Spire Norwich Hospital

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Norwich Hospital is part of Spire Healthcare Limited. Spire Norwich offers comprehensive private hospital services to patients from Norfolk and East Anglia. The hospital is located on the outskirts of Norwich with easy access to main driving routes and the local NHS Trust.

Healthcare is provided to patients with private medical insurance, those who self-pay and patients referred through NHS contracts. Hospital facilities include an outpatient service, diagnostic imaging service, 49 bed inpatient ward, six day case beds, two chemotherapy chairs and five chemotherapy beds. There were also three high dependency beds (HDU) advertised for use within the hospital. Theatre provision includes three theatres, two with laminar flow and a sterile services department. From April 2014 to March 2015 there were 6,262 visits to theatre.

Inpatient services for children under the age of 16 are not provided at Spire Norwich. Children are seen within the outpatient and diagnostic imaging departments for consultation appointments.

We inspected this hospital as part of our independent hospital inspection programme. This was the first comprehensive inspection of Spire Norwich Hospital. The inspection was conducted using the Care Quality Commission's comprehensive inspection methodology.

We carried out an announced inspection of Spire Norwich Hospital on 13 April 2016. Following this inspection we also undertook an unannounced inspection on the 26 April 2016, to follow up on some additional information.

The inspection team inspected the following core services:

- Medicine (specifically oncology services)
- Surgery
- Outpatients and Diagnostic Imaging

All services at this hospital were inspected during our visit.

We rated Spire Norwich Hospital as 'Good' overall with all core services achieving a good rating. However safety was rated as requires improvement within medical services and outpatient and diagnostic imaging services.

There was a cohesive, responsive senior management team that supported and empowered staff to deliver a high standard of patient focused care.

Our key findings were as follows:

Are services safe at this hospital/service

- There was a good incident management system at the hospital. Staff across all core-services were aware of incident reporting requirements and there was evidence of learning and improvement following serious incidents.
- The hospital collected data to support the safe running of the service. The clinical scorecard showed the hospital group target for aspects of care across all five domains. In Q1 2016 the Spire Norwich hospital was achieving or exceeding target in 82% of areas measured (32 of 39 measures were green which indicated results above the Spire target)
- Effective systems were in place for the management of medicines, the prevention and control of infectious diseases and ensuring equipment and the environment was maintained.
- Nurse staffing levels across the hospital were planned and met consistently.
- Safeguarding procedures were in place and staff received regular safeguarding training (combined level 1 and 2). However, staff in oncology services could not describe circumstances in which they would escalate safeguarding concerns.

Summary of findings

- Staff in outpatients had been trained to safeguarding children and young people, levels one and two combined, and not level three as is required by national guidance. The outpatient manager was level 3 trained but there was a risk that, at times, that there may be no staff on site with the appropriate level of training.
- Spire Norwich had a resource in place for children's appointments to have staff from another Spire site attend but there was no mechanism to check that these staff had appropriate level of training.
- We identified a number of out-of-date sealed sterile packs during our inspection. We brought this to the attention of the management team who took immediate action and implemented a process to prevent recurrence.
- There were processes in place to report, investigate and monitor surgical site infection and VTE compliance alongside incidences of DVT.
- Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) training was included within the mandatory training program. However, nursing knowledge of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was limited. None of the staff spoken to with were able to describe the practical application of the MCA or DoLS within their role.
- Not all records, including consent forms, were fully legible with amendments appropriately documented.
- A single patient record was not held on site although the hospital was taking steps to address this. However at time of inspection not all consultants' records were readily available and documentation that was available was limited in content.

Are services effective at this hospital/service

- Hospital policies were evidence based and referenced national guidance and legislation where applicable.
- Food and drink was available throughout the day and patient's dietary requirements were taken into consideration and provided for.
- There was good multidisciplinary team (MDT) working across the hospital. All services worked closely with the local NHS Trust to ensure consistency in patient care for NHS patients.
- The hospital met 100% of its CQUIN targets for 2015/16.
- Patient reported outcome measures (PROMs) data from April 2014 to March 2015 showed satisfaction, in line with the national average, in relation to patient outcomes following hip and knee surgery.
- Bed occupancy was below 80% throughout 2015 meaning access to beds and flow through the hospital was achieved easily.
- There was a good level of local auditing taking place across the hospital.
- There were good processes in place to obtain consent from patients.
- However, the hospital did not participate in all national audits for which it was eligible, particularly in relation to oncology services.
- The Spire target for compliance with the pre-operative fasting guidelines was 45%. The hospital was meeting this with results ranging between 50 and 70% in 2015; however this meant that up to 30% of patients were at risk of having fasted for a prolonged period.

Are services caring at this hospital/service

- Patient feedback received in person, on-line and via CQC feedback cards was positive. Patients felt able to ask any questions they had in relation to concerns and felt that these were answered appropriately by consultant or nursing staff.
- Friends and family Tests data (FFT) showed that 97% patients who responded in January 2016 were likely to recommend the hospital.
- A chaperone service was available to support patients undergoing intimate examinations.

Are services responsive at this hospital/service

- Outpatients had no waiting lists for patient's due to attend clinics.

Summary of findings

- Services were available for patients with additional needs, for example translation services and the ability for relatives to stay in the hospital with patients who require additional support.
- Formal training on dementia was provided to all staff within the 'Compassion in Practice' mandatory training module and at the time of our inspection, and 92% of staff had completed this module.Staff also had a clinical briefing on Dementia produced by the central team. Two senior members of staff were acting as dementia leads and a point of contact for staff requiring more information about dementia issues. It was not common for people living with dementia to be admitted to this hospital and a further training programme was due to be rolled out within the hospital from May 2016.
- The oncology service was flexible and able to provide additional days and sessions should the demand for the service increase.
- Medical review was available 24 hours a day seven days a week via clinics, the on-call system and via the respnsible medical officer (RMO).
- There was a robust system for dealing with, and learning from patient complaints. Spire Norwich had been asked to share their processes with other hospitals in the group to share best practice.

Are services well led at this hospital/service

- The hospital group had a clear vision and strategy underpinned by a set of core values for staff to follow. Staff we spoke with were aware of the vision, values and strategy for the service.
- Governance processes were well established. This included incident management, audit, policy management and learning from complaints. Information flow between key committees was well documented and there was a cohesive staff force with regards to issues and actions being taken to improve services.
- Robust systems were in place for ensuring consultant's practising privileges were monitored and reflected scope of practice.
- There was an open transparent attitude to serious incidents which involved both duty of candour to the patient, but also an open learning environment for staff with the support from senior management.
- Within 2015 Spire Norwich held 13 educations seminars for the general practitioner (GP) community and 51 GP practice-based educational events, such as 'radiology and urology update' which was an hour's evening session, and a lunch and learn training session delivered by a consultant urologist which were free events and could be used to build continued professional development (CPD) credits.
- The oncology service achieved MacMillan Cancer support accreditation for being a good environment to be treated for cancer in 2014.
- However, the service had been advertising a level 2 critical care service, when this service was not being provided. This was brought up during our inspection and an evaluation of the service was taking place. At the time of our unannounced inspection agreement had been reached to rebrand the service as an enhanced recovery service. This appropriately described the services on offer.

We saw several areas of outstanding practice including:

- Diagnostic imaging services used two software packages to allow both internal and external based staff the ability to view imaging and reports. There was a web based secure connection for consultants and radiographers to access imaging and reports whilst not located in the hospital. This software allowed secure access to documentation and images via iPad and mobile phones.
- There was a robust system and database in place which was used to record and monitor consultants competencies, completion of mandatory training, continued professional development, personal development review, indemnity, and revalidation. This information was considered as part of a rolling programme within the medical advisory committee (MAC) meetings, before being signed off by the hospital director and matron in order to re-establish consultant practising privileges.

Summary of findings

- There was an exceptional senior management team leading the hospital. The Hospital director, matron and MAC chair had clear oversight on the running of the hospital. They were all aware of the key risks and challenges as well as united in the future of the hospital. Staff had nothing but praise for the management team, stating they were visible, approachable and promoted an open culture.

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

Importantly, the provider must:

- Adopt a single patient record system, ensuring that all patient records are up to date, contain relevant information, include medical and nursing notes, patient risk assessments and administration pathway records. The hospital must have a robust system of monitoring the quality of records.
- Ensure that all staff that care for children complete level 3 safeguarding children training, in line with the intercollegiate document published by the Royal College of Paediatrics and Child Health. Ensure that there are suitably trained staff on duty, at all times, when children are seen and treated.

In addition the provider should:

- Ensure that all staff have access to major incident training and drills.
- Ensure staff understand the requirements and practice of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Review governance processes to ensure a greater level of management oversight with regards to oncology services.
- Consider participation in national audits related to cancer services where possible.
- Ensure that the quality of records, including consent forms, is improved to ensure documentation is clear, legible and accurate.
- Ensure that all departments are aware of risk management policies and procedures for the hospital. Furthermore, the provider should satisfy itself that all relevant risks to the safety and wellbeing of staff and patients have been identified and are being managed.
- Ensure that the medicines cupboards are locked at all times.
- Review preoperative fasting arrangements for patients and ensure regular monitoring to evidence improvement.
- Ensure there is a clear and well understood service specification for the provision of enhanced recovery care.
- Ensure auditing of RMOs awake periods during the night to assess safety of 24/7 working pattern and compliance to the European working time directive.
- Ensure that there is a system in place which allows people with specific needs, for example people with learning disabilities or dementia, to be identified prior to admission and flagged to appropriate staff so that additional needs can be considered.
- Review the safeguarding training and procedures to ensure that all staff are aware of what would constitute a safeguarding concern.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	Overall the medical oncology service at Spire Norwich Hospital was rated as good. Safe was rated as requires improvement with effective, caring, responsive and well led being rated as good. There were a number of out-of-date sealed sterile packs found during our inspection. Records were not always completed and there were no controls or checks on the number of booklets for chemotherapy administration the patient could have in their records. The electronic signatures on prescriptions were not always legible. Staff knowledge of safeguarding training was limited. Consultant oncologists did not work on site but were contactable by phone. However staff were up to date with mandatory training, and administration pathways and risk assessments for chemotherapy patients were in place. Evidence-based treatment protocols were jointly developed by the service and the local NHS trust. Patients received appropriate pain relief and their pain was routinely monitored. Staff were supported to complete service specific training, and develop their roles and careers within the organisation. Patients were well cared for. Patient relatives stated that the staff were caring, answered their concerns very quickly and did all they could to preserve the patient's dignity. Counselling and support services were offered to the patient, as well as relatives. This service worked closely with the Macmillan team to ensure patient needs were met. Oncology services were responsive. Patients received their first appointment within seven weeks of a referral being made, and more than half of these were seen within three weeks of the referral date. No specific complaints had been received about the oncology service within the last 12 months, and patients were informed about the complaints and compliments process. Oncology services were well led locally. There was a clear vision and strategy for staff. Staff were well

engaged, felt supported and respected the leadership at the hospital. There was an open friendly but professional culture at the hospital and in the oncology service.
The oncology service although small had achieved MacMillan Cancer support accreditation in 2014 for being a good environment to be treated for cancer. However there was limited evidence of monitoring the outcomes for chemotherapy patients, and there was limited oversight of oncology as a service by the medical staff through MAC and through Oncology team meetings. The risk register controls for monitoring risks were not as detailed as they could have been to ensure robust oversight of current risks.

Surgery

Good

Surgery at Spire Norwich Hospital was rated as good across all domains.
Staff were aware of how to report incidents and when this should be done. There was a clear escalation pathway for safeguarding concerns. Medication was stored appropriately, in line with manufacturer's guidance.
There were processes in place to report, investigate and monitor surgical site infection and VTE compliance alongside incidences of DVT.
A single patient record was not held on site although the hospital was taking steps to address this. However at time of inspection not all consultants records were readily available and documentation that was available was limited in content. Not all records, including consent forms, were fully legible with amendments appropriately documented.
Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) training was included within the mandatory training program but was not effective. Nursing knowledge of MCA and DoLS was limited. None of the staff were able to describe the practical application of the MCA or DoLS within their role.
Hospital policies were evidence based and referenced national guidance and legislation where applicable. Staff were seen to comply with local policies and had an understanding of national guidance. Pain relief was readily prescribed for patients post-operatively and to take home. Food and drink was available throughout the day and patient's dietary requirements were taken into consideration and provided for. Patient Reported Outcome Measures (PROMs) data from April 2014 to

Summary of findings

March 2015 showed satisfaction, in line with the national average, in relation to patient outcomes following hip and knee surgery. Consultant knowledge of the legal requirements surrounding the consenting of patients was good.
Staff provided compassionate, respectful care to patients. The latest Friends and Family Test (FFT) results were above 97% between July 2015 and December 2015. Patients who required additional support throughout their stay were highlighted at pre-assessment. Access to beds and flow through the hospital was achieved. Services were in place to accommodate patients whose first language was not English. Information was readily available for patients and was offered by staff as appropriate.
A clear vision and a set of values were embedded. Patient feedback was actively sought through questionnaires. There was a good governance structure in place; however route cause analyses (RCAs) often lacked detail. Learning was shared amongst staff by regular newsletters, emails and during handovers.

Outpatients and diagnostic imaging

Good

Outpatient and diagnostic services at Spire Norwich were rated as good overall. Safe was rated as requires improvement, caring, responsive and well led were rated as good. Effective was inspected but not rated.
Children were seen for appointments within the outpatient department by staff that had been trained to safeguarding children and young people level one and two combined, and not level three as is required by national guidance.
The outpatient manager was the childrens safeguarding lead and was trained to level 3 however there was a risk that, at times, there may be no staff on site with the appropriate level 3 training.
Spire Norwich Hospital had a resource in place to access RCN advice or support by telephone for any paediatric issues, however there was no mechanism to check that these staff had level 3 safeguarding training.
The hospital did not retain copies of all of the consultant's notes for each outpatient appointment. We were also concerned that no patient risk assessments were recorded or present within the patient notes despite having been told these assessments were carried out.

Summary of findings

There was an open reporting culture within the department and staff were encouraged to learn.
Robust systems were in place for ensuring consultant's practising privileges were monitored and medical review was available 24 hours a day seven days a week via clinics, the on-call system and via the responsible medical officer (RMO).
Patient feedback was extremely positive; patients spoke very highly of the care they received from staff.
Chaperone services were available at the patient's request. There was a specialist children's nurse available for children requiring any procedures to be undertaken.
There were no outpatient waiting lists for clinics and general practitioner (GP) feedback received about Spire Norwich was positive.
Governance systems were well established and good processes were in place for incident management, risk management and learning from complaints.

Summary of findings

Contents

Good

Spire Norwich Hospital

Services we looked at:
Medical care; Surgery; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Spire Norwich Hospital

Spire Norwich Hospital is a purpose built private hospital which was opened in 1983 by Bupa. During 1988 the site expanded to incorporate the original residential property positioned adjacent to the hospital which was redeveloped to provide outpatient services, this service expanded again in 2003 with the addition of six further consulting rooms and a treatment room. A third building neighbouring outpatients was also redeveloped to provide a Wellness service, the current site retains the Bupa Wellness facility in its original setting.

In 2007 a private equity company called Cinven bought the company from BUPA Hospitals LTD, and Spire Healthcare was established. Spire Healthcare became a public limited company when it floated on the London Stock Exchange in July 2014.

The hospital is situated close to the junction of the A11 and A47 providing ease of access to patients from Norwich, Norfolk and throughout East Anglia. The main hospital comprises, 3 theatres, 2 wards containing single patient rooms, oncology, imaging, physiotherapy and pharmacy. Continued improvements added static MRI in 2003 with static CT following in 2008. In recent years the hospital has benefited from extensive refurbishment ranging from sterile services and theatre air handling plant to updated patient rooms and a MacMillan accredited environment for their oncology department.

The Registered Manager is Daniel Cyprus, Hospital director, who has been in post for four years and four months.

