomiting (PONV). Anaesthetic staff told us they prescribed medicines for patients who had suffered PONV previously to prevent this recurring.
- Staff monitored fluid intake and output for some major operations to ensure patients were adequately hydrated. We observed that staff correctly recorded this on fluid balance charts.
- The hospital offered light snacks and drinks for day case patients before discharge home. There was a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- The hospital had a service level agreement with the local NHS trust so they could access the advice and support of a dietician when required.

## Patient outcomes

- There were 13 unplanned returns to theatre during the reporting period January 2015 to December 2015.
- January 2015 to December 2015, there were 17 unplanned readmissions to the hospital within 29 days of discharge.

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- There were 17 unplanned transfers of inpatients to another hospital during the same reporting period (0.26% of all patients treated during that period).
- Staff discussed the above figures at clinical governance and MAC meetings to identify any underlying trends.
- Staff asked all patients who were booked for joint replacement to consent to register on the National Joint Registry (NJR), which monitors infection, revision rates and prosthesis used.
- NHS patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patient's perspective. The PROMS results for hip and knee replacement surgery during the period April 2014 to March 2015 were similar to the England average, which showed most patients had an improved quality of life after hip replacement surgery. There were insufficient numbers to report for inguinal hernia surgery.
- The hospital followed NICE guidelines for preventing and treating surgical site infections (SSIs) using the SSI bundle. There were 15 SSIs in the reporting period January 2015 to December 2015. The hospital had investigated these incidents and identified no common contributory factors in the reported SSIs.
- There was a separate medicines management audit schedule including medicine reconciliation, controlled drugs (CDs) and missed doses. Results for 2015 showed that for nine of the 12 month period there was 100% compliance with medicine reconciliation.
- There was no national formal monitoring of outcomes for patients undergoing surgery self funded or funded by insurance policies. Spire Healthcare was working with the private hospitals information network (PHIN) on the future collation of clinical outcome data. One of the consultants at the hospital was working with the group looking at orthopaedic outcomes. However, information about patient outcomes was gathered by the hospital using a clinical scorecard, the National Joint Register, patient discharge questionnaires, information provided by insurance companies and complaints data.
- All staff, including agency and bank staff, undertook a formal induction process and completed mandatory training.
- Senior staff conducted annual appraisals for nursing staff and operating department assistants (ODPs) to enable staff to discuss their development and training needs in a formal way. Data provided by the hospital showed that 100% of employed staff had an annual appraisal completed in 2015.
- Staff spoke positively about the appraisal process. A member of staff told us their training needs and personal development goals were considered during the appraisal process and that they were supported to attend relevant courses to achieve their personal development goals.
- The RMO completed training and appraisals through their employing locum agency. They also had a Spire consultant mentor who they met with every three months to discuss and monitor progress with their development goals for the year.
- All nursing staff completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to do. This included VTE assessments, aseptic techniques and intravenous therapies. Competency assessments were completed before staff could undertake the specific procedure.
- Monthly clinical supervision was a part of individual departmental team meetings to enable learning and development. Multidisciplinary debrief sessions were called as necessary.
- The hospital supported ward and theatre staff to arrange training sessions and programmes. Examples included a team of theatre staff arranged Saturday training sessions on topics related to their area of working. On the wards, a member of staff arranged monthly teaching sessions, which were delivered and attended by the multidisciplinary team.
- Consultants and anaesthetists worked under a practising privileges agreement. The medical advisory committee (MAC) were responsible for granting and reviewing of practising privileges biannually. New consultants provided evidence of qualifications, training, accreditation and scope of practice, and there was a similarly robust process at biannual review.

## Competent staff

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- All surgical staff including nurses, allied health professionals and staff working under practising privileges held valid professional registration for their role.

## Multidisciplinary working (in relation to this core service only)

- Our observation of practice, review of records and discussions with staff confirmed effective multidisciplinary team working practices were in place. This included nurses, medical staff, pharmacists and physiotherapists.
- Nursing staff conducted effective handovers of care when new staff arrived on duty. We observed an afternoon handover meeting where staff discussed patient care and plans for discharge, surgical lists, staffing and any other events of importance for the day. The ward manager, ward nursing staff, RMO, pharmacist, and physiotherapist attended the meeting.
- Physiotherapy staff supported effective recovery and rehabilitation, including an appointment at pre-assessment for patients having orthopaedic surgery, and follow up at outpatient clinics. They visited the ward daily including weekends.
- Theatre staff took a written record of patient details to the ward to collect a patient for surgery. We observed safe and effective handovers of care between the ward, theatre and recovery staff.
- There was an onsite pharmacy staffed by one pharmacist and pharmacy technicians. Pharmacy staff were actively involved in the pre-admission, admission, inpatient and discharge processes. They participated in the Joint School (part of the pre-admission process)
- We observed detailed and comprehensive handovers between anaesthetists, ODPs, and recovery staff and again between recovery staff and the ward staff when the patient returned to the ward.
- The hospital had service level agreements in place to access the services of local NHS hospitals. This included microbiology services, dietetic support and the agreement for the local acute hospital to retrieve critically ill patients for intensive care treatment.

- The hospital sent discharge letters to GPs and district nurses about the patients' treatment and care. Staff liaised with GPs before admission if there were any queries about a referral.

## Seven-day services

- Nursing staff were available on the ward seven days a week.
- The three main theatres were open for elective surgery between 8.30am and 8.30pm Monday to Friday. Saturday theatre lists were arranged in response to demand. An on call surgery team consisting a surgical consultant, anaesthetist, operating department practitioner and theatre nurse was available outside normal working hours.
- 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. An on call consultant anaesthetist rota ensured there was anaesthetic support available 24 hours a day. Both consultant surgeons and anaesthetists were able to return to the hospital to reassess their patients within 30 minutes if required. There had been no reported incidents in 2015 where consultants had not been available within 30 minutes if needed.
- The RMO and nursing staff said consultants were always available out of hours for telephone advice and support.
- A RMO was available on site 24 hours a day, seven days a week.
- Physiotherapists were available during the working day. An on call service was available at night and during the weekends.
- Pharmacy services were available between 9am and 5pm. Outside of these hours there was a pharmacy on call rota between neighbouring Spire hospitals.
- The hospital did not routinely offer out of hours radiological services. However, radiology staff were on call if urgent x-rays or scans were needed.
- An on call manager rota was in place that meant staff always had access to a senior manager seven days a week..

## Access to information



# Surgery

- The hospital kept records on site for three years after admission, after which they were sent to an offsite storage facility. Staff could access paper records stored offsite within 24 hours. This meant that staff could access historical information about a patient they had treated before.
- The records contained a GP referral letter plus any notes from previous admissions to Spire Portsmouth hospital. Staff did not have access to a patient's NHS notes unless a consultant asked for them.
- For NHS patients, the hospital faxed a copy of the discharge letter to the GP within 24 hours in line with contractual obligations. All other patients were given a copy of the discharge letter when they left the hospital to give to their GPs. The hospital used formal Intensive Care Unit (ICU) and inter-hospital transfer forms for unplanned transfers of care. Staff told us they would also contact the NHS hospital to provide a verbal handover.
- Staff accessed policies and procedures via the hospitals intranet and were available for staff as paper copies in the ward areas.
- 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' after the pre-treatment consent process.
- We saw some anaesthetists obtained written consent from patients for the anaesthetic procedure. This meant they were assured patients fully understood the anaesthetic process, the risks associated with anaesthesia and that the patient consented to have the anaesthetic.
- Staff undertook training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been fully considered and authorised by the local authority. There was information about MCA and DoLS on a notice board on the ward.
- The hospital had not had the need to make any DoLS referrals but staff demonstrated a good understanding of situations when DoLS referrals would have to be made. .
- We observed nurses on the wards and in the recovery area sought verbal consent from patients before taking observations and delivering general nursing care.

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

- Staff assessed patients' mental capacity to make decisions about their care and treatment at pre-assessment. Staff were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care, which included a formal assessment of capacity by the patients consultant. If the assessment concluded the patient did not have capacity to make the decision, the plans for treatment would be halted until the patient regained capacity or a formal best interest decision was completed.
- Patients consented for surgery prior to and on the day of surgery. Our review of records showed they were completed and compliant with Department of Health guidelines. Staff told us they would seek the use of an interpreter where needed to sign consent forms and not rely on family members or friends.

## Are surgery services caring?

Good 

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

We rated caring as good because;

- We observed staff treated patients with kindness and compassion during our visit. Staff maintained patients' dignity and respect at all times.
- Feedback from patients about their care and treatment was consistently positive.
- Patients told us they had sufficient information about their treatment and were involved in making decisions about their care.

# Surgery

- Practices were in place to allow staff to provide good emotional support to patients.

## Compassionate care

- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received. They described staff as friendly, helpful, caring, considerate, kind and respectful. One patient said, 'the care, treatment and support here is fantastic'.
- We observed staff referred to patients in a caring way at handovers and ward meetings, and staff showed a keen interest in ensuring that patients had a pleasant and comfortable experience.
- We saw consultants talking with patients who were awake during surgery (for example eye surgery) in a caring and reassuring manner. We observed handover of patients from theatres to recovery by anaesthetists and ODPs re done with sensitivity towards the patient. Staff introduced themselves to the patient and explained what would happen in recovery.
- Staff treated patients with respect and dignity during our visit. We observed staff always introduced themselves to patients, and knocked on doors and waited for permission to enter patients' rooms. We saw staff in theatres being mindful of patients' dignity when they were in a vulnerable condition.
- The hospital participated in the 'friends and family test' (FFT). During 2015 the hospital reported consistently high levels (between 98% and 100%) of patients would recommend the hospital to their friends and families.

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

- Patients on the surgical wards said they understood their care and treatment and had adequate opportunities to discuss their surgery. One patient commented there was very good sharing of information between all members of staff involved in their care and them self.
- Patients and their relatives were encouraged to be involved in decisions made about their care and treatment. We observed staff taking time to ensure that patients and relatives felt involved in the individual's treatment plan.

- We observed staff in the anaesthetic and recovery rooms explaining care and treatment to patients and asking about their wellbeing. If there was a delay to the operating list staff said they would visit patients on the ward to explain the situation and keep them informed.
- Patient records we reviewed showed detailed evidence of discussion with families and their involvement in decisions about care and treatment where appropriate.

## Emotional support

- The hospital provided emotional support to patients. Patient appointment times at the pre-assessment were generous to allow sufficient time for explanation and reassurance. Staff said they liked working at the hospital because they had time to talk to patients, and try to relieve their anxieties.
- The breast cancer specialist nurse and cosmetic nurses provided additional skilled clinical and emotional support for patients and their families. For patients having cosmetic surgery, the cosmetic nurse met with them at pre-assessment and postoperatively at outpatient clinics. This gave patients opportunities to ask questions and for staff to identify any emotional support needs.
- Ward staff showed sensitivity towards the emotional needs of patients and their relatives. At the handover meeting we observed discussions about patients' anxieties and how to provide support.
- The hospital engaged with the local community to provide support for patients. The minister from the local Church of England parish visited the hospital weekly and as requested to offer support to patients and staff of any religious or non-religious belief.

## Are surgery services responsive?

Good 

**By responsive, we mean that services are organised so they meet peoples' needs.**

We rated responsive as good because;

- The provider and clinical commissioning groups determined the range of surgical services provided.

# Surgery

- Staff assessed patient's needs before surgery, and the hospital was able to take the needs of different people into account when planning and delivering services. For example, suitably trained staff ensured the hospital met the needs of patients living with dementia or a learning disability.
- The provider met the referral to treatment time targets for NHS patients, 92% of patients to be seen within 18 weeks.
- The hospital dealt with complaints and concerns promptly, and there was evidence that the hospital used learning from complaints to improve the quality of care.

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

- The hospital developed NHS services in conjunction with the local clinical commissioning groups (CCGs). The CCG checked the hospital provided NHS patients with services in line with agreed quality criteria at quarterly contract meetings.
- The hospital had an agreement with the CCG to provide specific treatment and care for NHS patients.
- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments with low risks of complication, and whose post-operative needs were met through ward-based nursing care.
- There were no facilities for emergency admissions and commissioners and the local NHS trust understood this.

## Access and flow

- There were 5,516 visits to theatre during the reporting period January 2015 to December 2015. Over 50% of the activity was for orthopaedics surgery. The majority of surgery was carried out as day case surgery.
- Referral to treatment times were measured for surgical NHS patients. The provider consistently met the national target of 92% of all admitted NHS surgical patients beginning treatment within 18 weeks of referral for treatment. There was no formal system for the management of referral to treatment times for insured or self-funded patients. However, we were informed by the Hospital Director (registered manager) that feedback

mechanisms such as post discharge questionnaires and feedback from insurance companies would identify if patients were dissatisfied with their referral to treatment time.

- Nursing staff discussed discharge plans at pre-assessment to ensure home adaptations and care packages were in place before surgery. This meant that staff were assured when offering surgical admissions that there would be no unnecessary delays in discharge due to obtaining specialist equipment or organising a care package.
- To support the flow of patients through the hospital the pre assessment team, physio team lead, pharmacy, theatre leads and matron attended multidisciplinary weekly planning meetings. In this meeting staff discussed the planned operations, identified potential risks for patients for example previous VTEs, identified patients suitable for enhanced recovery programmes, and planned staffing to meet the needs of patients planned to be admitted.