Our inspection team

The team included on site included four CQC inspectors, one assistant inspector and two specialist advisors: one surgical consultant and one outpatient nurse specialist. An additional oncology nurse specialist gave advice remotely during and after the unannounced inspection.

How we carried out this inspection

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

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

The inspection was announced and took place on 13 April 2016. We also undertook an unannounced inspection on 21 April 2016.

Before visiting, we reviewed a range of information including information held by us and information provided by the hospital. In addition to private healthcare services the hospital treats NHS funded patients and we contacted the main clinical commissioning groups (CCG) for their views on the hospital.

We talked with patients and staff from the ward and operating theatre areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' records. We also undertook a focus group at the hospital, on 12 April 2016, for a variety of staff to attend.

Patient views were also collected by means of comment cards in the immediate weeks running up to and immediately following the inspection.

Summary of this inspection

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

Information about Spire Norwich Hospital

Key Figures

- Summary of beds
- Overnight beds 43
- Day Case beds 6

Inpatient Activity Summary (January to December 2015)

- NHS funded – 1439
- Other funded – 4810

Outpatient Activity Summary(January to December 2015)

- NHS funded – 3987
- Other funded – 18403
- There were 6,262 visits to the theatre between Jan 15 and Dec 15. The five most common procedures performed were:
- Primary total prosthetic replacement of knee (307)
- Diagnostic endoscopic examination of bladder (including any biopsy) (285)
- Endoscopic resection of semilunar cartilage (271)
- Phacoemulsification of lens with implant (234)
- Diagnostic esophagogastroduodenoscopy (229).
- Diagnostic Imaging facilities on site include two general rooms (one with fluoroscopy) with mammography, orthopantomogram, intraoral dental x-ray, mobile X-ray, two mobile image intensifiers, ultrasound room, computed tomography **(**CT) scanning, dexa scanning and magnetic resonance imaging (MRI).
- The pathology services for Spire Norwich are outsourced to a nearby NHS provider.
- Oncology services are Macmillan accredited and include chemotherapy, intra-vesicular Bacillus Calmette-Guerin (BCG), intra-vesicular mytomycin.
- The accountable officer for controlled drugs is Daniel Cyprus, Hospital director

Good

Medical care

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

Information about the service

We inspected the Cavell oncology suite and specifically looked at chemotherapy at Spire Norwich Hospital.

The chemotherapy service was provided three days a week within the oncology suite which was accessed via the ward on the first floor of the hospital. Patients were treated in bedrooms each of which had an en-suite shower room, seating for three people and a TV.

The service had treated 72 patients with cancer between November 2014 and April 2016. The hospital provided an overarching oncology consultation service to 398 patients in 2015.

During this inspection we spoke with three clinical oncology staff, two support staff, one patient and their friend and one oncology outpatient and their relative during the inspection. We reviewed four sets of oncology patient notes, observed the environment, and inspected the medication and storage areas.

Summary of findings

Overall the medical oncology service at Spire Norwich Hospital was rated as good. However, safe has been rated as requiring improvement with effective, caring, responsive and well led being rated as good.

Staff were up to date with mandatory training and administration pathways for chemotherapy included the risk assessments required before, during treatment and in preparation for discharge.

Oncology services were effective. There were evidence-based treatment protocols used for chemotherapy, which were jointly developed by the service and the local NHS trust. Patients received appropriate pain relief and their pain was routinely monitored. There was good multidisciplinary team (MDT) working with the local NHS trust, and internally within Spire. Staff were supported to complete service specific training, and develop their roles and careers within the organisation.

Patients were well cared for. Patients and relatives stated staff were caring, answered their concerns very quickly and did all they could to preserve the patient's dignity. Patient feedback, for the whole hospital, showed that 97% patients who responded in January 2016 were likely to recommend the hospital. Emotional support was available for all people who used the service who were diagnosed with cancer.

Oncology services were rated as good for being responsive. Patients received their first appointment within seven weeks of a referral being made, and more than half of these were seen within three weeks of the

referral date. No specific complaints had been received about the oncology service within the last 12 months, and patients were informed about the complaints and compliments process. Counselling and support services were offered to the patient, as well as relatives. This service worked closely with the Macmillan team to ensure their needs were met.

Oncology services were well led locally. There was a clear vision and strategy for staff. Staff were well engaged, felt supported and respected the leadership at the hospital. There was an open friendly but professional culture at the hospital and in the oncology service. The oncology service although small had achieved MacMillan Cancer support accreditation in 2014 for being a good environment to be treated for cancer.

There was limited evidence of monitoring the outcomes for chemotherapy patients, and limited oversight of oncology as a service by the medical staff through the medical advisory committee (MAC) and through Oncology team meetings. The lead oncology consultant sits on the Medical Advisory Committee (MAC) with the MAC Chairman, Hospital Director, Matron, Clinical Governance Manager, representatives of all other major specialties and further senior managers, and the minutes of the MAC meetings reflect when he attended. The risk register controls for monitoring risks were not as detailed as they could have been to ensure robust oversight of current risks.

However:

Oncology services required improvement for safety because we identified a number of out-of-date sealed sterile packs during our inspection. Records were not always completed and there were no controls or checks on the number of booklets for chemotherapy administration the patient could have in their records. Oncologists did not work on site but were contactable by phone, which meant that patients who required consultant review could not be seen by a consultant. The electronic signatures on prescriptions were not always legible. Whilst the hospital team took actions promptly to address the immediate issues there remains the need to ensure regular oversight to fully embed new processes. Whilst safeguarding training was provided to staff, two out of the three, staff spoken to were unable to describe the type of concerns they might escalate as a safeguarding concern.

Good

Medical care

Are medical care services safe?

Requires improvement

Oncology services were rated as requires improvement for safe because:

- Administration pathway records were incomplete for two of the four sets of chemotherapy patient records we looked at.
- There were no controls or checks on the number of booklets for chemotherapy administration the patient could have in their records.
- Whilst safeguarding training was provided to staff, two of the three staff spoken to were unable to describe the type of concerns they might escalate as a safeguarding concern.
- Oncologists did not work on site and were contactable by phone, which meant that patients who required consultant review could not be seen by a consultant. This was a recognised gap in the service.
- The medicines cupboard was unlocked on the day we inspected and there was no regular audit undertaken of non-controlled medications in the oncology suite.

However we also found:

- Staff were aware of incident escalation and reporting policies and procedures within the hospital.
- Medication incidents were investigated and changes in practice made as a result of a near miss.
- Chemotherapy medicines were stored in a lockable cupboard within a locked storage room.
- Staff were up–to-date with mandatory training.
- Administration pathways for chemotherapy included the risk assessments required before and during treatment and to plan for discharge
- Nurse staffing levels were planned to meet the demand of the service and oncology nurses were supported to complete relevant training.
- The electronic signatures on prescriptions were not all legible. A process and flowchart was devised and implemented immediately for obtaining Spire Norwich chemotherapy prescriptions
- There were a number of out-of-date sealed sterile packs identified during the inspection. We brought this to the attention of the management team who took immediate action and implemented a process to prevent recurrence.

Incidents

- We spoke with five members of staff during this inspection, and of those all were aware of how to escalate and record incidents.
- Staff were able to identify how to escalate an incident. The nursing services manager provided an example of an incident that had been reported, investigated and lessons learnt shared with the staff involved.
- There were no never events relating to the oncology service in the last twelve months. A Never Event is defined as 'a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers'.
- Records of medication incidents provided showed that there had been one chemotherapy incident in November 2015, for a known side effect of chemotherapy. The incident report showed that the medication was stopped and the responsible medical officer (RMO) attended to the patient.
- Records of medication errors for January 2016 showed that the wrong chemotherapy medication had been prepared, but the error was spotted before administration to the patient. The medication was destroyed then reordered and the patient had to return the following day to receive treatment. The incident record showed the hospital changed the medication procedure following the near miss to prevent reoccurrence.
- Staff in the oncology department said that there were monthly meetings attended by the team and pharmacy colleagues where incidents were discussed.
- Nursing staff were aware of their responsibilities under duty of candour and could give examples of when this was undertaken.

Safety thermometer

- Patient outcomes were measured against a fixed set of criteria using the Spire clinical scorecard. Outcomes were compared nationally against other Spire hospitals

on a quarterly basis. Spire Norwich also benchmarked against NHS key performance indicators (KPI's) and CQINS, submitting data quarterly for all NHS patients treated.
- The hospital collected data to support the safe running of the service. Information seen included the percentage of cancer patients with a multidisciplinary team discussion. The clinical scorecard showed the hospital group had a target of 65% and in 2015 Spire Norwich hospital consistently exceeded the target and achieved 100%.

Cleanliness, infection control and hygiene

- The hospital had an infection control lead nurse and an infection prevention and control team with representation from departments throughout the hospital.
- There were no reported incidences of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (C.Diff) in 2015 for oncology services.
- The patient information board in the oncology suite included information about post-surgical infection rates (0) and cleanliness audit results (95%).
- Four of the five staff, when asked, stated they were up-to-date with mandatory training which included infection prevention training run by the lead nurse. Training records examined supported this.
- The oncology suite was cleaned by housekeeping staff and cleaning schedules and checklists for completion were in place and were monitored by the nursing services manager. Clinical areas had vinyl floor covering to ensure appropriate cleaning could take place and reduce the risk of infection.
- Separate oncology and needle sharps containers located in the storeroom were dated and not overfilled.
- Personal protective equipment such as gloves and aprons were available in the storerooms and staff were observed to adhere to bare below the elbows as compliant with best practice and utilise PPE appropriately.
- Hand hygiene foam dispensers were available at the entry to the oncology suite.

Environment and equipment

- The oncology suite had recently been upgraded. There were five bedrooms and two rooms with chemotherapy chairs all with en-suite shower rooms, seating and a TV in the Cavell oncology suite.
- The oncology suite did not have separate resuscitation equipment but shared equipment with the ward located on the same corridor. This was accessible and staff knew where this was located.
- The anaphylactic and extravasation kit boxes in the storeroom were sealed and dated for review in May 2016.
- There were two infusion pumps on a shelf in the medication store awaiting portable appliance testing (PAT) prior to use. The other equipment examined was within current service and testing date.
- We asked staff who was responsible for ensuring that consumable stock in sealed sterile packages were rotated to ensure equipment was used within the expiry dates. They told us they did not routinely check the dates or rotate equipment.
- The storeroom contained two trolleys that contained out-of-date equipment. Equipment included nine strips of needles; eight blood giving sets; three infusion sets; one infusion bag; three intravenous infusion bags and three intravenous catheters. When questioned staff stated that these were trolleys rarely used. We drew this to the attention of management team who removed the items and implemented a new system of checking and rotating stock whilst we were on site to reduce the risk of reoccurrence.
- The oncology suite has two chemotherapy spillage kits and all staff had received training on how to use these within the last 12 months, including porters and housekeepers.

Medicines

- Consultants, who were based at the local NHS hospital, prescribed all chemotherapy medicines to patients. These prescriptions were then sent to the Spire Norwich to enable staff to administer treatment.
- Medicines including chemotherapy medicines were kept within a locked store with a keypad entry. The store was managed by the pharmacy team, who undertook regular audits, and monitoring on the chemotherapy medicines.
- The oncology suite did not store any controlled drugs within it. All medicines were requested from pharmacy and delivered to the suite when required.

- Non controlled medicines were stored within a lockable cupboard in the locked store and chemotherapy medication was stored in the fridge.
- The fridge temperatures were monitored and consistent records were made of the checks to ensure that medications were stored at the correct temperatures. Fridge temperatures were noted to be within recommended range.
- The medicine cupboard in the storeroom was unlocked on the day we inspected. We asked staff about this and they told us the storeroom door was always locked and patients could not access the store however this contradicted our findings on the inspection day.
- Whilst the staff informed us that the pharmacy team audited all medicines, the pharmacy team and audit records confirmed that only the controlled medicines were audited. The non-controlled medicines in the oncology suite were not routinely audited, however the hospital put audits in place immediately during the inspection and this was checked and found to be in place during the unannounced vinspection.
- The patient survey showed Spire Norwich was consistently scoring less favourably on advising patients of side effects of medication when they returned home than other hospitals within the Spire group. The average for all Spire hospital was 87% and this service scored below 85%.

Records

- We examined four sets of records for patients who were being treated with chemotherapy. Each record contained a completed protocol template (administration pathway) for the specific chemotherapy being administered.
- The chemotherapy protocols were in booklet form and were completed with required information including the patient contact details, and clinical history.
- All the patient notes folders looked at contained a photocopy of the patient consent form signed by the consultant at the local NHS trust. Each administration pathway booklet contained completed treatment checks of observations during treatment.
- There were no controls or checks on the number of booklets for chemotherapy administration the patient could have in their records. One out of the four patients administration pathway booklets examined contained no clinical history, just a sticker with the patient's age and address. Another administration pathway had an incorrect patient's name sticker at the front and no history detailed within it.
- We raised this as a concern with staff and were told both patients were known to the service. It was unclear to the staff why this had happened, and they were asked to ensure the records were updated and correct to ensure patient safety.
- The electronic signatures on prescriptions were not legible in four of the five sets of records reviewed. Issues with the prescriptions related to the two consultants with the greatest volume of patients. Following inspection the senior management team held a meeting with one of the oncology consultants and reiterated the necessity and process for obtaining the original chemotherapy prescription as a requirement. A process and flowchart was devised and implemented immediately for obtaining Spire Norwich chemotherapy prescriptions.
- Failure to maintain robust records management, in particular a single contemporaneous record of care, was identified as a risk on the hospitals risk register. This meant that the team had oversight and some existing controls, such as pre-treatment checks, to lower the risk.

Safeguarding

- We asked three members of staff about safeguarding. They all told us they had done the on-line mandatory training. However the safeguarding training records examined did not distinguish the level of training required, for example level 1, 2 or 3, or identify what had been undertaken by each professional group.
- Subsequent data provided by the hospital confirmed safeguarding training for both adults and children was a combined Level of 1 and Level 2. Hospital wide combined safeguarding children and adults training for 2015 was 93.8%, against a target of 90%.
- Of the three staff spoken to, two were unable to describe the type of concerns they might escalate as a safeguarding concern.
- The oncology notice board had information about the lead clinicians responsible for safeguarding. All staff were aware who the lead clinicians for safeguarding were, and how they would contact them.

Mandatory training

- Staff stated they were up-to-date with mandatory training. The records provided for mandatory training, were not specific to each area of the hospital, but related to all staff.
- Between January and December 2015 between 92% and 97% had completed mandatory training, which included subjects such as health and safety, fire safety and moving and handling. Overall hospital target for mandatory training compliance was 95%.
- Data provided showed that by the end of Q1 (January to March 2016) 53% of staff were up to date with mandatory training. This cumulative average was ahead of target.

Assessing and responding to patient risk

- The administration pathway included pre-treatment tests and risk assessments including venous thromboembolism (VTE); neutropenic sepsis; treatment and observations such as temperature, pain or discomfort and side effects during treatment.
- The observations were rated red, amber or green (RAG) to alert staff to seek help should the patient deteriorate during chemotherapy. The booklet also contained a checklist for discharge including contact or onward referrals to primary or other NHS care.
- A member of staff described how they would summon help for a deteriorating patient. This included contacting the responsible medical officer (RMO). Two members of staff stated that response from the RMO was very good, and despite them not being specifically oncology trained, two out of the four RMO on rotation had worked in oncology areas previously.
- We reviewed a patient record where the RMO had been contacted to assist with a deteriorating patient. The patient was treated appropriately and full documentation, detailing the RMO intervention, was provided to the oncologist.
- The oncology service uses the UKONS (UK oncology nursing society) triage tool to detail any chemotherapy adverse side effects. Although the unit is only open for three days there is a chemotherapy competent nurse on duty between Monday and Friday 9am to 5pm for patients to call for advice. Out of hours patients were advised to call a designated number to speak with the team at the local NHS hospital.
- The service had a policy for extravasation, which staff were aware of and knew how to manage. Extravasation is the process by which any liquid (fluid or drug) accidentally leaks into the surrounding tissue. In terms of cancer therapy, extravasation refers to the inadvertent infiltration of chemotherapy into the subcutaneous or subdermal tissues surrounding the intravenous or intra-arterial administration site.
- The service has a service level agreement procedure in place for access to plastic surgery at the local trust in the event of extravasation. There were allocated plastic surgeons at the hospital who were responsible for this care. The medicine Savene is held at the local trust and would be couriered over when needed.
- The unit has two chemotherapy spillage kits and all staff had training last year including porters and housekeepers.