## Meeting people's individual needs

- Nursing staff assessed patients' individual needs at pre-assessment and communicated them to all departments using a communications form. Pre-assessment nurses alerted the ward about patients living with dementia or a learning disability so they could organise the required support to meet the patient's individual needs.
- There was a dementia link nurse for the ward, who was responsible for the training of others. Nursing staff were able to describe how they would alter their communication style to meet the needs of individual patients living with dementia. For example, allowing more time to explain procedures and asking relatives to be present. They said, where required, relatives or carers of patients with a disability would be enabled to stay with the patient to support them during their hospital admission.
- Recovery staff went to the ward to meet patients with learning disabilities or other specific needs. They could accompany the patient to theatre and be present in recovery to provide a familiar face if needed.
- For patients whose first language was not English the hospital had access to a 24 hour translation service.

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Information leaflets were available in alternative languages. For immediate translation services, the hospital had a list of members of staff who could speak languages other than English.

- The chef catered for the needs of patients with specific dietary needs for religious, cultural or medical reasons.
- The hospital employed specialist breast care and cosmetic surgery nurses to provide individual patients with tailored advice, support and care.
- Specialised support such as stoma nurse support and dietetic support was accessed through service level agreements with the local NHS trust.
- The hospital offered enhanced recovery and rehabilitation for orthopaedic patients, with physiotherapists who provided individualised care for patients. Staff planned care and treatment to allow early mobilisation and independence. The hospital held a 'joint school' pre-operatively for NHS patients. The aim was to educate the patients about pre-operative preparation and plans for recovery and discharge within three to four days. The hospital had a plan to introduce this for self funding and insurance funded patients.
- Consultants discussed dates for surgery with patients at their outpatient appointment. Patients could choose to have their operation at a time suitable to them. Staff planned elective surgical admissions to take account of the need to carry out appropriate investigations.
- There was open visiting on the ward to allow patients to have emotional support from family and friends.
- Patients were able to telephone the ward after discharge, for further help and advice about any concerns or questions on their return home.

## Learning from complaints and concerns

- The hospital provided information about how to raise a concern or make a complaint in pre admission information. Information about how raise a concern or complaint was also displayed in the hospital.
- In common with other independent and NHS hospitals, the Spire Hospital Portsmouth experienced a steady increase in complaints in the past three years. The hospital received 102 complaints in 2015. Between January 2016 and March 2016 the hospital received 1.43% complaints as a percentage of total patients seen.

- Complaints received were discussed at weekly meetings attended by the head of departments. This ensured staff across the hospital were aware of all complaints received and staff acted to resolve the complaint in a timely manner.
- Staff told us about learning and changes in practices that were implemented in response to complaints. These included ensuring chaperones were always available during consultant cosmetic consultations and ensuring patients and their GPs fully understood processes for accessing post operative physiotherapy after patients were discharged from hospital.
- Clinical performance posters displayed in the hospital detailed examples of learning from recent complaints.
- Staff told us they aimed to resolve concerns in a timely way to improve the patient experience at that time.

## Are surgery services well-led?

Good 

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

We rated well-led as good because;

- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff were aware of the risks, and action taken to mitigate these risks for their individual departments.
- Staff across the service enjoyed working at the hospital. They described an open culture and felt supported by their management. They were extremely complimentary about their managers and positive about the recent changes in management at the hospital.
- The hospital gathered patients' views using patient surveys and the 'friends and family test'. They analysed results and made service improvements as a result.

## Vision and strategy for this this core service

# Surgery

- 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 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, and demonstrated commitment to them in their care practices and personal development plans.
- The hospital had goals set of the year 2016. These included clinical and financial goals, with the main emphasises placed on clinical goals, this included surgery. This was confirmed in conversations with staff who all said the management team always considered clinical needs of patients as a priority over financial needs of the service.

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

- The hospital had one risk register that was separated into departmental risks. At the time of the inspection there were 13 risks identified for theatres and nine for the ward areas. The risk register detailed who had overall responsibility for each risk and actions taken to mitigate the identified risk. Where action did not fully mitigate the identified risk, there was a plan of action, with the date due the action was due to be completed and detail of who was responsible for ensuring the action was completed.
- The hospital had introduced a hospital wide risk register at the beginning of 2016. The hospital was embedding the processes for reviewing the risk register. The risk register was reviewed at head of departments meetings and at the combined health and safety and risk committee meetings.
- We saw that an entry in the risk register regarding the airflow systems in theatres did not reflect current practices at the hospital. The register detailed the risk that failure of UCV systems within theatres would reduce the ability to carry out UCV essential surgery and that in the event of “failure of laminar airflow (UCV) in theatres specific operations will be stopped (joint etc.)”

However, this did not reflect the practice carried out in theatre 2 that did not have a UCV system. At the unannounced inspection the risk register had been reviewed and amended detailing joint surgery could be carried out in a conventional theatre that did not have UCV systems.

- There were clinical governance structures in place. Representatives from the senior management team and head of departments team attended and fed into the clinical governance team meetings. We saw from records that staff at clinical governance meetings discussed complaints and incidents, including any learning and trends related to these events. They also discussed audits, staff training and vacancies, policy reviews, patient satisfaction scores and NICE guidelines.
- Consultants from a variety of specialities attended the MAC meetings on a quarterly basis. Records showed an average of 16 consultants attended the MAC meetings. We saw from records that incidents, complaints, audits and practicing privileges were reviewed.

## Leadership / culture of service related to this core service

- Many staff had worked at the hospital for a long time and said it was a good organisation and hospital to work for. Staff spoke positively about the teamwork they experience at the hospital. Staff said they felt respected and valued at the hospital and senior staff and management encouraged them to complete further training and qualifications.
- All staff we spoke to were very positive about the Hospital Director (registered manager) and senior management team. Staff said senior managers were very visible on the wards and approachable. They operated an ‘open door policy’ and encouraged staff to raise concerns directly with them. The hospital director recognised excellence and good work by staff with “inspiring people” awards. Staff described the ward manager as a positive role model, who was supportive of all staff.
- Staff said they worked well as a team and felt supported by their immediate managers who lead their departments well. There were low staff sickness and vacancy rates across the service with a high record of staff stability between January 2015 and December 2015.

# Surgery

- Consultants we spoke with were positive about senior members of the hospital and described good working relationships.
- No whistle blowing concerns were reported to the CQC between January 2015 and December 2015.