Nursing staffing

- Data from nursing rotas demonstrated that staffing levels for the oncology suite were sufficient at all times to provide care with two chemotherapy nurses on duty. Where there was an increased demand for services the team would offer staff overtime or utilise bank staff to cover the patient lists.
- The hospital collected information about agency and bank staff usage. This was not specific to oncology. Staff stated that agency staff usage was not routine in oncology, but they do use internal staff from their bank of staff.

Medical staffing

- Staff from the human resources department described the recruitment procedure for granting practicing privileges to medical staff. The background checks described included evidence of appraisal, indemnity, registration with the GMC and interview by the hospital director and bi-annual review of this information.
- We reviewed the medical cover for the oncology suite, as well as the working arrangements with the local NHS trust. Oncology staff predominantly worked on the NHS site where they assessed patients, and were contactable by phone when a patient was receiving treatment at Spire Norwich. There were no oncologists on site on the day of our inspection.

Major incident awareness and training

- The hospital had an overarching plan for emergency incidents. The oncology suite was included in this plan

and this was available. There was a local major incident policy for Spire Norwich dated March 2016 however staff had not received any major incident specific scenario training.

Are medical care services effective?

Good

We rated the oncology service as good for effective because:

- Evidence-based treatment protocols used for chemotherapy were jointly developed by the service and the local NHS trust.
- Patients received appropriate pain relief and their pain was routinely monitored.
- Patients had a choice of food and drink and said they were offered refreshments regularly.
- Oncology staff told us they were supported to complete service specific training, and develop their roles and careers within the organisation.
- There was good multidisciplinary working (MDT) working with the local NHS trust, and internally within Spire.

However:

- There was limited evidence that the service participates in national audits.
- The hospital did provide Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training but this was not effective and staff had limited knowledge.

Evidence-based care and treatment

- Evidence-based administration pathways had been jointly developed with the service and the local NHS trust for each specific type of chemotherapy.
- The hospital provided treatment for the following types of cancer: breast, colorectal, gastrointestinal, gynaecological, lung, prostate, skin and urological cancers.
- There were policies, procedures and protocols in place for the prescribing, administering and disposal of chemotherapy. Staff on the oncology suite were aware of these.
- The hospital had a local audit plan dated 2016, and had completed local audits on chemotherapy for 2015. However participation in the audit activity and outcomes was not widely shared amongst staff. Staff were unaware of audit outcomes and two nurses informed us that they did not take part in the audit activity.
- The service did not partake in the national audits for cancer including the national bowel cancer audit, or the national prostate cancer audit.
- The service was meeting quality standard 61 from the National Institute for Health and Care Excellence (NICE)'infection prevention and control' when it came to line and catheter insertions for patients receiving chemotherapy. Patients who receive chemotherapy can have their immunity compromised as a side effect of treatment, which is why ensuring higher compliance with infection control requirements is essential.
- The Gold Standard Framework for end of life care was used and staff showed us the forms used to plan for terminally ill patients.

Pain relief

- The administration pathway included prompts for staff assessing patients' conditions during treatment; for example pain or nausea. These were completed in the four sets of chemotherapy records inspected.
- Two patients who were receiving treatment stated that they were not in pain, and that staff were very attentive to their pain needs throughout their treatment.
- On the day we inspected, a chemotherapy patient asked about take home medication they normally received when they were discharged. The nurse calmly told the patient she had forgotten to ask pharmacy to provide this. She politely asked the patient to take a seat whilst she contacted the pharmacy by telephone straight away. She then offered to escort the patient to the pharmacy to collect the medication.

Nutrition and hydration

- The waiting areas of the oncology suite had cold and hot drinks making facilities.
- One patient told us "we are fed and watered quite well". This patient also said they were given a choice of a hot or cold meal during their day stay.
- Nutritional advice was available to patients through the Spire Norwich Hospital. The service does have access to a nutrition expert, and for women specifically diagnosed with breast cancer there is a designated nutritionist for breast cancer.

- If a referral to a dietitian was identified as needed, the service can refer patients into the local NHS trust for advice and treatment.
- All patients receiving chemotherapy are required to have regular screening for malnutrition and weight loss, the service records this using the MUST tool.

Patient outcomes

- We saw evidence of an audit carried out to ensure biopsies were justified for suspected malignant breast cancer (the procedure was known as wide local excision (WLE)). The results showed that for a small sample of 14 patients, 13 patients had three forms of clinical assessment prior to surgery as recommended by the British Association of breast surgeons best practice guidelines 2009 and all these patients had malignancy.
- The UKONS information collected was being audited for the first quarter of 2016/17 and an outcome already identified was that "Significant patient medical history was not being detailed on the pad". The clinical lead informed us that an action plan was implemented to address this.
- Staff completed a further multidisciplinary team (MDT) audit to ensure that all patients have been discussed at MDT with documented evidence in the medical notes.
- There were no outcomes for national audits on cancer as the service did not participate in them.

Competent staff

- Oncology nursing staff provided evidence of recent and planned service specific study activity; for example, a one day annual update training course provided by a nearby university, this included an update on bladder cancer, Mitomycin C medication and a practical session.
- The breast care clinical nurse specialist said she had been encouraged by the consultant and supported by the hospital to undertake a breast care qualification to become a Macmillan breast cancer specialist nurse.
- The clinical lead informed us of their plans currently in progress to develop a generic clinical nurse specialist for cancer post at the Spire Norwich Hospital.
- The three oncology nurses had all received an appraisal within the last year and had all achieved chemotherapy competent training.
- One oncology nurse said that she had recently been supported to undertake a lymphedema course and would be developing a business case to extend the current service.
- Two members of staff stated they had commenced their employment as bank staff members between nine and 12 years ago and stayed because they had been encouraged to join the hospital team and supported through training, including a masters degree.

Multidisciplinary working

- The oncology service receives new referrals via an electronic referral system. Spire staff then contact the site specific clinical nurse specialist (CNS) to ensure the MDT discussion and plan of care is forwarded to the Spire.
- The clinical lead informed us that the service has a good working relationships with hospital Clinical Nurse Specialists (CNS's) and the Spire Breast Care nurse specialist attends the Breast MDT at the local trust.
- The MDT working with the local NHS trust was well established with all oncologists who worked for Spire oncology services providing care at the local hospital, which meant that patients care was smoothly handed over to the Spire Norwich Hospital.
- There was continual dialogue on the treatment to be provided between the oncology nurses and the oncologists.

Seven-day services

- The chemotherapy service was provided three days per week, Tuesday through to Thursday only. This was sufficient based on the number of patients and clinical need.
- Should additional days be required, dependent on demand, then additional days would be added to the schedule.
- All tests, radiology, therapies and other required specialised services were provided through the local NHS trust. The service and Spire Norwich specifically provided day chemotherapy services only.
- For out of hours support and advice the service has arrangements with a team at the local NHS hospital, who provide cover out of hours.

Access to information

- Nursing staff had access to the patient records maintained by Spire, these were securely stored in a locked room. All nursing and medical documentation was in paper form. Test results, including x-rays, were held electronically with medical staff having access as required.

Good

Medical care

- The NHS records of care, diagnostics, and diagnosis as well as treatment plan were sent to the Spire Norwich as part of the treatment plan so all staff had access to the required records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Four sets of notes contained a photocopy of the consent form signed by the NHS consultant.
- Two oncology staff told us they only see patients being actively treated; they said that patients who were for palliative treatment towards the end of their life were not usually treated at Spire Norwich Hospital.
- The consent for treatment form was subject to review and a new one to be implemented. This change was discussed and agreed through the medical advisory committee (MAC). The consultants reported in the February 2016 meeting that the current form was not 'fit for purpose'.
- All consent to chemotherapy forms examined were completed on the NHS form and met the requirements of consent for treatment.
- Mandatory training provided to the staff did include training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards(DoLS). However staff could not articulate this and knowledge was limited.
- Management staff told us a plan was in place to implement dementia training and this was a key clinical priority for 2016.

Are medical care services caring?

Good

Oncology services were rated as good for caring because:

- Patients, their relatives and a patient's friend told us the staff were caring, answered their concerns very quickly and did all they could to preserve the patient's dignity where possible.
- The hospital collected patient feedback for the friends and family test (FFT) on a monthly basis. The feedback was for the whole hospital and showed that 97% patients who responded in January 2016 were likely to recommend the hospital.
- We observed positive interactions between the staff, patients and relatives throughout our inspection.
- Patients felt involved and supported during treatment.
- A member of oncology staff provided the evidenced based documentation used to support patients to make difficult decisions in advanced stages of terminal illness.

Compassionate care

- The hospital collected patient views on a monthly basis. The information collected was not broken down by service type, and not specific to oncology, but showed that 97% of patients asked in January 2016 were likely to recommend the hospital.
- We spoke with two patients who had received or were receiving chemotherapy. They both told us their care was very good. One patient told us, "I can't think how to improve it (the service)".
- Patients, relatives or friends all stated that staff were "professional", "friendly" and "supportive".
- One patient said that staff were particularly good at maintaining their dignity as far as possible during intimate examinations and or procedures and that they appreciated this approach.
- Patients and relatives were very satisfied with their care. For example a patient returning for a follow up appointment commented on the oncology service "I can't recommend it highly enough" and of the nurse who supported her "She's a lovely girl".
- We observed staff interact positively with patients and their colleagues and provide care for a chemotherapy patient in the department in a calm friendly manner.
- Staff explained to patients what would happen next in a calm polite manner and checked, through open questions, their understanding.

Understanding and involvement of patients and those close to

- The clinical nurse specialist for breast care described how she supported patients to discuss their worries including making decisions about end of life care.
- The patients, relative and friends felt involved in their or their relative's/friend's care.
- One patient we spoke with told us questions were answered very quickly; concerns were dealt with swiftly. A staff nurse responded very quickly to a patient with a question about take home medication kindly and calmly.

Good

Medical care

- The hospital collected patient feedback and scored highly for the question 'Were you involved as much as you wanted to be in decisions about your care and treatment?' Results for November 2015, December 2015, and January 2016 were 88%, 89%, and 91% respectively.

Emotional support

- The breast care nurse specialist used a form, completed by patients, to discuss and assess support required. The form included tick boxes with headings such as physical concerns, practical concerns or emotional concerns to help patients remember the areas of concern to discuss at their next scheduled appointment. The form included a scoring tool for the overall level of patient concern of 1 to 10.
- The 'identifying your concerns' form was jointly developed by the Department for Health and MacMillan Cancer Support. The breast care nurse specialist told us this was used together with the MacMillan cancer support care planning template. We saw that the documents provided prompts to signpost patients to other services depending on the overall score for example counselling services.
- The patients we spoke with told us they felt supported through their treatment.

Are medical care services responsive?

Good

We rated the oncology service as good for responsive because:

- Patients referred for treatment had their first appointment within seven weeks of a referral being made and more than half of these were within three weeks of the referral date.
- No specific complaints had been received about the oncology service within the last 12 months.
- The service was flexible and able to provide additional days and sessions should the demand for the service increase.
- The oncology service was accredited by BUPA as a breast cancer care centre,
- Counselling and support services were offered to the patient, as well as relatives. This service worked closely with the Macmillan team to ensure their needs were met.
- There was information available for patients in the service, which informed them of how to raise any concerns, compliments, or complaints about their care in the service.

Service planning and delivery to meet the needs of local people

- There had been changes and investment to the oncology suite, with a recent upgrade that included en-suite shower rooms, seating and a TV in the Cavell oncology suite.
- The service was working on improving delivery of the service and were working collaboratively with the local NHS hospital where consultants were based. For example service level agreements were in place with the NHS hospital that included access to plastic surgery.
- There were no formal plans at the time of inspection to expand the provision of service though there was flexibility to do this if required.

Access and flow

- The chemotherapy day unit was open each Tuesday, Wednesday and Thursday from 9am to 5pm.
- 72 NHS patients had received cancer treatment between November 2014 and April 2016.
- Of these patients 46 patients received their first treatment within three weeks and all of them received their first treatment within seven weeks of being referred.
- The service monitored all patients who were referred on their internal system to ensure that they delivered access to treatment in a timely way. This was reported internally within Spire and monitored.

Meeting people's individual needs

- The oncology service was visited by Macmillan Quality Environment Mark assessors before being awarded the quality mark. The assessors looked at signposting for the environment, the privacy and dignity afforded to patients and accessibility of car parking before the award was given.
- The oncology suite had a small waiting area. There were magazines, patient information leaflets, hot and cold drinks making facilities and seating for up to four people in this area.

Good

Medical care

- Staff met and spoke with patients on each visit that they made to receive their treatment. We observed staff asking patients why they needed, and offering them additional support or counselling through Macmillan if they wanted to talk to someone.
- Access to counselling and support services for patients and their families was available through the local Macmillan service, which the Spire Norwich worked closely with to ensure that patient's individual needs were met.
- The oncology service was accredited by BUPA as a breast cancer care centre, which meant that they have demonstrated they can meet the needs of women diagnosed with breast cancer.
- The service had recently changed their translations services process prior to our inspection. They now ask patients at the time of issuing a letter for their appointment to ask if they require an interpreter. The service no longer allows relatives to translate for patients, which is in line with best practice.

Learning from complaints and concerns

- There was information available for patients in the service, which informed them of how to raise any concerns, compliments, or complaints about their care in the service.
- Patient complaints were an agenda item at team meetings and staff that were unable to attend team meetings had to sign when they had read the minutes of the team meeting.
- Records of complaints showed there were no specific complaints about the oncology service between September 2015 and February 2016.

Are medical care services well-led?

Good

The oncology service was rated as good for well-led because:

- The hospital had a vision and strategy that was accessible to all staff.
- Staff were well engaged, felt supported and respected leadership at the hospital.
- There was an open, friendly, professional culture at the hospital and in the oncology service.
- The oncology service although small had achieved MacMillan Cancer support accreditation in 2014 for being a good environment to be treated for cancer.

However:

- There was limited evidence of monitoring the outcomes for chemotherapy patients.
- There was limited oversight of oncology as a service by the medical staff through MAC and through Oncology team meetings.
- The risk register controls for monitoring risks were not as detailed as they could have been to ensure robust oversight of current risks.

Vision and strategy for this this core service

- The hospital group had a vision and strategy and staff had the core values on their computer screen savers.
- Staff were aware of the vision, values and strategy for the service.

Governance, risk management and quality measurement for this core service

- The Medical Advisory Committee (MAC) February 2016 meeting minutes discussed the changes and investment to the Oncology suite over the last two years. The minutes did not discuss all services within the hospital at all meetings. However the lead oncology consultant sits on the Medical Advisory Committee (MAC) with the MAC Chairman, Hospital Director, Matron, Clinical Governance Manager, representatives of all other major specialties and further senior managers, and the minutes of the MAC meetings reflect when he attended.
- The oncology team undertook monthly meetings to discuss the oncology service. This meeting was attended by nurses and clinical managers only, and there were no medical staff attendance recorded for January to April 2016. It was recorded in the minutes that consultants would be met with individually to discuss the service and Consultants were invited to attend these meetings where appropriate.
- There were nine recorded risks related to oncology on the hospital risk register. Two of these were rated as amber: failure to maintain robust records management; and patient's discharge is incomplete e.g. without correct medication or without follow-up appointment.
- Whilst there were plans and action points in place for the monitoring of these risks, some of the recorded controls were limited in detail. For example 'HD & HoCS

in discussions with Oncology consultants to ensure all patient information is provided'. There were no monitoring activities or sanctions for failure to provide records documented.
- Audit plans for the service excluded oncology specific measures to monitor patient outcomes for chemotherapy, which meant that there was limited assurances in the provision and service of chemotherapy being monitored.
- The senior management team responded to concerns raised regarding prescriptions and consultant cover and were committed to improving the oversight to increase patient safety. The hospital director and matron met with the consultants to discuss both immediate and long-term improvements.