## Public and staff engagement






- Staff encouraged patients to complete a patient satisfaction survey before discharge. The hospital used this with the 'friends and family test' feedback to evaluate their service provided to the patient. Clinical performance notice boards displayed information about actions the hospital had taken in response to patient comments. This included improvements to signs in the hospital so patients and their relatives could find the departments they were going to.
- The hospital had developed a 'heart to heart' group for former patients to share experiences and provide learning for the service.
- The registered manager and senior management team communicated regularly about developments and information was shared with the staff teams. There were regular staff forums.

- Information about governance, risks, training and hospital information was displayed in suitable areas of the wards. Information was shared by email correspondence and information was available on the trust's intranet.
- Staff meetings and handover periods provided opportunity for managers to engage with staff and ensured information was passed on to staff. Records of staff meetings and discussions with staff confirmed this occurred.

## Innovation, improvement and sustainability

- The practice of some anaesthetists in obtaining consent from patients for anaesthesia, in addition to consent by the surgeon, meant they were assured patients understood the benefits and risks associated with anaesthesia.
- There was a plan to refurbish theatres so all theatres would have an UCV system. The hospital manager told us the refurbishment was scheduled for August 2016.

# Outpatients and diagnostic imaging

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

## Information about the service

Outpatient services at Spire Portsmouth Hospital cover a wide range of specialities. These include ENT (Ear, Nose and Throat), urology, general surgery, orthopaedics, gynaecology, ophthalmology, pain management, cardiology, dermatology, gastroenterology, neurology, respiratory medicine and rheumatology. Diagnostic imaging facilities provided by Spire Portsmouth Hospital include x-Rays and ultrasound. Magnetic resonance imaging (MRI) scans are available on site. The hospital also provides outpatient physiotherapy services.

The outpatient clinic has 12 consulting rooms, four treatment rooms, one respiratory room and one ENT room. Any specialty can use the consultation rooms. Clinics are all consultant led.

The physiotherapy department comprised of one gym and three examination rooms. There is also one women's health room.

In the period April 2015 to March 2016 there were 40,562 outpatient appointments, 15,577 of which were new appointments and 24,985 were follow-up appointments. The hospital provided a service for NHS patients through block NHS contracts. A total of 2,711 NHS patients were seen in outpatient clinics, 1,051 of these being first appointments and 1,660 being follow-up appointments.

During our inspection, we visited the outpatients, physiotherapy and diagnostic imaging services. We spoke with six patients and 15 staff, including nurses, medical staff, healthcare assistants, physiotherapists, administrators, receptionists and managers. We reviewed information provided on CQC feedback cards from patients

using the service. We reviewed patient records and staff training records. We observed care provided. Before, during and after our inspection we reviewed the provider's performance and quality information.

# Outpatients and diagnostic imaging

## Summary of findings

Overall this core service was rated as 'good'.

Outpatient areas were clean and that equipment was well maintained. Staffing levels were as planned for safe care. Patient records were available for appointments, and the department had timely access to test results.

There was good multidisciplinary team working. Staff told us there was good support in their role, with appropriate opportunities to develop their skills further.

We observed that staff were caring, compassionate, and treated patients with dignity and respect. Patients told us they felt informed about their treatment and had been involved in decisions about their care.

Hospital staff, together with consultant private secretaries, managed and scheduled clinics appropriately. This ensured good availability of appointments for patients across all specialities.

There were effective governance processes in place. Staff worked well together in teams, and were positive about the leadership of the service at both local and senior level. There was an open culture and staff were encouraged to make suggestions to improve services for patients. The hospital used different methods to gather feedback from patients about their experience.

Although there were appropriate systems in place to keep patients safe and medicines were generally managed safely. In diagnostic imaging a member of staff who was not an authorised health professional was authorised by the hospital to administer contrast media products. When we brought this to the attention of the radiology manager, this practice was ceased immediately.

## Are outpatients and diagnostic imaging services safe?

Good 

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

We rated safe as 'good' because:

- Staff had a good understanding of how to report incidents, and there was learning from incidents.
- Staff carried out appropriate mandatory training for their role. Staff told us they had support to keep this up-to-date.
- Clinical areas and waiting rooms were all visibly clean and tidy. Infection prevention and control practices were followed, and regularly monitored, to prevent the unnecessary spread of infections.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested in-line with manufacturer's guidance.
- Records were stored securely on site and actions taken to reduce risks to private patient records taken off site by consultant secretaries. Staff told us that patient records were available before appointments.
- In diagnostic imaging, local rules and safe systems of work were in place. There was a nominated radiation protection supervisor (RPS), who had received appropriate training.
- Staff could demonstrate the procedures in the event of a medical emergency. There was a call bell system in clinical areas and an on-call team within the hospital who were advanced life support (ALS) trained. Staff received simulation training, to ensure they could appropriately respond if a patient became unwell or a major incident happened

However,

- A member of staff who was not an authorised health professional under the legislation relating to Patient



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Group Directions, had been permitted to issue two contrast media products via PGD. When we brought this to the attention of the radiology manager, this practice was ceased immediately.

## Incidents

- The hospital had reported 373 clinical incidents in the period January 2015 to December 2015. The overall rate of incidents reported during that period had risen slightly in the reporting period; this demonstrates a good reporting culture. The hospital reported there were no serious incidents requiring investigation in outpatients during the period October 2014 to September 2015.
- All staff knew their responsibility to report incidents using the electronic reporting system. The hospital did not collate number of incidents reported by department but we saw a number of incidents were reported by outpatients staff, and action was taken as a result.
- In the diagnostic imaging department, there were clear processes for reporting incidents about the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- The hospital held a multidisciplinary weekly incident meeting, attended by heads of department or deputy, which all staff found very helpful for sharing learning. Service manager in radiology took a member of staff with them to this meeting.
- The medical advisory committee (MAC), a leadership group of consultants, held meetings every three months in which an overview of reported incidents were discussed.
- Safety alerts, for example about medical devices, medicines or infections, were received by the hospital and communicated to heads of department. Learning was shared through meeting minutes.
- Senior staff told us they received information and training on the duty of candour. However, not all staff we spoke with knew about the duty of candour. The duty of candour 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 these persons. There had not been any incidents in out patients or diagnostic imaging meeting the threshold for action under duty of candour

## Cleanliness, infection control and hygiene

- Outpatient, physiotherapy and diagnostic imaging departments were visibly clean and tidy.
- The hospital had an infection control lead nurse, who maintained links with the local NHS infection control team. The lead nurse monitored the service through audits, provided guidance and managed the infection prevention programme. This included training and supporting link nurses in each department of the hospital, including outpatients and radiography.
- We reviewed cleaning records for outpatient clinic rooms. The rooms showed cleaning had taken place regularly.
- Hand sanitisers were widely available throughout the outpatient, physiotherapy and imaging departments to encourage hand hygiene. Compliance with good practice was checked through quarterly hand hygiene audits and checks on usage of hand gel.
- Nursing staff and other healthcare workers adhered to the 'bare below the elbow' guidance to allow thorough hand washing and reduce risk of cross infection.
- The hospital scored 100% for cleanliness, compared to the national average of 98% for the patient-led assessment of the care environment (PLACE) audit in 2015.
- The hospital had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA) or
- Personal protective equipment, such as gloves and aprons, was readily available for staff in all clinical areas. The equipment helped to ensure staff safety and reduce risks of cross infection when staff performed procedures.
- Cleaning records showed that cleaning took place in accordance with a fixed schedule.