Leadership and culture of service

- There was an open culture amongst the staff working within the service. Staff on the oncology suite told us the ward manager was approachable and supportive.
- Staff were friendly, welcoming and proud of the difference they made to patients undergoing challenging treatment.
- Staff within the focus group told us the hospital matron and director made a good team and they were supportive and approachable.

Public and staff engagement

- The service undertook routine patient surveys and follow up questionnaires to understand their experiences and provide feedback on how the service could improve.
- The service advertised the option to provide feedback and get involved in the service on their website and in the patient leaflets.
- Staff felt engaged and included in the service. There were regular meetings established to look at the service they provide and how they can improve the experience for the patients.
- The hospital conducted an annual staff satisfaction survey and the results are presented and analysed by each department. Results for 2015 showed improvement for all questions asked of all staff in 2013/14.
- Staff had participated in a number of fund raising events throughout 2015 such as a charity bike ride, race for life and a Spire Norwich Bake off / Macmillan coffee morning to support and raise funds for cancer research.

Innovation, improvement and sustainability

- The oncology service achieved Macmillan Cancer support accreditation for being a good environment to be treated for cancer in 2014.

Good

Surgery

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

Information about the service

At Spire Norwich Hospital there is one inpatient ward, one day surgery ward, a pre-assessment unit and three operating theatres. There are also three high dependency (HDU) beds. These are split between a three-bedded area on the day surgery unit and one single HDU bed within a side room on the inpatient unit.

The hospital saw a total of 2,287 inpatient stays, 3,962 day case patients and 6,262 visits to theatre in 2015. The hospital admitted a total of 56 patients into HDU in 2015.

During the inspection we spoke with 25 staff members including consultants, other doctors, nursing staff, operating department practitioners, care assistants and senior managers. We spoke with two patients and reviewed four patient records.

We also spoke with a further 24 members of staff at the focus group held the evening before the inspection. This was attended by staff from across the hospital including medical, nursing and allied health professionals, administrative, catering, housekeeping and engineering staff.

We reviewed policies, procedures and compliance with national guidance and legislation throughout all areas of the hospital.

Summary of findings

Surgery services at Spire Norwich Hospital were rated as good overall.

Staff were awares of how to report incidents and when this should be done. Learning was shared amongst staff by regular newsletters, emails and during handovers. There was a clear escalation pathway for safeguarding concerns. Medication was stored appropriately, in line with manufacturer's guidance.

Surgical site infection rates for hip and knee arthroplasty were above the national Spire average but better than the national targets set by Public Health England There were systems and process in place for investigation and monitoring to reduce the risk to patient safety. The hospital had a good performance record in relation incidences of DVT during 2015 with processes in place for reporting, investigation and monitoring. Incidents of DVT were reported, root cause analysis undertaken and action plans in place to improve patient safety. There were monitoring systems in place and policies and procedures were complaint with NICE guidelines.

Not all consultants stored copies of their medical documentation at the hospital so records were not readily available and documentation that was available was limited in content. Not all records, including consent forms, were fully legible with amendments appropriately documented.

Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) training is included within the mandatory training program but was not effective. Nursing knowledge of both MCA and DoLS was limited.

Good

Surgery

None of the staff spoken to were able to describe the practical application of the MCA or DoLS within their role. However, staff on the ward had an improved knowledge of the MCA when asked. The senior nurse planned to continue this method of engaging with staff and to look at Deprivation of Liberty Safeguards (DoLS) and share further knowledge around this area.

Medication security was not robust with regard to the key controls for the treatment room, where all medication was stored. There was no system in place to ensure the key safe code was changed regularly.

Hospital policies were evidence based and referenced national guidance and legislation where applicable. Staff were seen to comply with local policies and had an understanding of national guidance, for example NICE guidance. Pain relief was readily prescribed for patients post-operatively and to take home. Food and drink was available throughout the day and patient's dietary requirements were taken into consideration and provided for. Patient Reported Outcome Measures (PROMs) data from April 2014 to March 2015 showed satisfaction, in line with the national average, in relation to patient outcomes following hip and knee surgery. Consultant knowledge of the legal requirements surrounding the consenting of patients was good.

Staff provided compassionate, respectful care to patients. Staff understood and maintained patient dignity. The latest Friends and Family Test (FFT) results were above 97% between July 2015 and December 2015. However, in the latest patient led assessment of the care environment (PLACE) data, the hospital scored 83.7% below the national average (86%) for maintaining the privacy, dignity and wellbeing of patient.

Patients who required additional support throughout their stay were highlighted at pre-assessment. Bed occupancy was below 80% throughout 2015 meaning access to beds and flow through the hospital was achieved easily. Services were in place to accommodate patients whose first language was not English through the use of a translation service and staff were aware of how to access this. Information was readily available for patients and was offered by staff as appropriate.

A clear vision and a set of values were in place. Staff were fully aware of these and promoted them in day-to-day working. Patient feedback was actively sought through questionnaires and PLACE assessments were carried out annually.

Good

Surgery

Are surgery services safe?

Good

Surgery services were rated as good for safe because:

- Staff were aware of how to report incidents and were encouraged to do so.
- Mandatory training compliance for 2015 ranged between 92 and 97% against a Spire target of 95%
- The latest PLACE results for condition appearance and maintenance of the environment was 88%, which is above the national average of 74%.
- Medication was stored appropriately and in line with manufacturer's guidance.
- Appropriate controlled drugs procedures were in place and being adhered to.
- Nursing patient records were readily available and stored appropriately.

However:

- Not all consultants stored copies of their medical documentation at the hospital
- Records, including consent forms, were not always legible.
- The hospital had a poor performance record in relation incidences of DVT during 2015 however there were processes in place for reporting, investigation and monitoring.
- Surgical site infection (SSI) data for 2015 showed that SSI rates for hip and knee arthroplasty operations were above the Spire average. However processes were in place for monitoring and investigating and root cause analysis undertaken to identify themes.
- Hand hygiene audits were not undertaken to ensure effectiveness of hand washing techniques.
- There was no document to evidence the surgery team briefings that took place as part of the safer surgery checklist. This was rectified by the theatre manager during the inspection.
- Medication security was not robust with regard to the key controls for the treatment room, where all medication was stored. This was rectified during the inspection.

Incidents

- From January 2015 to December 2015, the hospital reported no never events, one unexpected death and two serious incidents.
- Staff we spoke to were aware of incident reporting requirements. This included identifying incidents and the subsequent reporting of them.
- When a serious incident, or other incident requiring investigation, occurred, lessons were learnt and shared. RCAs were carried out and we saw evidence of information and outcomes being disseminated to staff in email and hardcopy form. Serious incidents were also discussed at team meetings and escalated through the hospitals governance system.
- Shared learning was also seen from other hospitals within the organisation. Examples were given of serious incidents that could affect all Spire hospitals being shared nationally to enable wider learning.
- Staff were aware of their responsibilities under duty of candour and could give examples of when this was undertaken, for example when a patient post surgery was transferred to the local NHS trust and the situation was fully explained.

Safety thermometer

- Patient outcomes were measured against a fixed set of criteria using the Spire clinical scorecard. Outcomes were compared nationally against other Spire hospitals on a quarterly basis. Spire Norwich also benchmarked against NHS key performance indicators (KPI's) and commissioning for quality and innovation (CQINS), submitting data quarterly for all NHS patients treated.
- Compliance with national early warning score (NEWS) completion was above 99% throughout 2015, with the hospitals target being 95% or above.
- The hospital recorded no incidents of pressure ulcers of grade two or above in 2015. The hospital was at or below the mean for Spire hospitals nationally in 2015 for patient falls and pulmonary embolism (PE) occurrences.
- In quarters two and three of 2015 the hospital breached its target of unplanned readmissions within 31 days of surgical treatment. However, during the last quarter of 2015 an improvement was seen, reducing from 0.32% to 0.27%. The hospitals target is below 0.3%. The hospital was aware of this and it was noted in the clinical governance action plan for quarter four in 2015, with actions to monitor. and results for Q1 2016 showed that the hospital had exceeded the target by achieving 0.2%

Good

Surgery

- The hospital had a good performance record in relation incidences of DVT during 2015 with processes in place for reporting, investigation and monitoring. Incidents of DVT were reported, root cause analysis undertaken and action plans in place to improve patient safety. There were monitoring systems in place and policies and procedures were complaint with NICE guidelines. Data for Q1 2016 showed improvements with the hospital achieving or bettering the Spire national average in all aspects of VTE monitoring. 90% compliance against VTE prophylaxis administered within recommended timescales was achieved against a target of 80%.
- Surgical site infection (SSI) data for 2015 showed that SSI rates for hip and knee arthroplasty operations were above the Spire average. There had been six surgical site infections reported in total, with three reported as serious adverse events on the Spire reporting system. This equated to 0.55 per 100 discharges. The Spire mean for hip and knee arthroplasty operations SSI's was 0.18 per 100 discharges.
- There had been a total of 10 SSI's across all surgical procedures in 2015, which equated to 0.16% of total patients. Each surgical site infection was reported through the clinical governance meetings, investigated and root cause analysis undertaken to identify themes.
- Quarter 2 and quarter 3 had seen the highest number of SSI with 5 and 3 respectively.
- The clinical governance meeting minutes (November 2015) evidenced that monthly monitoring was in place to attempt to highlight areas for improvement and improve patient safety. The eight cases were reviewed; no common theme of specialty was noted. Action points from RCAs included a number of points including documentation omissions /errors, (including strength and type of skin preparation. patient warming measures not noted on care pathway when patients hypothermic) and the potential impact of VTE prophylaxis on SSI being discussed with the consultant microbiologist. Data from Q1 showed a worsening picture although the data stemmed from two patients with previous infections that were identified through readmission in Q1.
- The hospital recorded no incidents of pressure ulcers of grade two or above in 2015. The hospital was at or below the mean for Spire hospitals nationally in 2015 for patient falls and pulmonary embolism (PE) occurrences.

Cleanliness, infection control and hygiene

- Domestic cleaning was undertaken by housekeeping staff. Patient rooms, corridors, ward areas, waiting areas and en-suite facilities were all visibly clean. Corridors were carpeted, however treatment areas, for example patient rooms and treatment rooms, were laminate flooring. This complied with the Department of Health (DH) Health Building Note 00-09: Infection control in the building environment 3.115 states that, "Carpets should not be used in clinical areas. This includes all areas where frequent spillage is anticipated. Spillages can occur in all clinical areas, corridors and entrances." Patient rooms, theatres and treatment rooms did have laminate flooring in place which enabled easy cleaning.
- Clinical staff were responsible for cleaning clinical equipment, for example monitors. Equipment was labelled with a green sticker and dated once cleaned. All clinical equipment observed was visibly clean.
- Staff completed annual infection control training in electronic format as part of their annual mandatory training program. In 2015, 94.8% of staff had completed their infection control mandatory training against a target of 95%.
- Infection prevention training included training for hotel services and housekeepers. This extended training to these groups commenced in 2016 to drive standards forward and the training was led by the IPC lead and patient service manager.
- Staff were aware of when and how to use appropriate personal protective equipment (PPE) such as gloves and aprons. Staff were observed to use PPE appropriately throughout the inspection.
- Staff used hand sanitiser before and after patient contact and followed a 'bare below the elbows' policy. Sinks were available within patient's bathrooms, treatment rooms and sluice rooms. Staff were aware of when they should wash their hands. From January 2016 to March 2016, the hospital identified no MRSA or clostridium difficile (C. Diff.) cases.
- The hospital undertook hand sanitiser use audits in 2015 and patient perception of hand hygiene audits in 2014 and 2015, as detailed in the hospitals annual Infection Control Report 2015. Hand sanitiser audits consisted of weighing the amount of alcohol gel used over a set period, and basing the results against a predicted usage of two pumps per patient contact. The Spire target for hand sanitiser use per patient admission

is 18. The hospital met the target in two quarters of 2015, scoring 21.8 in quarter one and 21 in quarter four. The hospital did not meet the target in quarters two and three, scoring 14.8 and 16.5.

- Patient perception of hand hygiene audit was undertaken in quarter three. The audit asked how confident patients were that staff decontaminated their hands at appropriate times. No data is available on the number of audit questionnaires disseminated, however the return rate was 17% in 2015, which was a fall from 2014 when the return rate was 22%.
- The data provided by the hospital shows the results for 2015 were; 70% of patients answered extremely confident, 31% reasonably confident and 0% for not confident. This was an improvement on the 2014 results which were; 12% extremely confident, 9% reasonably confident and 4% not confident.
- However, the hand hygiene patient perception audit figures equal 101% for 2015 and 25% for 2014. No explanation for the disparity within the results is evident within the Infection Control Report 2015.
- Hand washing audits were not undertaken at the hospital due to the location of sinks within patient bedrooms. However, staff were observed washing their hands before dispensing medication and prior to setting up for clinical procedures within treatment rooms. The hospital uses alternative methods of audit, such as the use of an ultraviolet light box, to assess the effectiveness of the hand washing techniques used by staff as part of the annual mandatory training as well as staff induction.
- Endoscopy was undertaken within the theatre suite, in theatre 3. There was a pathway for clean and contaminated flexible endoscopes. Space was limited but staff maintained a one way system to prevent cross contamination. Equipment was decontaminated in line with national guidance. Documentation records were in place that provided a full audit and traceability process.
- Theatre staff used appropriate decontamination processes before commencing surgical procedures. Scrubs were worn within the theatre environment and these were laundered by an external company on a daily basis.
- There were three theatres available for use at the hospital. Two of the theatres had laminar flow systems installed and were utilised for any joint replacement surgery, two had the ability for laser surgery to be undertaken.
- Surgical instrumentation was cleaned, packed and sterilised within the central sterile services department (CSSD) on site. The CSSD was compliant with regulation and was due for SGS re-accreditation in June 2017. There was a clear process for tracking and traceability of theatre instrumentation. Staff were knowledgeable and aware of responsibilities. During the inspection autoclave two had failed and the external company engineer was contacted immediately. All instrument sets were clearly labelled not for use. Set numbers were logged on the meditrac system and non-conformance paperwork and the sets were separated and set aside to be rewrapped and processed again.

Environment and equipment

- Waste management was compliant with Safe Management of Waste (2011) DH guidance.
- All equipment checked across the hospital was within its service date and clearly labelled with the next date of service. Contemporaneous records were held by the engineering department detailing the service history of all equipment, when equipment is next due for service and by which contractor. 254 out of 256 pieces of equipment were up to date with servicing.
- Work requisition books were in each ward area. These were checked twice a day by an engineer to establish repairs that needed to be undertaken.
- Resuscitation equipment was available on Level 2, Level 3 and within theatres. The hospital only treats patients over the age of 16 as inpatients and within theatres. The resuscitation trolleys contained full adult advanced life support equipment and paediatric basic life support equipment. All resuscitation equipment checked was in date, with intact packaging where needed and stored appropriately.
- The high dependency unit was equipped with portable monitoring equipment, a portable arterial blood gas (ABG) machine and patient transfer bag. The transfer bag contained equipment required to transfer a deteriorating patient between high dependency and theatres or to a waiting ambulance for transfer to an intensive care unit.
- The most recent patient led assessment of the care environment (PLACE) scores for the hospital were published by PLACE on 11th August 2015. The hospital scored 88.6% for the condition, appearance and maintenance part of the assessment, which was better than the national average of 74.5%.