## Environment and equipment

- All of the items of equipment checked were labelled with the last service and review date. All had an asset number to allow easy tracking if they needed servicing or maintenance. There was a local asset register in each

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department with a departmental equipment coordinator to oversee it. The hospital had robust arrangements for servicing and repairs, (and disposal), of equipment

- In the diagnostic imaging department, specialised personal protective equipment was available and used in radiation areas. Staff wore personal radiation dose monitors.
- Signs in the diagnostic imaging department identified when x-rays were being taken, with warning not to enter the room.
- The recent radiation protection recommendation (2016) noted that the mammography unit was at maximum limit for collimation. Collimation is a method, in radiology, of restricting and confining the x-ray beam to a given area. A hospital had a plan in place for a new digital unit.
- Resuscitation equipment was located in outpatient department on a trolley. The trolley was sealed with tamper-proof tags. We saw a daily check sheet which recorded the trolley had been checked to ensure equipment was available and in date.
- Housekeeping team managed the waste disposal. There was clear labelling of all clinical waste bins in clinical rooms.

## Medicines

- Contrast media and medicines were safely stored in the diagnostic imaging department. Contrast media is a substance introduced into a part of the body in order to improve the visibility of internal structures during radiography. All medicine cupboards were locked and the keys held securely in the department. Staff we spoke with knew how to access the keys.
- Radiographers were authorised to work under Patient Group Directions (PGD) to administer contrast media and other medicines required during diagnostic imaging processes. PGDs are written directions that allow the supply and / or administration of a specific medicine by a named authorised health professional to a well-defined group of patients for a specific condition. However, we found an assistant radiographer, a member of staff who was not an authorised health professional under the legislation relating to PGDs, had been permitted to issue two contrast media products

via PGD. In practice we also found the radiographers giving verbal orders for administration by an assistant. When we brought this to the attention of the radiology manager, this practice was ceased immediately.

- Medicines were stored safely in OPD. All medicines cupboards were locked and the keys held by the lead nurse on duty. Staff we spoke with knew who held the keys. Fridges were locked and temperatures checked daily and logged, and any corrective action taken if outside the range, to ensure medicines were stored at the correct temperature. We checked a random sample of medicines in OPD and radiology, all of which were in date. The OPD used FP10 prescription pads for consultant to prescribe medicines. These were stored securely and their use monitored.
- The OPD undertook three monthly audits of controlled drugs. Outpatient department received support from pharmacy department. There were processes for medicines to be dispensed in accordance with their prescriptions.

## Records

- The individual consultant's secretary created patient record files for private patients seen for the first time in OPD. Staff in OPD reported these were available in a timely manner and contained accurate and legible information to enable the consultant to assess the patient appropriately.
- Records held by the hospital were held securely on site by the medical records department for three months then stored at the national distribution centre. When records were in the outpatient department they were either held in the consulting/treatment room with the relevant practitioner, or stored in secure areas of the department. Staff handling patient information had completed an information governance training programme.
- The hospital had taken steps to reduce the risks for any patient records managed off site by consultant secretaries. This included ID badges and security checks for secretaries visiting the hospital and a request that they attend information governance training. Consultants were responsible for security of records when off site. All GP letters and discharge letters were collated on site at the hospital.

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- Staff said records were always available for scheduled appointments.
- The hospital's radiological images were stored on a nationally recognised PACS (Picture Archiving and Communication System). This was a safe way to retrieve x-ray images from other hospital information systems.
- The imaging department had access to an image exchange portal for images held on other systems. This access meant staff could view patients' existing x-rays instead of exposing them to unnecessary repeat x-ray procedures

## Safeguarding

- The hospital had a safeguarding children and vulnerable adults policy. The head of clinical services was the safeguarding lead for the hospital, and he was level 3 trained.
  - Staff confirmed in conversations that safeguarding vulnerable adults was included in their mandatory training. Hospital training records confirmed this, 97.6% staff completed safeguarding e learning.
  - Staff that we spoke with demonstrated a good understanding about safeguarding processes. They knew what actions they needed to take if they suspected a patient or a visitor to the hospital had been subject to abuse.
- There was always a registered medical officer (RMO) on duty, who was trained in advanced life support. They provided support to the outpatient staff if a patient became unwell. Patients who became medically unwell in outpatients would be transferred to the inpatient ward or to the local acute NHS trust in line with the emergency transfer policy. Staff in all outpatient departments knew how to respond to patients who became unwell and how to obtain additional help from colleagues. If a patient become unwell support was provided from either that department or the hospital emergency team, depending on the severity of the patient's illness. Staff reported that this rarely happened.
  - Staff in all outpatient departments had training in basic life support, with some staff trained in intermediate and advanced life support.
  - Staff completed scenario-based training provided by the in-house resuscitation lead, including resuscitation simulation, at least every six months. Teams were not aware when the training would take place.
  - The appointed Radiation Protection Adviser (RPA) was provided through a service level agreement (SLA) with the local acute NHS Trust. There was an appointed and trained Radiation Protection Supervisor. Their role was to oversee equipment safety and quality checks, and ionising radiation procedures, in accordance with national guidance and local procedures.

## Mandatory training

- The hospital overall compliance for the period January 2015 to December 2015 was 84% mandatory training undertaken as e learning against a target of 95%. This did not include the data for information governance, which was 95%, against a target of 95%.
  - Consultants completed their mandatory training at the NHS establishment they routinely worked at. They were required to provide evidence of completion of mandatory training to the hospital and medical advisory committee (MAC).The registered manager told us if doctors were not up to date with mandatory training, and did not provide current and valid practice certificates, they were suspended from practice until the training was renewed and evidenced.
- The RPA report 27 August 2015, confirmed senior staff had very good radiation protection awareness, excellent systems in place and information was disseminated well to the team.
  - The x-ray department undertook patient safety questionnaires before commencing the magnetic resonance imaging (MRI).The purpose of this questionnaire was to ascertain if the patient had any metal objects in their body so that the clinician can assess whether it is safe for them to have the scan. Staff also asked patients verbally whether they had any metal objects in their body.
  - Processes were in place and followed to ensure the right patient received the correct radiological scan at the right time. A senior radiographer reviewed all x-ray requests before x-ray. Consultant radiologists reviewed all GP referrals before x-ray.