- The hotel services team undertook occupied room surveys twice a month where patients were asked three questions regarding the cleaning and maintenance of the rooms. These responses were discussed, logged and actions addressed. An example provided showed that a chair had been replaced as it had become worn and could not be easily cleaned.
- The CSSD department had a contingency plan and service level agreement organised with the nearest NHS trust. This meant that should major failure of washers or autoclaves occur the instrumentation could be processed at the other hospital and service to patients could be continued.
- There was a named laser protection supervisor (LPS) within theatre and they were supported by a laser protection advisor (LPA) at a nearby trust. All systems were in place to ensure safe use of laser within theatres. For example local rules were in date until January 2017, service records were maintained, there was a list of authorised users and the last annual audit on 7 September 2015 noted compliance was good. There had been three recommendations, two had been completed, a risk assessment had been undertaken appropriately and the third recommendation was in process.

Medicines

- Treatment rooms, where medication was stored, were checked on day case ward on level two, inpatient ward on level three, theatre recovery and HDU.
- Controlled drugs (CD) were managed appropriately. CD registers were accurate and correlated with the stock within theatre recovery, day case ward and inpatient ward. Nine randomly selected CD's were checked, three from each area. A further patients own controlled drug was checked within day case. CD's were checked daily by two registered nurses. Patient own CD's were also checked and correlated with the register.
- Treatment rooms within day case and inpatient wards were locked using numerical key pads. All medication was stored appropriately in locked cupboards or fridges, in accordance with manufacturer guidance.
- Medication security was not robust with regards the key controls for the treatment room, where all medication was stored. Senior nursing staff stated codes should be changed regularly but were unable to provide details on exactly when. Senior nurses were unable to state when the codes were last changed or due to be next changed. Concerns were raised to senior staff during the inspection about this and a program of changing the key codes was implemented immediately.
- Within the high dependency unit (HDU) medication was audited monthly by the critical care lead nurse. Evidence of these audits were seen during the inspection. No CD's were kept within HDU. HDU would access the CD cupboard within day case ward if required.
- Intravenous (IV) fluids were stored safely within treatment rooms.
- Fridge temperatures were checked on a daily basis and evidence of recording was seen with monitoring of temperatures to ensure medications were stored appropriately.

Records

- We reviewed four records during the inspection. Staff were able to find the records requested quickly and without delay. Nursing records, including risk assessments were completed in full.
- Pre-operative assessments were completed and accurately documented within the medical notes.
- One out of the four reviewed consent forms was not fully legible and one contained an alteration that was not dated or timed, however was initialled. This meant it was not clear that the amendments had been made pre surgery.
- Single patient records were not embedded within the hospital at the time of inspection. Staff told us consultant documentation is often missing or limited within patient records.
- The four sets of notes looked at during the inspection had documentation from a consultant however it was brief and undetailed. The hospital had identified the single patient record as a challenge but were working towards achieving this and were monitoring progress. This was in the early stages but data provided showed only 27 Consultants out of 218 compliant; there was an action plan in place for full contemporaneous records, prioritising those with admitting rights. However at time of inspection there was a risk to patient safety as not all details of treatment, assessments and documentation were available at all times.

Safeguarding

- From January 2015 to April 2016 no safeguarding concerns had been raised.
- Staff were able to describe the local arrangements in place to report safeguarding concerns. Support was available from the ward managers, the safeguarding lead nurse or the Matron.
- However, outside of normal working hours when support was not available staff were unsure as to how to escalate concerns. One senior nurse told us they would not know how to refer to the local authority in the event of matron or safeguarding lead nurse being absent. This meant that safeguarding referrals could be delayed placing patients at risk.
- Nursing staff had completed Prevent training (radicalisation recognition and prevention) and the hospital's mandatory training modules on safeguarding referenced female genital mutilation (FGM). Staff were aware of the importance of radicalisation and FGM, however were unsure of their legal duty in the reporting process for either. One senior nurse said she would try to discuss FGM with the patient but if it was for religious reasons there wasn't anything the hospital could do. Health and social care staff now have a legal duty to report all cases of FGM.

Mandatory training

- Staff were aware of their responsibility to undertake and complete mandatory training. Mandatory training was delivered via the Spire electronic system.
- Training compliance was reported as being between 92% to 97% across the 10 courses by the end of 2015 against an overall Spire target for mandatory training compliance of 95%
- In 2015, 97% of staff had completed their information governance (IG) mandatory training. This was also an improvement on 2014 when 96% of staff completed IG training. By the end of quarter one 2016, 53% of all mandatory training had been completed which meant the hospital were well ahead of trajectory.

Assessing and responding to patient risk

- If any specialist requirements or concerns were highlighted during the pre-assessment period, patients were referred to either the consultant or the anaesthetist depending on the requirements or concerns raised.
- In June 2008, the World Health Organization (WHO) launched a second Global Patient Safety Challenge, 'Safe Surgery Saves Lives', to reduce the number of surgical deaths across the world. The WHO checklist is a core set of safety standards that encompass the Five Steps to Safer Surgery designed to improve patient safety. The five steps are briefing, sign in, time out, sign out and debrief which encompass all stages of the patient journey.
- The sign in, time out and sign out were part of the Spire patient pathway. Staff were observed and checks were completed before general anaesthetic administration with direct questioning of patient name, date of birth and which operation and site, with site marking being noted. Time out checks were observed before incision, swab, instrument and needle counts were observed.
- Staff huddles were taking place before each list and with each change of consultant to ensure safety and a coordinated approach to the surgery and staff would verbalise a debrief however there was no documented evidence in place to evidence this or enable audit and learning. This was raised with the team directly and immediately taken forward by the theatre manager. A daily record to document step one and step five of the checklist was produced and implemented on the 14 April 2016.
- The instrument checklists were not designed to clearly demonstrate and provide assurance that all items of surgical instrumentation were accounted for at every stage, e.g. at packing, first count, final count and receipt into the wash area in the sterilising department. This was raised as a potential concern with the theatre manager who responded appropriately. All the instrument set checklists were updated with two additional columns, to confirm which instruments are present into theatre & leaving theatre, and were implemented 18 April 2016.
- In the event of a difficult intubation a fibre optic laryngoscope is an essential emergency piece of equipment. There was a process in place for the two fibre optic laryngoscopes to be decontaminated when the potential of a difficult intubation was identified in advance from the patients anaesthetic assessment. Once processed the scope should be used within one hour. During inspection the two scopes were stored in a ventilated clean air cupboard but had no tracking tags in place to identify when they had last been processed. In the event of an emergency there was the potential that a scope may be used without full decontamination. Again the theatre manager responded immediately to

concerns and completed a risk assessment. The department has acquired five disposable, single use, flexible fibre optic laryngoscope which means a scope is available at all times for immediate use.

- In the event of a cardiac arrest staff ring a single number and relevant staff are paged. The cardiac arrest team is made up of the responsible medical officer (RMO), theatre staff and senior nursing staff. Emergency call bells were available in each patient bedroom and consulting room.
- The hospital used the National Early Warning Score (NEWS) to assess patients. NEWS is a nationally recognised scoring system to establish the stability and deterioration of a patient based on predetermined parameters for observations such as pulse, temperature, pain and blood sugar.
- NEWS were completed appropriately in accordance with hospital guidance. Escalation plans accompanied the NEWS assessments and were appropriately implemented.
- Pre-operative assessments were completed either within the outpatient setting prior to admission or by patients completing a pre-assessment form at home. This was brought into hospital on the day of admission.
- In the preceding 12 months to the inspection, 56 patients had been admitted to HDU. All of these patients were level one patient's and none required level two care.
- Having raised the concern that the hospital would not be compliant for level 2 patients, in relation to staffing and competency it was acknowledged by the hospital that although branded a Level 2 Critical Care Unit they did not provide care or treatment to Level 2 patients. The service was set up to safely care for extended recovery level 1b patients.
- The branding and specification of this service was under review following our inspection. The services transfer policy confirmed that all patients requiring level 2 critical care treatment would be transferred to the local NHS Trust.
- Criteria was in place for escalation of deteriorating patients, including transfer to the nearest NHS hospital for level two or level three care. Staff were aware of the process and examples were given of its effective implementation.
- All registered and non-registered clinical staff were trained to a minimum of basic life support (BLS) for resuscitation. Six nurses held current advanced life support (ALS) certificates.
- Pathology services were provided by a nearby NHS trust, the hospital had a blood transfusion protocol in place, and a nationally based acute transfusion reaction (ATR) guideline in place should a patient have a reaction to blood transfusion.

Nursing staffing

- In total there were 39 whole time equivalent (WTE) registered nurses, 5.2 WTE operating department practitioners (ODP) and 14 WTE care assistants covering theatres and the wards.
- Nurse staffing was split over three shifts in a 24 hour period; the 'early shift' 7am to 3pm, 'late shift' 1pm to 9pm and 'night shift' 830 pm to 730am, allowing for a handover to occur between staff to ensure continuity of care.
- The number of staff on each shift was dependant on the expected number and acuity of patients. Acuity was monitored on a daily basis by senior nursing staff and additional staff brought in when required.
- The use of agency staff had notably reduced within 2015. The hospital scorecard had shown agency usage to be 28.4%, 20.7%.13.1% and 7.6% respectively for each quarter throughout 2015 against a Spire target of 3%.

Surgical staffing

- There was a responsible medical officer (RMO) at the hospital 24 hours a day, seven days a week. The RMO's worked seven 24-hour shifts in a row, with facilities on site for them to sleep over night. The RMO's hand over at midday on a Monday
- There was no auditing of how many times the RMO was woken during the night. Concerns were raised over the ability for the RMO to work the following day if they had been awake for long periods during the night. This was raised to the hospital during the inspection. The hospital had a process to contact the agency and request cover for the RMO should it be required, for example during sickness or to cover sleep time. We were informed that replacement cover could be provided within two hours or earlier if possible.
- Individual consultants remain responsible for patients whilst the patient is an inpatient for advice and

guidance should this be required. The consultants should be contactable 24 hours a day. The RMO was aware of how to contact consultants and was happy to do this when necessary.
- The consultants were required to provide written confirmation of cover when they were unavailable or on annual leave to ensure patient safety and senior medical advice was maintained.

Major incident awareness and training

- The hospital had procedures in place in the event of an incident occurring on site. The engineering manager spoke of the process for power failure. Backup generators were in place to provide power. Essential equipment, for example within theatres and imaging department, ran from separate circuits. Emergency lighting would come on in the event of a power failure.

Are surgery services effective?

Good

Surgery services were rated as good for effective because:

- Pain relief was readily prescribed post theatre and to take home as required.
- Pain assessments were regularly carried out and acted upon
- Food and drink was readily available for patients throughout their admission.
- The latest PROMs data suggests good outcomes from the patients perspective.
- Staff appraisals were above 80% for all staff groups, meeting the target of 75%.
- Systems were in place to ensure the safety and continuous maintenance of equipment within the hospital.
- Specialist staff, including consultants, pharmacists and engineers, were contactable 24 hours a day seven days a week and staff felt empowered to contact them out of hours if required.
- Consultants had a good understanding of consent and consent was being gained prior to surgical procedures.
- Nursing staff were gaining consent prior to undertaken any intervention.

However:

- Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) knowledge amongst nursing staff was limited and none could give appropriate examples of the practical application of the MCA or of DoLS. However, staff on the ward had an improved knowledge of the MCA when asked. The senior nurse planned to continue this method of engaging with staff and to look at Deprivation of Liberty Safeguards (DoLS) and share further knowledge around this area.

Evidence-based care and treatment

- Staff were aware of, and worked in line with, local policies and procedures.
- Staff were also seen following relevant National Institute of Health and Clinical Excellence (NICE) guidance. For example, in relation to the administration of intravenous (IV) medication (NICE QS66).
- Within theatres, staff were aware of the World Health Organisation (WHO) safer surgery checklist. The WHO checklist was observed being used within theatre and was embedded into the routine of the patient's pathway.
- Staff were seen following relevant National Institute of Health and Care Excellence (NICE) guidance. Staff also had an understanding of NICE guidance, for example in relation to the administration of intravenous (IV) medication (NICE QS66).

Pain relief

- The hospital did not have a dedicated pain team or nurse specialist for pain.
- Within the hospital there was a pain management group, where patient outcomes and trends were compared and reviewed. The pain group forum is established and meets on a quarterly basis, comprising of nursing staff, recovery staff and RMO, with consultant anaesthetist support and input.
- There was a pharmacist on site Monday-Friday to dispense and provide advice and support.
- Patient's we spoke with felt their pain was managed appropriately.
- Pain assessments were being undertaken and documented as part of the NEWS, however reassessment following the administration of pain relief was not consistent.
- 'As required' (PRN) pain relief was prescribed within theatre. Ward staff told us patient's rarely come back from theatre without PRN pain relief prescribed,

ensuring patient's remained comfortable post-operatively. Ward staff told us the RMO's are supportive and willing to review pain relief if requested by nursing staff.
- Prescriptions for pain medication reviewed were completed in full, legible and appropriate doses prescribed. Evidence of regular and appropriate administration in line with the prescription was seen.
- Patient's pain scores were also recorded in 100% of cases on the clinical scorecard in 2015, with the exception of Quarter 2, April 2015 to June 2015, where compliance fell to 98%. The hospital's target for recording pain is 95% or above. 100% had been achieved in Q1 2016.

Nutrition and hydration

- Preoperatively patients were advised to not have fluids for two hours prior to surgery and solid food for six hours prior to surgery. Information on fasting was sent or given to patients during the preoperative assessment or consultation.
- Patients had a daily menu to choose meals from and food was prepared fresh by the onsite catering staff. Patients had access to food between meal times as required. Water was available to all patients throughout the day.
- Patients with special dietary requirements were highlighted at pre-assessment and their needs were catered for throughout their stay.

Patient outcomes

- There was a good level of local audit in place for 2015, with the hospital undertaking a range of 13 audits including patient reported outcome measures (PROMS) data review, patient satisfaction survey and VTE documentation. This had been increased to 16 areas in 2016 which demonstrated that the hospital was proactively seeking to identify areas for improvement. The additional audits were physio documentation, pre-assessment patient satisfaction and drug fridge and ambient temperature.
- The hospital had a Clinical Audit and Effectiveness Committee which met monthly. Audits were reviewed by this committee and discussed at clinical governance committee meetings and the MAC meetings to ensure robust oversight.
- The latest patient reported outcome measures (PROMs) data provided covered April 2014 to March 2015. For knee replacement, 92% of 276 patients asked recorded an improvement in health with particular relevance to their knee surgery. 82% of the 276 patient recorded an improvement in generic health issues following knee replacement surgery.
- For hip surgery, 99% of 345 patients asked recorded an improvement in health with particular relevance to their hip surgery. 89% of the 345 patient recorded an improvement in generic health issues following hip surgery. The hospital's PROMs outcomes are around the national average for all aspects. The national average compares both independent health care providers and NHS providers.

Competent staff

- Staff joining the hospital received both corporate and local inductions, this was extended and included all bank staff. In 2015, 88% of new starters went through induction.
- The hospital provided evidence of 100% revalidation rates for all clinical staff working in inpatient areas, including theatres.
- Appraisals had been completed for 88% of nursing staff (inpatient areas only), 91% of care assistants (inpatient areas only), 90% of allied health professionals, 80% of clerical staff and 98% of all other support staff in 2015. The hospitals target for appraisals was 75%.
- Six registered nurses were advanced life support (ALS) trained. The hospital planned to train a further five registered nurses in ALS during 2016. One registered nurse was trained in emergency paediatric life support (EPLS).
- The resident medical office (RMO) had undertaken all required training to satisfy the agencies criteria. All RMO qualifications and suitability were assessed by the hospital's matron before commencement of employment.
- The engineering staff had yearly competency assessments carried out by the engineering manager. Evidence was seen during the inspection that 100% of the engineering staff were up to date with their competency assessments.
- The laser protection supervisor had undertaken all necessary training and was next due for an update in September 2017.