## Assessing and responding to patient risk

# Outpatients and diagnostic imaging

## Nursing staffing

- Outpatient departments do not have set guidelines on the number of nurses required. Outpatient, diagnostic imaging and physiotherapy departments reported they had sufficient numbers of staff to meet the workflow and patient needs in a safe manner.
- Consultants could contact the outpatient services at any time requesting an ad hoc clinic. This was agreed if there was an available consulting room and sufficient nursing staff.
- All outpatient areas, reported that they did not use any agency staff for the period April 2015 to March 2016.

## Medical staffing

- The hospital at the time of the inspection employed 199 medical staff working under practising privileges. The granting of practising privileges is an established process whereby a medical practitioner is granted a permission to work within an independent hospital. The hospital had robust processes for checking doctors were appropriately qualified and competent, before granting practising privileges.
- The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and MAC chair liaised appropriately with the General Medical Council and local NHS trusts to check for any concerns and restrictions on practice for individual consultants. The General Medical Council is a public body that maintains the official register of medical practitioners within the United Kingdom.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital OPD and administration team.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- In the diagnostic imaging department, there was an SLA for consultant radiologist support from the local NHS acute trust hospital. This allowed for timely reporting of scans and images to support diagnosis and safe treatment.

## Major incident awareness and training

- A hospital-wide fire alarm test took place on a weekly basis and staff knew when this was planned. Fire evacuation drills were held three times a year. All staff understood their responsibilities if there was a fire within the building.
- The hospital had local and corporate business continuity plans with supporting documentation to use in events such as internet or electricity failure. The business continuity plans were available in folders at reception and on their intranet.

## Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate 

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

We inspected but did not rate effective as we do not currently collate sufficient evidence to rate this.

- National guidelines were used, there was evidence that clinical audits were being undertaken, including recording of patient reported outcomes.
- Staff were supported in their role through appraisals. All staff were appraised or had appraisals booked with their managers. Staff were encouraged to participate in training and development to support them to deliver good quality care.
- There was evidence of multidisciplinary team working across the hospital and with the local NHS acute trust. There was good sharing of information for example sharing of radiology images electronically between the hospital and local NHS trusts.
- Consent forms were completed for all minor surgical procedures.
- Patients pain needs were met appropriately during a procedure or investigation carried out in clinic.

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- The hospital had a process for checking competency and granting and reviewing practising privileges for consultants. Radiology staff were aware of competencies of consultants for procedures and use of equipment.

## Evidence-based care and treatment

- Staff in OPD reported they followed national or local guidelines and standards to ensure patients received effective and safe care.
- In the diagnostic imaging department, there was good evidence that compliance with national guidelines was audited including audits against radiation exposure. Changes were made to practices in response to audit findings.
- The diagnostic imaging service had taken action in response to RPA report, local rules were updated in February 2016 and a radiation protection committee was set up, in line with best practice.
- The imaging department ensured the adoption and use of diagnostics reference levels (DRL's) as an aid to optimisation in medical exposure. The radiation exposures were audited regularly.
- IR(ME)R audits were undertaken as required by the regulations. Actions taken as a result of these audits were seen.
- New practices were reviewed and signed off by consultant radiologists.
- Consultant radiologists reviewed all GP referrals for imaging to ensure patients are not receiving unnecessary exposure to radiation.

## Pain relief

- In OPD, staff discussed options for pain relief with the patient, during their consultation before any procedure being 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 they may need 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

- The Medical Advisory Committee (MAC) monitored outcome data for individual consultants as part of the biannual review of consultant's practising privileges. This included readmission rates, development of venous thromboembolism (VTE) and hospital acquired infection.
- Patients were offered opportunities to participate in data collection to measure outcomes of treatment. All patients who were booked for joint replacement were asked for consent to be registered on the National Joint Registry (NJR), which monitors infection and revision rates. We saw in medical records that we reviewed, patients had consented to participate in the register which ensured their care and joint replacements were monitored nationally.

## Competent staff

- Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- Appraisal rates for the year April 2015 to March 2016 were 100% for nursing staff in OPD, 100% for healthcare assistants in OPD and 95% for allied health care professionals, which included physiotherapists and radiography staff.
- Staff told us the induction process was comprehensive including department tours and introductions to heads of department and colleagues. Staff were supernumerary for a period during their induction.
- Consultant radiologists signed competency forms detailing which procedures they could carry out and which equipment they could use. Sample signatures were kept within the imaging department so that x-ray referrals could be checked.
- There was training for radiology helpers to gain professional qualifications. Basic radiographers developed extended skills in magnetic resonance imaging (MRI).
- Monthly clinical supervision was a part of individual departmental team meetings to enable learning and development.
- The registered manager and Medical Advisory Committee followed a process to ensure all consultants who had practising privileges at the hospital had the

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relevant competencies and skills to undertake the treatment they were performing at the hospital. The registered manager reviewed the competencies and skills biannually. This included review of outcomes, appraisal and revalidation.

- The OPD did not have details of the individual consultant's competencies or restrictions on practice. Competencies of consultants in outpatients were monitored by the senior management team who told us senior staff in outpatients would be informed if there were any instances where restrictions on a consultants' practice was required. Staff told us if they found the clinician practicing anything unusual, they would raise those concerns directly with the director of the hospital for resolution.

## Multidisciplinary working (related to this core service)

- There were service level agreements with the local acute NHS Trust, for support services to the hospital. This included processing and reporting on radiology, radiology monitoring, and support with life support training including the provision of emergency scenarios.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups. During the inspection, a patient attended an outpatient appointment following surgery. They were then referred to a physiotherapist. The OPD completed the various forms for referral and arranged for the patient to be seen by the physiotherapist on the same day. This meant the patient did not have to make another visit to the hospital.
- 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 if any further action was needed.

## Seven-day services

- OPD ran clinics Monday to Friday from 8am until 8pm, there were occasional Saturday clinics.
- The diagnostic imaging department ran from 8am until 6pm, with an on-call service available at the weekend.

## Access to information

- Staff we spoke with reported timely access to test results such as from bloods and diagnostic imaging.

Results were available for the next appointment or for certain clinics, during that visit, enabling prompt discussion with the patient on the findings and treatment plan.

- Medical staff mainly used their own private patient records during the outpatient consultation and took responsibility for ensuring the records were available.
- X-rays were available electronically for consultants to view in the clinic.
- 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 their treatment. Medical staff we spoke with confirmed the transfer methods used and understood the required security aspects of data transfer.
- Doctors dictated clinic letters and they were typed by their private secretaries. GP's were sent the clinic letter and a copy was retained on the patient records. A copy of the letter was in the patient's record.

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

- Information about the Mental Capacity Act 2008 and associated Deprivation of Liberty Safeguards was covered in the mandatory safeguarding training. Staff demonstrated, in conversations, a good understanding about their role with regard to the Mental Capacity Act.
- Patients received relevant information, both verbal and written, to make informed decisions about their care and treatment.
- The consent process for patients was well-structured, with written information provided before consent being given.
- Verbal consent was obtained for x-rays, outpatient procedures and physiotherapy treatments carried out.

## Are outpatients and diagnostic imaging services caring?

Good 

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

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We rated caring as 'good' because:

- Staff in all outpatient areas were caring and compassionate. Patients commented positively about the care provided from all of the outpatient staff. Staff treated patients courteously and respectfully.
- Staff maintained patient privacy and dignity.
- Patients were given information and were involved in decisions about the treatment they received.
- Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

## Compassionate care

- We observed that staff took all possible steps to promote patients' dignity and they were afforded privacy at all times. We observed all clinical activity was provided in individual consulting rooms and doors were always closed, to maintain privacy and confidentiality.
- Signs offering patients a chaperone were clearly displayed in waiting areas and clinical rooms. Staff told us that they always offered to chaperone patients undergoing examinations. We saw medical staff requesting chaperones for their patients.
- Throughout the inspection, we saw staff speaking in a calm and relaxed way to patients. Patients told us staff were helpful and supportive.
- The hospital took part in the Friends and Family Test (FFT). There was no breakdown of the figures therefore it was not possible to identify the significance of these figures with regards to outpatients. In the period July to December 2015, 98% of patients recommended the hospital to their friends and families.
- Similarly the in hospital wide patient satisfaction survey for the year December 2014 -2015, overall 98% patients reported they were treated with dignity and respect whilst in the hospital.
- In the Patient Led Assessments of the Care Environment (PLACE) in April 2015 showed privacy, dignity, and wellbeing scored 91%, this was higher than the England average of 87%.

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

- Staff ensured patients understood and were involved in their care and treatment. 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.
- We observed staff listened and responded to patients' questions positively
- During our inspection, we saw there was a wide range of health promotion literature in waiting areas. Staff told us patients were provided with written before and after care information leaflets.
- Comments from patients who received physiotherapy indicated they were fully involved in their plan of treatment.
- In the in hospital wide patient satisfaction survey for the year December 2014 -2015, overall 98.5% patients reported they were as involved as they wanted to be in decisions about their care and treatment.

## Emotional support

- When having conversations with staff, it was clear they were passionate about caring for patients and put the patient's needs first, including their emotional needs.
- During the inspection, we heard how a consultant had to break bad news to a patient. The OPD arranged the patient's appointment on the day to coincide with the local chaplain's weekly visit to the hospital just in case the patient needed additional emotional support.
- The oncology service had identified the need to provide more psychological support for those receiving bad news in OPD and staff completed additional training in breaking bad news.

## Are outpatients and diagnostic imaging services responsive?

Good 

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

We rated responsive as 'good'.

# Outpatients and diagnostic imaging

- Services were planned and delivered in way that met the needs of patients. The hospital environment was designed and maintained to support the individual needs of patients and to support privacy.
- Patients told us that there was good access to appointments at times that suited their needs.
- Waiting times and delays were minimal. NHS physiotherapy and x-ray appointments were on time and patients were generally kept informed of any delays in outpatient clinics.
- There was information on specific procedures, conditions and hospital charges in the waiting area. This was in English and not in other languages or formats, such as braille. The hospital reported that they had minimal numbers of patients who could not understand English. For those patients, they had good access to translation service, when needed.
- Staff were knowledgeable about the complaints process and confident that complaints were investigated. There was evidence of learning changes in response to complaints. However, individual staff did not always receive feedback about the outcome of complaints.
- Reception desks were a sufficient distance away from waiting areas so patients could speak to receptionists and staff, without their conversation being overheard.
- Patient Led Assessments of the Care Environment (PLACE) for February to June 2015 showed the hospital scored 95% that was higher than the England average of 87%.
- There was ample seating in the waiting area. There was access to tea and coffee in the waiting area. Outpatients, diagnostic imaging and physiotherapy were located immediately adjacent to the main reception desk.
- There were written information leaflets in the reception area about general health and wellbeing and services offered by the hospital.
- OPD had 12 treatment rooms. They were general treatment rooms used for minor procedures such as removal of sutures, wound dressings and removal of skin lesions.

## Access and flow

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

- 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.
- The hospital was a provider of Choose and Book which is an E-Booking software application for the National Health Service (NHS) in England which allows patients needing an outpatient appointment or surgical procedure to choose which hospital they are referred to by their GP, and to book a convenient date and time for their appointment.
- Clinics were held Monday to Friday, 8am to 8pm, with occasional outpatient clinics held at weekends to meet patient's needs.
- There was a combined waiting area for OPD, diagnostic imaging and the physiotherapy departments, a range of different style chairs meant patients could chose a chair that was comfortable for them while waiting.
- The consultants' secretaries arranged patient appointments with the outpatient reception team. They liaised with patients and gave them a choice of the time of their appointment.
- The hospital's own administration team managed the NHS patients who used Choose & Book and were subject to NHS waiting time criteria. All referral to treatment (RTT) waiting times for every month were above or met the target of 95% for 18 weeks for the reporting period (Jan 15 to Dec 15). RTT measured the total period waited by each patient from referral to treatment and helped managed each patient's journey in a timely and efficient manner.
- For NHS patients the hospital consistently met the six-week referral targets for diagnostic imaging.
- Staff told us that physiotherapy and x-ray clinics usually ran to time. Staff told us that on rare occasions if there were delays, they would speak to patients and keep them informed, either directly or via the reception team.
- Patients could get their x-rays carried out by the hospital on the same day as their appointment.



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Staff in the imaging department reviewed clinic lists daily to determine if any patients would require an x-ray. They liaised with OPD staff accordingly to schedule patients for imaging.

- There was no formal system in place to inform patients if a clinic was running behind schedule. OPD staff advised the reception team who, in turn, advised patients as they arrived for their appointment. Information regarding how long patients waited was not captured and could therefore not be analysed to identify any concerns.
- Staff in OPD reported that it was not unusual for clinics to run over their time allocation. Nursing staff stayed on duty, working over their rostered hours to ensure patients had their consultation. To reduce the number of visits made to the hospital, the OPD organised appointments to ensure other needed procedures such as x-rays or ultrasounds or scans took place at the same time as the patient's OPD visit.

## Meeting people's individual needs

- Staff knew how to support people with complex or additional needs and made adjustments wherever possible. However, staff noted 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. There were policies for accessing translation services and the OPD considered those when arranging the length of patient appointments.
- The reception area had installed a loop system for the hard of hearing patients.
- In diagnostic imaging, ranges of leaflets were available and provided to patients about diagnostic imaging procedures.