Multidisciplinary working

- Staff of all disciplines worked alongside each other throughout the hospital. Physiotherapists were requested to review patients as required. Nursing staff felt empowered to ask for assistance from anaesthetists or consultants.
- We observed a patient deteriorate during the inspection and the subsequent response from staff. Ward staff sought assistance from the HDU lead nurse and the RMO who both attended. A discussion was observed between nursing staff and theatre staff for advice and to alert theatres to the deterioration. All staff involved worked cohesively as a team, ensuring a timely response to the needs of the patient.

Seven-day services

- The onsite pharmacy was open 8:30am to 6pm Monday to Friday. Outside these hours, a member of pharmacy staff, either a technician or pharmacist, was available via the on call system to provide pharmaceutical advice and support to the staff.
- Theatres were staffed and used Monday to Friday 8am to 9pm and Saturday 8am to 5pm. There was an on call team for theatres outside of the hours which meant that emergency provision could be provided should a patient need to return to theatre urgently.
- There was an RMO onsite 24 hours a day. The RMO had access to the patient's consultant throughout the period of admission, or a nominated consultant in their absence. The RMO felt happy to contact the consultants out of hours when required.
- There was an engineer available between 6am to 6pm Monday to Friday. An out of hours on call system operated outside of these hours for emergencies.

Access to information

- All nursing and medical documentation, including risk assessments, care plans and theatre documentation, was in paper form.
- Test results, including x-rays, were held electronically. The consultants and RMO had access to these as required.
- Nursing staff stated that consultants often did not include their own documentation within the patient medical records. This was highlighted as a challenge by the hospital director and matron and was being addressed with consultants.
- The hospital was looking to implement a single care record to replace the current system where documentation is made in several places. The single patient record is an ongoing project.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Medical staff were completing consent forms prior to procedures and had a good understanding of consent and how and when this should be sought. Consent forms were completed in full, however were not always legible. Appropriate levels of risk were documented on the consent forms and evidence of discussions with patients was seen.
- Nursing staff had a good understanding of consent and when consent was required but did feel less confident to challenge a consultant on issues of consent, which could mean a risk to patient safety.
- Spire provides an online E-learning package for Mental Capacity Act (MCA) that incorporates within it Deprivation of Liberty Safeguards (DoLS). Training records year to date demonstrated hospital staff compliance at 85% against a Spire target for mandatory training of 95%. However this training was not effective. Despite the online training having a section on scenarios staffing could not reflect the training into practical examples.
- Nursing staff had limited knowledge of the Mental Capacity Act (MCA), mental capacity assessments or Deprivation of Liberty Safeguards (DoLS). When questioned staff could not provide appropriate examples of when a DoLS application may be needed and there was confusion between the differences of safeguarding requirements and that of the MCA. However, staff on the ward had an improved knowledge of the MCA when asked. The senior nurse planned to continue this method of engaging with staff and to look at Deprivation of Liberty Safeguards (DoLS) and share further knowledge around this area.
- One senior nurse was unable to explain the Mental Capacity Act or the safeguards the Act affords to patients and staff. The senior nurse had some knowledge of mental capacity assessments, however this was limited and knowledge of practical application was not offered.
- When asked to explain DoLS, one senior nurse and one staff nurse gave an example of a patient with

communication difficulties. The nursing staff believed a DoLS might be needed due to communication difficulties of the patient concerned. This would have be an incorrect use of a DoLS.
- No DoLS applications had been made by the hospital to the local authority. Staff told us that these would be done by Matron rather than by staff at ward level.
- During the unannounced follow up inspection, work had been undertaken by the hospital to improve staff understanding of these subjects. We spoke with senior nurses' and noted their knowledge and understanding of MCA had increased and examples of its practical application were discussed.

Are surgery services caring?

Good

We rated surgery services as good for caring because:

- Staff were seen to provide compassionate and kind care to patients and relatives.
- The latest Friends and Family Test results (July 2015 to December 2015) results were consistently above 93%;
- Theatre staff ensured patients' dignity was maintained throughout their theatre journey, from transfer to theatre through to recovery.
- Staff involved patients and, where appropriate, relatives in the care planning and decision making process.
- Staff provided reassurance and emotional support to patient and relatives before and after procedures.
- Chaplaincy services could be accessed by staff for patients throughout their stay at the hospital.

However:

- The hospital scored 83%, below the national average, for privacy and dignity in the latest patient led assessment of the care environment (PLACE).
- No formal emotional or counselling services were offered by the hospital for patients during their stay.

Compassionate care

- Staff were seen to provide compassionate, kind and considerate care throughout the inspection. Staff from all professions interacted with patients and relatives in a professional but thoughtful manner. We saw staff offering to escort patients to their rooms on arrival and providing assistance to those with disabilities.
- Reception staff on Level 2 were supportive to patients who required assistance to complete paperwork prior to their pre-assessment or admission.
- Senior nursing staff had undertaken Dementia Friends training that highlights the physical and emotional difficulties faced by people with dementia and how a supportive network can help alleviate some of the concerns.
- Staff explained procedures to patients and requested consent prior to undertaking interventions.
- Patient's dignity and privacy was considered by theatre staff throughout the patient's journey through the operating theatre. Patients were covered throughout transfer from the ward areas to theatres. Patients were only uncovered once in the operating theatre and only as far as required to safely undertake the procedure.
- Patients within recovery were also kept covered and spoken to with kindness and respect following their procedure. Patients who were confused and agitated following anaesthetic were supported and comforted by nursing staff within recovery.
- Staff were fully aware of their responsibility to keep patient information confidential and the expectations of patients around privacy and dignity. However in the most recent patient led assessment of the care environment (PLACE) scores for the hospital were published in August 2015. The hospital scored 83% for privacy, dignity and wellbeing which is below the national average of 86%.
- The Spire patient survey asks all patients whether they were given enough privacy when discussing their condition or treatment and whether they felt they were treated with respect and dignity while they were in hospital. The average score for both measures in the 2015 survey was 97%.
- From July 2015 to December 2015 the hospitals Friends and Family Test (FFT) results were above 93%. However, there had been a declining picture from 100% between July to September to 97% in October, 96% in November and 93% in December.
- The hospital's clinical scorecard results for 2015 showed that the target was missed for percentage of patients responding excellent to the overall care and attention provided by nursing staff, scoring an average of 79% in 2015. This had increased to 81 % in Q1 2016 against a Spire target of 85%.

Good

Surgery

- In comparison the results for the care and attention by consultant met target at 89% average for 2015 and had increased to 91% in 2016 Q1.

Understanding and involvement of patients and those close to them

- Staff involved patients throughout their pathway of care. Staff explained procedures to patients in a calm, non-rushed way that allowed time for conversations about uncertainties or worries on the part of the patient.
- Staff gave an example of a patient with learning difficulties when their relative was able to stay and be as involved in the care delivered as they wanted.
- Staff were witnessed complying with NICE QS15 guidance, which focused on providing positive patient experience within adult services.

Emotional support

- Clinical and non-clinical staff checked on patients well-being regularly and spent time with patients to discuss concerns and provide support and reassurance prior to their procedure. A service was available to patients and relatives to access throughout their stay. Senior nursing staff knew how to contact the service.
- Counselling may be facilitated within the hospital for any patient whomever requires it. Additionally, access to a clinical psychologist and bereavement counselling may be facilitated, the hospital also has an Honorary Chaplain as well as contact details for multi faith leaders.

Are surgery services responsive?

Good

Surgery services were rated as good for responsive because:

- Services were planned to meet the needs of the patient.
- Bed occupancy was consistently below 80% throughout 2015 meaning access and flow of patients was maintained.
- Services were available for patients with additional needs, for example translation services and the ability for relatives to stay in the hospital with patients who require additional support.

However

- In 2015, 38% of patients, on average, were fasted for longer than necessary.

Service planning and delivery to meet the needs of local people

- From January 2015 to December 2015 the hospital had admitted 2,287 inpatients, 3,962 day case patients and 6,262 patients through theatre.
- From January 2015 to December 2015 there had been eight unplanned transfers of a patient to another hospital.
- The hospital operated an open visiting culture, allowing relatives to visit patients as they wanted.
- Patient information leaflets were available throughout the hospital; however these were only available in English. Staff were unaware if these could be obtained in any other language.

Access and flow

- Patients had timely access to assessments, diagnosis and urgent treatment. There were no delays in accessing treatment once a diagnosis had been made.
- Surgery was predominantly elective with 17 unplanned returns to theatre between January 2015 and December 2015.
- Bed occupancy figures for 2015 show that the hospital ran between 54% and 79% occupancy, averaging at 66% over the year. December 2015 had the lowest bed occupancy rate of 54%, however this would be expected.
- On discharge General Practitioners (GP) were sent a copy of the discharge letter, detailing treatments received and any follow up required.
- Data from the clinical scorecard demonstrated that the target for the percentage of patient's responding with 'excellent' to the question of being prepared for discharge was missed, with an average score of 59% in 2015, against a target of 71%. This had improved slightly in Quarter 1 2016 increasing to 61%. The percentage of patients answering excellent or very good in this measure in 2015 was 88%.

Meeting people's individual needs

- Staff had access to translation services for patients who did not speak English or were hearing impaired. Staff were aware of the services but were unsure how to access it. No evidence of the translation service being used was seen.

- Staff had an understanding of the additional needs of patients with dementia, including additional monitoring. Staff told us that they rarely saw a patient with dementia as the hospital is made up of single rooms it was difficult to monitor patients with dementia.
- Formal training on dementia was provided to all staff within the 'Compassion in Practice' mandatory training module and at the time of our inspection, and 92% of staff had completed this module. Staff also had a clinical briefing on Dementia produced by the central team. Two senior members of staff were acting as dementia leads and a point of contact for staff requiring more information about dementia issues. It was not common for people living with dementia to be admitted to this hospital and a further training programme was due to be rolled out within the hospital from May 2016.
- The hospital was compliant with mix sex accommodation requirements. The inpatient and day case wards were both individual patient rooms with individual bathrooms. Within recovery, both male and female patients were present. However, the use of curtains enhanced the patient's privacy within these areas.
- Each single room had a television, access to the internet and a nurse call button.
- Staff were able to accommodate patients individual dietary requirements. Staff informed the catering on admission of any dietary requirements, for example vegetarian or coeliac disease.
- Staff in pre-assessment gave an example of ensuring that a specialist diet was available for a patient with cancer as this had been recommended by the patients oncologist. Additional time was made at pre-assessment to ensure that all possible adjustments were considered and implemented prior to admission.
- Patients were asked to select their menu choices in the morning for lunchtime service and again in the afternoon for evening meal service. The latest PLACE results from August 2015 scored ward food at 96%, with the national average being 89%.
- The Spire target for compliance with the pre-operative fasting guidelines was 45%. The hospitals clinical scorecard for 2015 showed results that ranged between 50% and 70% compliance. This meant that 30% of patients were at risk of having fasted for a prolonged period. The Spire target had been raised to 50% for 2016 and the hospital achieved 65% in quarter 1 (January to March 2016).

Learning from complaints and concerns

- The hospital had a complaints policy in place for staff to follow.
- Fifteen complaints between September 2015 and February 2016 had been received by the hospital. The hospital did not provide data which was broken down into directorates, therefore no specific data is available for the surgical areas.
- Learning points from complaints and concerns were shared with staff in staff bulletins and via email from the ward manager. Any significant concerns that were raised were also discussed at staff hand over times.
- Staff were unable to provide an example of when practice had changed following a complaint from a patient or relative.

Are surgery services well-led?

Good

We rated well-led for surgery services as good because:

- The hospital has a clear vision and set of values in place and staff are aware of these.
- The hospital director, matron and medical advisory committee (MAC) chair had clear oversight of the management of the hospital. They were united, aware of risks and challenges and supported and empowered the staff.
- There was a robust process in place for consultant appraisal and oversight of practicing privileges.
- The hospital director, matron and heads of departments were extremely responsive to areas of concern raised and implemented immediate changes were possible to reduce patient risk.
- There was an open door culture at the hospital and staff were encouraged and felt empowered to raise concerns.
- Patient perception was gathered regularly and results disseminated to staff.
- The leadership at the hospital was praised by all staff and all staff were proud to work at the hospital.

However:

- The service had been advertising a level 2 critical care service, when this service was not being provided. This was brought up during our inspection and an evaluation

of the service was taking place. At the time of our unannounced inspection agreement had been reached to rebrand the service as an enhanced recovery service. This appropriately described the services on offer.
- Route cause analyses were not always completed in full and lacked detail.

Vision and strategy for this this core service

- The hospitals vision and values reflected the Spire's national vision and values. The hospitals vision was to be recognised as a world class healthcare business bringing together the best people to develop the best clinical environments and deliver the highest quality care.
- The hospital's values were based around six core areas: caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on our promises and keeping it simple.
- Staff were aware of and understood Spire's vision and values.
- From discussions with patients and observing staff throughout the inspection, staff were working in a way that promoted the vision and values of the service. Nursing staff were proud and passionate about the care they were able to provide to patients.

Governance, risk management and quality measurement for this core service

- Robust systems were in place for ensuring consultant's practising privileges were monitored. Data was stored electronically on a central Spire database and demonstrated Spire Norwich compliance at 99% as of 20 April 2016, which was the highest across the 38 Spire hospitals. The hospital director and matron were very clear on the process for granting and reviewing practicing privileges and gave examples of suspension when consultants documentation was lacking.
- The medical advisory committee (MAC) reviewed all new applications for consultant practicing privileges and oversaw any new clinical procedure requests to ensure consultant operated within their scope of practice. The MAC chair was knowledgeable and supportive of the hospital, aware of the risks and challenges and sat on the clinical governance committee to ensure medical oversight of clinical concerns and practices.
- Every appraisal and indemnity check was read and signed off by the hospital director and matron. The hospital produced evidence of a consultants whole practice at the consultant request ahead of an annual NHS appraisal. Provided the hospital had two weeks' notice they could produce a report detailing an individual consultant whole practice figures including number of patients, cases undertaken, complaints etc. This meant there was transparency across the private and NHS sector and gave assurance re scope of practice.
- The hospital had a risk register in place which highlighted the risks and contained action plans to mitigate the risks. However, the actions were often brief and lacked depth and measurable outcomes.
- Senior managers (heads of departments), the matron and hospital director were extremely responsive to areas of concern raised and implemented immediate changes were possible to reduce patient risk.
- Following incidents, the hospital undertook route cause analysis (RCA) to establish learning points and improvements to mitigate future incidents. The RCA's were concise, with timelines detailing the event in chronological order, and actions to be taken to reduce risk in the future and to share learning where needed. However where actions had been identified these were not always documented as completed. For example one of the RCA reviewed had identified four actions to take place. Three of the four had not been documented as complete despite deadlines of January for two actions and February 2016 for the third.
- Review of clinical governance meeting minutes demonstrated senior team discussions around risk, clinical reliability and patient safety. However at times details in these minutes were lacking, with themes around incidents and follow up on actions and learnings not identified.
- All hospital policies were appropriately referenced and signposted to the evidence base. For example the resuscitation policy references the Resuscitation Council, and the Vulnerable Adults Policy references the Department of Health, Care Act 2014 and the Equality Act 2010.
- Although the hospital consisted of four high dependency (HDU) beds. These beds did not meet any national standards for the provision of critical care services. For example, Guidance for the Provision of Critical Care Services (GPICS), National Competency Framework for Critical Care Nurses (NCFCCN) or guidance from the Faculty of Intensive Care Medicine.

- It was recognised that there was an internal branding issue as the service would not, nor had in the past, treated patients categorised as a level 2 patients according to the guidance.
- During the unannounced follow up, senior nursing staff confirmed HDU had been renamed an enhanced recovery unit (ERU) which is capable of treating level one patient's only however it was noted that the website still reflected level 2 care.
- The hospitals policy for transferring patients to NHS level two or three facilities was reviewed and deemed appropriate.
- Nationally, Spire hospitals were meeting the clinical scorecard target for fasting pre-anaesthetic. Spire reduced the target from 75% in 2014 to 45% in 2015, and raised it to 50% for 2016. Between January and March 2016 Spire Norwich achieved 65% against their target of 50%, which showed the hospital was making progress to ensure patients were not fasted for unnecessary amounts of time. However we were concerned that the reduction of the targets around fasting pre-anaesthetic could increase the risk of harm to patients.