## Learning from complaints and concerns

- There were 34 complaints across OPD, physiotherapy, and diagnostic imaging services in 2015. The hospital director monitored all complaints and responded to in-line with the hospitals policy. Patients who

complained received an acknowledgement of within two working days and a full response within 20 working days. The relevant head of department with the involvement from consultants and nurses if needed, investigated these complaints.

- All staff received information about the complaints procedure as part of their induction. The staff we spoke with were clear on the process and procedure
- Staff were confident complaints were investigated, but said they did not always receive feedback about the outcome of complaints.
- There were examples of learning from complaints. For example, there was a complaint where sutures were not fully removed in OPD as they were not all seen by the naked eye. The patient had to return to the OPD to have them removed. The hospital reviewed this complaint and purchased cosmetic magnification lamps. These lamps magnified the wound and identified sutures that could not be seen by the naked eye.

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

Good 

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

We rated well-led as 'good'.

- There was a hospital clinical strategy. Most staff knew the details of the strategy. They exhibited the ethos of the strategy in their commitment to provide quality and compassionate care for patients in an effective and efficient manner.
- There were governance processes which were effective in monitoring and managing quality and risk.
- Staff had confidence in their immediate managers. Staff reported that senior management within the hospital were visible and always approachable.

## Vision and strategy for this this core service

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- The service vision was to deliver fast access to treatment, fast scans and diagnostics, time to care and a safe and clean environment. The corporate 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 Hospital Director (registered manager) used this and corporate values as the basis of the hospital wide strategy and vision for high quality and safe care.
- The hospital had goals set of the year 2016. These included both clinical and financial goals, with a focus on clinical goals.
- All staff demonstrated a commitment to providing quality and compassionate care for patients in an effective and efficient manner. Some staff also talked about growing and developing their service to meet the needs of patients and to increase business revenue.
- Managers in outpatients, physiotherapy and diagnostic imaging knew about the executive team plans for developing their respective services. The plan for closer working with the local Clinical Commissioning Group was resulting in greater business for the hospital.

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

- There was defined governance and reporting structure in the hospital, which fed into the hospital governance processes. There was a clinical governance committee with a range of sub committees including clinical audit and effectiveness, infection control and risk committees. This along with the health and safety and risk committee fed into the senior management team meeting. Discussions at all these meetings included a range of safety and quality issues. The outpatient sister was member of the clinical governance committee and the radiology lead a member of sub committees and the health and safety and risk committee.
- There were regular heads of department meetings and departments held their own team meetings, for sharing information from hospital clinical governance meetings. The minutes of the hospital clinical governance committee were shared with OPD and diagnostic imaging departments.
- The medical advisory committee (MAC) met quarterly and membership covered all disciplines. The clinical governance committee minutes and were shared at the MAC. Quality and risk issues were discussed, including complaints, incidents, audits and the MAC approved practising privileges and any new techniques or equipment. The MAC chair told us of practising privileges being suspended if consultants did not produce an appraisal.
- There was a hospital risk register and there were items on the risk register OPD, imaging and physiotherapy departments. The failure to have a single patient record and high percentage of hospital business generated through external consultant secretaries and risk to security of patient records was identified as a high risk. Staff were aware how to escalate items onto the risk register.
- There was a recent decision to stop children’s services at the hospital, including outpatients, as the registered manager was not satisfied the hospital could to support the service safely.

## Leadership / culture of service

- Managers in the outpatient, radiology and physiotherapy departments had clinical roles and were easily accessible. Staff reported good support and guidance from their managers. Managers were passionate about their teams and caring for their patients.
- In outpatient department, the team leader was working with the hospital administration team to streamline the booking process to release administration time within the outpatient department.
- The senior management team were highly visible within the hospital. Staff told us their names were known by the Hospital Director. They felt very much part of the hospital team.
- Medical staff we spoke with confirmed a positive relationship with the Hospital Director who provided strong leadership of the hospital.

## Culture within the service

- There was a positive attitude among staff with regard to wanting to share learning from incidents and complaints across the hospital and organisation.

# Outpatients and diagnostic imaging

- All staff said they felt listened to and respected. They felt they could raise concerns and they would be investigated.
- Staff told us there was also limited opportunity for sharing experiences at a peer level across the organisation.
- Staff also wrote directly to the hospital director and always received a response regarding the concerns raised.
- In 2015, 88 staff received inspiring people awards. Staff nominated other staff members for these awards. There was also an employee of the month scheme in place whereby an employee was selected based on them having demonstrated exceptional delivery of the core values of the hospital.

## Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test.
- The hospital were developing a mystery shopper initiative with patients recruited through OPD to report on their pathway, four or five had been recruited at the time of inspection.
- Staff told us that they were able to meet with the Hospital Director who was very visible in the organisation. She regularly met with them at lunch or pre-arranged sessions. This allowed staff to discuss in an open forum their thoughts and ideas for the hospital.

## Innovation, improvement and sustainability

- Most staff reported the hospital supported innovation with the executive team responsive to requests and suggestions for improvement. For example, the service had introduced a new fertility treatment that had received patients from other countries.

# Outstanding practice and areas for improvement

## Areas for improvement

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

- The hospital must ensure the door from theatre 1 and theatre 2 into the shared preparation room cannot be opened at the same time.
- The hospital must ensure assessments of all risks associated with practices in theatres are carried out in a timely manner and actions to mitigate any identified risks are recorded, monitored and reviewed.

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

- Action taken to mitigate any identified risks in theatre practices should take into consideration national guidance and recommendations.

- Incidents should be appropriately graded and investigations should follow best practice in root cause analysis.
- The hospital should ensure continued progress of action plan to achieve Joint Advisory Guidance accreditation in gastrointestinal endoscopy.
- There should be continued work to have a copy of oncology patients MDT notes 100% of the time.
- The hospital should ensure compliance with all mandatory training to meet hospital target of 95%.
- All staff should receive feedback on complaints from patients.
- There should be more monitoring of outpatient clinics to identify any improvements.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures	<p>Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment</p> <p>How the regulation was not being met:</p> <p>Regulation 15(2)</p> <ul style="list-style-type: none"><li>• Theatre 1 and theatre 2 shared a preparation room. There was no mechanism to ensure only one theatre door into the preparation room was open at a time. This did not meet national guidance recommendations and posed a risk of cross infection.</li><li>• There were no assessments of risks associated with preparing for surgical procedures at the same time in the same preparation room.</li><li>• There was no assessment completed to identify any risks the practice of preparing surgical equipment in the preparation room for use in theatres with UCV systems had for patients.</li></ul>