Leadership / culture of service

- The hospital was led by a hospital director and a matron. They were supported by the chair of the (MAC), operations manager, commercial and finance manager and business development manager. Local teams were then led by heads of departments that provided local support and management to staff.
- All staff we spoke to praised the leadership within the hospital and felt there was a clear 'open door' culture at the hospital.
- Staff told us that hospital management were visible and regularly visited clinical areas to talk to staff, patients and relatives. Matron participated in ward rounds, in uniform, once a week which enabled her to support the team and remain attached to the clinical teams.
- Staff that attended the focus group praised the hospital management teams and thought that the hospital was like a family. Nursing, medical, allied health professionals and support staff were all complementary about the culture within the hospital. One new employee said they had been accepted into the hospital and felt part of the team from the very beginning.

Public and staff engagement

- Patient opinion was gathered using patient surveys offered to all patients during their stay, friends and family test and patient led assessment of the care environment (PLACE) which is carried out annually.
- Staff felt empowered to make comments or suggestions that would improve the patient experience or staff wellbeing.
- Staff were engaged through weekly and monthly news bulletins that highlighted both departmental, hospital wide and national issues. These were also used to motivate staff by commending and celebrating good practice and improvements.

Innovation, improvement and sustainability

- Staff were encouraged to make improvements through innovative thinking. Staff felt listened to and acknowledged when making a suggestion.
- From the comprehensive inspection, a senior nurse had highlighted a lack of knowledge and understanding amongst nursing staff with regards the Mental Capacity Act (MCA). The senior nurse had read around the subject and by the unannounced inspection 10 days after the main inspection, the senior nurse had begun to share the knowledge at handover time. Staff on the ward had an improved knowledge of the MCA when asked. The senior nurse planned to continue this method of engaging with staff and to look at Deprivation of Liberty Safeguards (DoLS) and share further knowledge around this area.

Good

Outpatients and diagnostic imaging

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

Information about the service

During 2015 the Spire Norwich outpatient department provided 22,390 outpatient appointments to NHS and private patients. 7,913 of these attendances were new appointments, and 14,477 were follow-up appointments. NHS referrals accounted for 19% of the department's activity with 5,426 patients being seen for new and follow up appointments. Private appointments accounted for the remaining 81% of outpatient contact. .

The Radiology department was a consultant-led service, with 16 Radiologists covering a range of specialities including; gynaecological ultrasound, muscular-skeletal, interventional tomography (CT) routes and dynamic breast imaging. The service had two radiation protection supervisors working on-site and the radiation protection advisor visited the hospital annually to provide quality assurance, training and advice.

The outpatient area was separate to the main hospital. Car parking was available immediately outside the building providing ease of access. The nearest NHS hospital was 1.3 miles away.

Outpatient clinics ran from 8:30am to 6:30pm Monday to Friday and the department was open on alternate Saturdays from 09:30am to 1:30pm for clinics.

During this inspection we reviewed four sets of individual staff competency files for nursing staff. We spoke with consultants, managers, allied health professionals, nursing staff, health care assistants and patients. We reviewed six sets of patient's medical records to assess the completeness of records within Spire Norwich.

Summary of findings

Overall outpatient and diagnostic services were rated as good. Four of the five domains were rated, with the exception of effective, which was inspected but not rated. Safe was rated as requires improvement with caring, responsive and well led rated as good.

Staff had received combined children and young people safeguarding training to level 2. The outpatient manager had received level 3 training however, if they were not on duty, there was a risk that children could be seen and treated without a member of staff on site with the appropriate level of training. This was mitigated by an arrangement that registered nursing staff, childrens branch, from other Spire hospitals could be contacted for advice, however there were no checks in place to ensure these staff were up to date with training.

The hospital did not retain copies of all of the consultant's notes for each outpatient appointment, with just 27 of the 218 consultant's notes being retained by the hospital. This meant that in the case of emergency relevant patient information may not have been available to ensure patients received safe and appropriate care.

There was an open reporting culture within the department and staff were encouraged to learn from incident investigations and infection control procedures were well established. There had been no reported incidents of MRSA or C-Diff during 2015. An external health and safety consultancy had attended in 2015 and rated Norwich Spire as 93% compliant which exceeded the target of 85%.

Good

Outpatients and diagnostic imaging

Robust systems were in place for ensuring consultant's practising privileges were monitored and medical review was available 24 hours a day seven days a week via clinics, the on-call system and via the Resident Medical Officer (RMO). Radiography staff had both internal and remote access available to review patient imaging and reporting, via a secure electronic system.

Patient feedback was extremely positive; patients spoke very highly of the care they received from staff. Chaperone services were available at the patient's request. There was a specialist children's nurse available for children requiring any procedures to be undertaken.

There were no outpatient waiting lists for clinics and general practitioner (GP) feedback received about Spire Norwich was positive.

Governance systems were well established and good processes were in place for incident management, risk management and learning from complaints. Information flow between key committees was well documented and staff felt supported by senior management and spoke of them being approachable and visible. There was an open transparent attitude to serious incidents which included duty of candour to the patient, and an open learning environment NONs vulnerable patient attending clinic. This meant that patients were at risk of not receiving any extra care or support they needed.

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated outpatients and diagnostic imaging as requires improvement for safe because:

- Nursing staff had combined level 1 and 2 safeguarding children and young people training and not level three as required.
- There was no evidence of monitoring competency and training of staff from other Spire hospitals with regard to caring for children.
- The hospital was working towards a single patient record however record keeping was not consistent.

However;

- Good incident reporting levels, including near misses and no harm demonstrated a safe culture.
- Lessons were learnt and shared from incidents.
- Learning from root cause analysis investigations had prompted changes in practice to ensure patient safety was maintained.
- Outpatient environments were clean and tidy with cleaning schedules completed and green 'I am clean' stickers used to identify cleaned pieces of equipment.
- Pharmacy staff attended ward and service areas daily to assist with any medication queries.
- An externally led consultancy audit was conducted in relation to health and safety and this resulted in the hospital receiving a compliance rate higher than that of the target; 93% achieved against an 85% target.

Incidents

- The hospital had reported 643 incidents between January and December 2015, averaging 54 incidents a month. There were no serious incidents reported within 2015.Near miss incidents were reported as well as incidents resulting in harm. This demonstrated an open, honest learning culture in relation to clinical incidents.
- There had been no 'never events' reported within outpatients or diagnostic imaging between April 2015 to March 2016.
- Radiology incidents were reviewed within the radiation protection committee, where lessons learnt were shared amongst peer specialists.

Good

Outpatients and diagnostic imaging

- The operations manager advised that there had been no incidents of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) at the hospital within 2015. Data we reviewed prior to inspection confirmed this.
- We asked three members of staff about the department's most recent incident and each of them described the same serious incident to us. All three members of staff were able to tell us about the lessons learnt following this incident which had prompted a change in practice with the use of a suture recording form to accurately record how many were provided, so staff knew exactly how many to remove.
- Staff told us that incidents were discussed as part of the monthly ward/department meetings. Minutes were sent to staff members who were not on duty at the time of the meeting and hard copy minutes were available for staff to read in staff room breakout areas.
- Within the staff coffee lounge, there was a 'what we found, and what we did' poster providing brief details of the outcome of a root cause analysis investigation following a serious incident. This enabled the sharing of lessons learnt with staff members.
- Staff were aware of duty of candour and when this would be relevant however not all staff had experienced a situation that would require it.

Cleanliness, infection control and hygiene

- All areas visited within the outpatient environment were visibly clean and tidy.
- The outpatient waiting areas, consulting rooms and treatment areas visited were all visibly clean and tidy.
- There were good infection prevention and control procedures in place. Outpatient consultation rooms had vinyl flooring rather than carpet which was cleaned by domestic staff. This meant that a clean safe environment was provided.
- Within 2015 staff across the hospital had been measured as being 95% compliant with completing their infection prevention and control annual mandatory training modules. Whilst on inspection we observed the majority of staff using the hand sanitiser gel to decontaminate their hands as they moved from one area of the hospital to another.
- There were posters displaying the world health organisation (WHO) '5 moments of hand hygiene' displayed in clinical areas to remind staff to decontaminate hands.
- Nursing and health care assistant staff were bare below the elbows in line with best practice guidance within both diagnostic imaging and outpatient departments, and there were posters displayed to encourage staff to be bare below the elbows whilst completing clinical care in line with hospital policy.
- NHS patients were routinely screened for Methicillin-resistant Staphylococcus Aureus (MRSA). There were no reported cases of MRSA or Clostridium Difficile **(**C-Diff) at Norwich Spire within 2015. We noted one case of Methicillin-sensitive Staphylococcus aureus (MSSA) having been reported at the end of 2015. This was dealt with proactively and in line with best practice.
- Cleaning schedules were regularly completed for outpatient areas.
- Green 'I am clean' stickers were used within the outpatient and radiology departments to indicate that following use, staff had cleaned equipment ready for the next use.
- In order to maintain good infection control and cleanliness standards each department had a nominated member of staff who attended regular infection control meetings. These meetings were supported by a consultant microbiologist.
- There was a clear route for the escalation of infection control issues to the infection prevention committee who were able to provide more specialised guidance and advice.

Environment and equipment

- There had been significant recent investment on updating the radiology equipment, and the laser room for ophthalmology had been moved, refurbished and re-equipped.
- A new Yag laser had been purchased at the end of 2015, and there was evidence of laser usage books being completed appropriately. The laser usage book system had been endorsed by the laser protection advisor (LPA).
- The hospital had a laser protection supervisor (LPS) who was trained by the LPA. The LPA was external to the hospital and visited annually to provide safety quality assurance checks on laser equipment and environments.
- Spire Norwich had not reported any outpatient laser incidents.

Good

Outpatients and diagnostic imaging

- There was a warning sign outside the laser room to indicate to staff or patients when the laser was in use, and it was dangerous to enter the room.
- Appropriate radiation protection equipment, such as lead vests, were used by staff.
- There was an adult resuscitation trolley and a paediatric grab bag and anaphylaxis kit located next to the nurses station in the outpatient's department. The paediatric anaphylactic kit and grab bag were both tagged. However, at the time of inspection we found that the Hudson paediatric oxygen mask was out of date. This was raised with staff at the time, and replaced immediately.
- During 2015, RPS Health & Safety Consultants conducted an external health and safety audit and awarded Spire Norwich Hospital with an overall compliance score of 93% against a target of 85%.
- The oxygen cylinder and blood pressure machine in the outpatient's department had been regularly serviced.
- Medical equipment within the outpatient department had service dates sticker and indicated when the next service was due. This meant we were assured that equipment maintenance was being managed.
- The outpatient manager confirmed that none of the consultants brought in their own equipment to use within outpatient consultations. If a consultant wished to use their own equipment, appropriate approval processes were in place via the hospital director.
- Wheelchairs and umbrellas were available for patient's use in the reception area.

Medicines

- There was an on-site pharmacy, staffed by Spire staff which was open Monday to Friday between 8:30am to 6pm. Out of hours an on-call system was in place for hospital staff to contact the duty pharmacist.
- Prescriptions used within the outpatients and diagnostic imaging department were recorded and monitored by the pharmacy team and stored securely within a locked drug cupboard.
- The main drug cupboard within the outpatient's department was kept in the storeroom, which was monitored for room temperature.
- The medication fridge located in an outpatient treatment room was securely locked, to ensure patient safety.
- Pharmacy staff attended wards on a daily basis to assist with any medication queries. They also attended when a patient was being discharged from hospital and had any medicines given to them to take at home. In these circumstances a pharmacist would be available to answer any specific questions the patient may have before leaving the hospital.
- Medical gas cylinders were checked and were in date of receiving their service.
- The Pharmacy Manager stated quarterly controlled drug audits were completed within the hospital and action plans were developed where full compliance was not achieved.
- Contrast media used within the diagnostic imaging department was stored securely in a locked cupboard, which the duty radiographer had keys to access.

Records

- There was a clear process for tracking records throughout the hospital. The medical records team utilised a card tracker to signify if notes were in outpatients or on the ward. Notes were held at the hospital for three months and then archived off site at the national distribution centre (NDC).
- Medical records were situated adjacent to the outpatient department which meant staff could easily deliver and collect notes. There was a system for organising and making notes available for use. The medical records team printed the clinic list one week in advance but also reviewed this daily to be aware of any changes. Clinic notes were collected by the outpatient staff first thing each morning, the notes were held in clinic for use and then medical records staff would collect the returns and file. Preadmission notes were collated two weeks in advance and inpatient notes were collated three days in advance.
- The computer system recorded previous notes that were held offsite at the NDC. Staff could request these to be sent back, if ordered before 1pm then the notes would be delivered the next morning. In-patient notes were sent to the ward three times a week to ensure they were available on day of admission.
- If the situation arose that patient notes were not available medical records staff would make up a temporary file. A card system was in use to indicate where a temporary file was in circulation. Once original notes were received from the NDC medical records staff would collate both sets into one.

Good

Outpatients and diagnostic imaging

- Information provided prior to the inspection demonstrated that 75% of outpatient appointments were conducted without full medical records. The hospital confirmed that many patients may be attending for the first time adding that, most patients had a general practitioner (GP) referral letter containing relevant information, and many consultants were registered with the Information Commissioners Office and held their own patient records which the hospital could obtain within 24 hours. Other patients had a Spire hospital record which could be accessed.
- The hospital had identified the single patient record as a challenge but were working towards achieving this and were monitoring progress. This was in the early stages but data provided showed only 27 Consultants out of 218 compliant; there was an action plan in place for full contemporaneous records, prioritising those with admitting rights.
- The hospital director advised us that the process for obtaining 'missing' patient notes, was to contact the consultant's secretary and request a copy to be sent immediately to the hospital, and consultant's later confirmed that this was the process used, adding that the hospital held all the contact numbers for both the consultant's and their secretaries.
- There was an organised process for obtaining NHS records for patients treated at the hospital under the agreed NHS service level agreement. The booking form for NHS patient is added onto the computer system and then the hospital request the notes. The notes arrive, date stamped, checked against notification list and stored securely in the bookings office. The notes are taken to the ward the day before surgery and collected back afterwards. The NHS notes are held on site until the operation has been clinically coded, which is undertaken by an external coder who comes once a week. Once coded the notes are boxed and sealed with a tamper proof indicating seal. Spire porters transport the notes to and from the hospital and the NHS trust, liaising directly with the NHS waiting list coordinator.
- Within the outpatient notes we reviewed, the patient history section in all six sets of the notes had been completed, was legible and had been signed by the Consultant.
- Nursing staff we spoke with explained with the outpatient clinics being consultant led, the consultants made notes in the patient's medical record in relation to any decisions, plans or treatment undertaken. Nursing specific tasks such as suture removal and minor operations were documented and planned by the nursing staff.
- The radiology manager explained that radiology services used their own abbreviated version of the World Health Organisation's (WHO) Safer Surgery checklist which was one side of A4 paper with 20 questions, designed to ensure that appropriate checks were put into place ahead of a surgical procedure.
- A consultant gastroenterologist said that computer accessibility in theatre was an issue, and added that providing operating notes on carbonated paper was a concern as there was a risk that patient notes may not be filed appropriately. Their suggestion for improvement was to have a 'real-time' software package which operating notes could be stored upon and linked into the main patient's electronic hospital record.

Safeguarding

- There had been no safeguarding incidents reported in 2015.
- Hospital wide combined safeguarding children and adults training for 2015 was 93.8%.
- Hospital wide training for safeguarding had been separated into childrens and adults for 2016 and at the end of January 2016 children's safeguarding demonstrated 15% compliance and adult safeguarding demonstrated 20% compliance, with target aims of achieving 25% by the end of March 2016.
- Within the regular heads of department meetings and clinical governance meetings, safeguarding was a standard agenda item and featured as a key priority within 2016 for the hospital.
- Children were seen for appointments within the outpatient department by staff that had been trained to safeguarding level one and two combined, and not level three as is required by national guidance.
- The outpatient manager was the safeguarding lead and was trained to level 3. The manager worked full time however when the OPD manager was not on duty there was a risk that there may be no staff on site with the appropriate level 3 training. Spire Norwich Hospital had a resource in place to access RCN advice or support by telephone for any paediatric issues, however there was no mechanism to check that these staff had level 3 safeguarding training and that the training was in date.

- Local links had been established in terms of safeguarding with Spire Norwich and Safeguarding Adults Practice Consultants for both Norwich and Southern areas for pooling of resources and the ability to discuss cases. These networks were in addition to the hospital being part of the Norfolk Adult Safeguarding Board.

Mandatory training

- Mandatory training modules were available electronically and covered the following; fire safety, health and safety, infection prevention and control, safeguarding adults, safeguarding children, violence and aggression, manual handling, compassion in practice and E&D. Training compliance was reported as being between 92% to 97% across the 10 courses by the end of 2015 against an overall Spire target for mandatory training compliance of 95%
- The pharmacy department provided an e-learning package in relation to controlled drugs which was aimed for use by pharmacy staff or registered general nurses.

Assessing and responding to patient risk

- Radiology staff spoke of a good working relationship with radiology staff at the local NHS trust. Patient imaging could be securely viewed via the imaging exchange portal for multi-disciplinary team meetings in order to aid the continuity of care of patients transferred between the two hospitals.
- Diagnostic imaging had developed an adaption of the world health organisation (WHO) surgical safety checklist for use in interventional radiology which provided a serious of data checks including verifying the site to be treated with the patient, and if a pregnancy test had been completed where appropriate, to avoid unintended exposure to an unborn child. The checklist was printed in green ink which was easily recognisable within a set of patient notes.
- Nursing staff within the outpatient department stated that if a patient's condition deteriorated then the resident medical officer (RMO) was available. If further treatment was required then there was an agreement in place with the local NHS Trust who would receive and treat the patient.

Nursing staffing

- There was often little difference between the planned and actual nursing hours within the outpatients department. Many of the shifts were either eight or 10 hours.
- The outpatients department did not use any agency, and where substantive staff were not available to cover shifts, bank staff were used. This ensured that these members of staff understood the hospital and its policies and could easily step in to provide consistent care.
- Staff stated that the numbers of paediatric patients seen and treated in the outpatient department was very low. On the occasions that the booking team received details of paediatric patients, they contacted the parent or guardian of the child to arrange an appointment time with the consultant. There was a specialist children's nurse available for advice in relation to children requiring any procedures to be undertaken. The RCNs were Spire members of staff who worked at another Spire hospital. However there was no mechanism in place at the hospital to ensure that these members of staff had completed appropriate levels of mandatory training.
- The outpatient manager told us that the agreement was that they could provide telephone advice to Norwich members of staff when any queries occurred in relation to treatment of children within the outpatient department. The RCN's would also conduct children's risk assessments.
- Radiographers were available on site and provided diagnostic imaging services Monday to Friday between the hours of 8am and 830pm. There was an on-call system available to enable radiographers and radiologists to be contacted outside of core hours.

Medical staffing

- Administration staff told us that there were three consultants who would see paediatric patients, two were paediatricians and one was an ear nose and throat (ENT) consultant who had completed relevant child safeguarding training and was experienced in treating children with ENT procedures.
- The majority of consultants working at Spire Norwich held clinics for between five to six hours a week, and confirmed that the rest of the time was spent in the NHS

Good

Outpatients and diagnostic imaging

trust. The Outpatient Manager confirmed that there were no waiting lists for appointments, and monitored the length of wait patients had in the waiting room, adjusting consultant clinic slots to minimise wait times.

Major incident awareness and training

- There was a local major incident policy for Spire Norwich dated March 2016. Within that policy it was stated that testing of the major incident plan would form part of the annual business continuity plan.
- Nursing staff we spoke with said that they had not received any emergency incident training either in electronic or scenario based sessions. However evidence provided to us showed that staff had received fire evacuation training, emergency oncology product spillage training, and violence and aggression training.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

At present we do not rate effective for outpatient and diagnostic services in acute independent hospitals but areas of good practice found were as follows:

- Hard copy evidence of full clinical audit reports being completed, including analysis, recommendations and action plans within pharmacy and radiology.
- National guidance such as the national institute of health and clinical excellence (NICE) and that of the royal colleges was being followed by medical staff.
- The outpatient's department had previously been involved in relevant national clinical audits and had registered for participation in the 2016 national comparative blood transfusion audit.
- The hospital conducted quarterly controlled drugs audits to ensure that patient safety was paramount.
- There was a robust system for ensuring consultant's practising privileges were monitored on a regular basis, and reviewed by both the medical advisory committee and the hospital director for final approval.
- Spire Norwich had identified 2016 training dates for staff to attend to enable them to become 'dementia friends' to support patients with dementia.
- Medical review was available 24 hours a day seven days a week via clinics, the on-call system and via the resident medical officer.
- The dynamic breast imaging clinic was a multi-functional one-stop clinic for breast care patients
- Radiography staff had both internal and remote access available to review patient imaging and reporting, via a secure electronic system.
- As an element of their enabling excellence annual appraisals, radiology staff had agreed to lead on a clinical audit within radiology. This assisted to embed local ownership and responsibility for on-going monitoring and service improvements.

However;

- Nursing staff were not familiar with the terms; Mental Capacity Act (MCA) or deprivation of liberties (DoLS) which demonstrated that e-learning training was not effective.

Evidence-based care and treatment

- Within the Radiology department clinical audits were planned and completed. We saw evidence of a 'referral form audit' which had taken place in March 2016. Results had been analysed and improvement actions, where identified, implemented.
- A consultant we spoke with confirmed that they used the same national guidance within Spire Norwich that they would use with their NHS employer, such as the Royal College of Surgeon's guidelines.
- Review of November 2015 clinical governance minutes, demonstrated that new National Institute of Health and Clinical Excellence (NICE) guidance was reviewed for applicability to Spire Norwich Hospital, and NICE was a standing agenda item for these meetings, but implementation of applicable NICE guidance was not recorded in either the clinical governance minutes or the action plan from review of June to December 2015 papers
- The outpatient department at Spire Norwich had listed the Blood transfusion - National Comparative Blood Transfusion audit on their 2016 audit plan which is a biennial audit.

Pain relief

- A recent patient survey demonstrated that 90% of patients were happy with the pain relief they had received whilst being treated at Spire Norwich.

Good

Outpatients and diagnostic imaging

Patient outcomes

- We saw a prescription chart audit report. The audit reviewed criteria such as whether or not patient's had any allergies and that the correct quantities of medication had been prescribed. Where full compliance was not met the pharmacy manager told us that action plans would be completed for ward or service areas. This was a monthly audit conducted within the hospital.
- As part of radiology staff's 'enabling excellence' (annual appraisal) review, the radiology manager had set objectives for each member of staff to complete a clinical audit. Examples included; Lumbar spine x-ray procedures, and whether the pregnancy status of female patients had been checked in theatres ahead of imaging taking place.
- The audit report for 'referral form audit' completed in March 2016 within the diagnostic imaging department which reviewed a number of safety checks such as whether the patient had three forms of identification, the referral form was signed by a consultant, and all the relevant clinical information had been recorded such as the body part and side of the body. It was standard protocol for radiology staff to go back to the consultant if all of these elements were not present on a referral form. The standard for this audit was 80% compliance with the audit criteria, and this audit had passed.
- Patient outcomes were followed up through their follow up appointments, post-operative calls and through the investigation and analysis of complaints received. Within the hospital there was a pain management group and venous thromboembolism (VTE) group, where patient outcomes and trends were compared and reviewed.

Competent staff

- There was a robust system and database in place which was used to record and monitor consultants competencies, completion of mandatory training, continued professional development, personal development review, indemnity, and revalidation. This information was considered as part of a rolling programme within the medical advisory committee (MAC) meetings, before being signed off by the hospital director in order to re-establish their practising privileges.
- Within the reporting period of January to December 2015, 100% of nursing staff and 83% of health care assistants had completed their enabling excellence annual appraisals.
- Radiographers and radiologist's had responsibilities for ensuring two way information flow co-ordinating with; infection prevention and control, clinical audit, and health and safety.
- Nursing revalidation, covering competency assessments, personal development review, continued professional development, professional registration fees and completion of mandatory training were overseen by the outpatient manager, and signed off by matron.
- Radiographers were required to double-report 10% of imaging reports to ensure consistency amongst staff.
- We saw attendance sheets for practical sessions of mandatory training including; basic life support, manual handing for clinicians, and manual handling for non-clinical roles. The operations manager said that this training used to be outsourced to a training company but had been seen as a development opportunity by physiotherapy staff and was now run on a rolling programme by three physiotherapists and one outpatient nurse.
- Resuscitation scenarios were facilitated on alternate months across all clinical departments to provide staff with effective practical update and support on the local resuscitation process. Debrief and constructive feedback was given to participating staff after each scenario to promote learning.
- The dynamic breast imaging clinic was a multi-functional one-stop clinic for breast care patients which utilised the skills of a specialist breast nurse to support patients through their treatment. These clinics enabled patients to have their consultation, examination, mammogram, family history to be taken with a risk calculation, advice, and a personalised care plan.
- The outpatient's manager explained that nursing staff had eighteen months of clinical supervision following recruitment due to the additional skills required to cover these roles.
- The radiology manager plus another member of radiology staff were responsible for the role of 'radiation protection supervisor'; this meant that that there was always a radiation protection supervisor on site. The 'radiation protection advisor' (RPA) and 'laser protection

advisor' role was conducted by a radiologist at a nearby NHS trust. The RPA provided annual quality control checks, training for staff at Spire Norwich and guidance on paperwork to use.
- A member of nursing staff within the outpatient department told us that nursing staff received basic paediatric life support training.
- Health care assistants completed competency checks which were then countersigned by a registered general nurse.

Multidisciplinary working (related to this core service)

- The pharmacy department had a good working relationship with the pharmacy at the local NHS Trust. A serious incident example was provided where Spire Norwich pharmacy did not stock Novorapid insulin which was urgently required for a diabetic patient, but Spire were able to borrow this medication from the local NHS Trust pharmacy at short notice.
- Spire Norwich received NHS waiting list referrals. The case mix was pre-agreed as part of the service level agreement (SLA) and patients were seen for pre assessment at Spire Norwich prior to receiving surgery.

Seven-day services

- Outpatient and diagnostic imaging services were open five days a week, and alternate Saturdays but outside of core hours and on Sundays there were consultants, and radiographers available via the on–call system for advice, or alternatively the responsible medical officer (RMO) could be contacted.

Access to information

- Clinical and quality communication boards displayed the hospitals compliance with key clinical indicators and were shared within patient areas around the hospital. These were one of the hospital's key clinical priorities identified within the 2016 action plan.
- Diagnostic imaging services used two software packages to allow both internal and external based staff the ability to view imaging and reports. There was a web based secure connection for consultants and radiographers to access imaging and reports whilst not located in the hospital. This software allowed secure access to documentation and images via iPad and mobile phones.
- Consultants were not permitted to take hospital records off site, unless authorised by the hospital director (registered manager), matron (Caldicott Guardian) or operations manager, and appropriate tracking documentation completed. Consultants had to adhere to Spire healthcare information governance and security policies including the confidentiality code of practice, as well as with any information governance and security requirements specified by the General Medical Council and their Royal College.
- GP referral letters would also be available for private patients, unless self-referring. In each of the outpatient consulting rooms there was secure access to the hospital's digital imaging records, NHS imaging reports, as well as cellular pathology and blood sciences reports systems.
- Radiology staff attending the focus group said that the department was essentially 'paperless' with the exception of one service offered. Staff suggested that receiving communication electronically all via the same electronic platform would be an improvement.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing and radiography staff were unfamiliar with the terms 'Mental Capacity Act' and 'deprivation of liberties' despite receiving training via e-learning. Training records year to date demonstrated hospital staff compliance at 85% against a Spire target for mandatory training of 95%.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients and diagnostic imaging as good for caring because;

- Patient feedback received in person, on-line and via CQC feedback cards was overwhelmingly positive. Patients felt able to ask any questions they had in relation to concerns and felt that these were answered appropriately by consultant or nursing staff.
- A chaperone service was available to support patients undergoing intimate examinations, and there was an established system consultant's used to request chaperone assistance.

Good

Outpatients and diagnostic imaging

- The number of children seen in the outpatients department was low, but was a specialist children's nurse available for advice in relation to children requiring any procedures to be undertaken.

Compassionate care

- A colorectal consultant said that the nursing staff made sure that there was always a chaperone available to assist with patient comfort during procedures, they also confirmed that they did not currently record the use of chaperones within patient notes.
- A bleep system was used within outpatients to request health care assistant support for supply of a chaperone to accompany a patient, which was a subtle way of providing support to potentially anxious patients.
- Patients were offered use of a chaperone for intimate examinations, and consultants requested health care assistant presence for chaperoning services by using the call bleeps located at the outpatient's nurses station. One of the health care assistants stated they had been appropriately trained to provide this service.

Understanding and involvement of patients and those close to them

- The majority of feedback received from patients and their families was extremely positive with patients finding reception, nursing and medical staff all very friendly, professional and helpful. We did however hear of one outpatient receiving a negative experience post operatively following orthopaedic surgery, but this had not been raised informally for staff awareness, or formally as a complaint, due to the patient not wishing to be identified.
- Care quality commission feedback cards were left in the outpatient department before and during the inspection process. On review of the 25 cards, 24 had positive comments about patient's experience of the outpatient department.

Emotional support

- A chaplain was available to offer patients and families of patient's spiritual support whilst in hospital.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatients and diagnostic imaging as good for responsive because:

- Outpatients had no waiting lists for patient's due to attend clinics.
- Staff within the radiology department were utilising multi-skilling within radiological specialities, to ensure that all specialities had rota cover for inpatient and outpatient requirements.
- December 2015 general practitioner survey results demonstrated the GPs found booking processes at Spire Norwich to be 83% 'very easy' and 17% 'quite easy'.
- Patients generally did not have lengthy waits for outpatient appointments once they had arrived.
- There was a robust system for dealing with patient complaints, and Spire Norwich had been asked to share their processes with other hospitals in the group to share best practice.
- An ongoing educational programme was offered to local general practitioners.
- There was no flagging system in place to alert staff to patient with higher levels of specific individual needs ahead of arrival in clinic.
- Referral to treatment (RTT) waiting times for NHS patients were above 95% for non-admitted patients beginning treatment within 18 weeks of referral to the service.

Service planning and delivery to meet the needs of local people

- The Radiology manager said that there had been a programme of work conducted over the last two years to ensure that radiology members of staff were multi-skilled to allow for cross cover of specialities as patient needs dictated.
- Spire Norwich offered an educational programme for general practitioners throughout the year.
- There was one service led agreement (SLA) in place for the hospital to undertake treatment of NHS patients within a set specialty agreed between the hospital and the local NHS trust. This showed collaborative working to reduce patient waiting times and improve access to treatment.

Good

Outpatients and diagnostic imaging

Access and flow

- The hospital had no waiting lists for outpatient clinics. Staff informed us that dermatology clinics could be 'oversubscribed', but when this occurred patients were asked if they would accept cancellation appointments, and the majority did.
- The appointment booking team leader explained the process for referrals being received from general practitioners (GPs). The administrative team initially triaged the details received from the GP, and the nursing staff provided a secondary clinically focused review. If the request was urgent or clinic availability allowed the patient to be seen within five days, the administrative team telephoned the patient to confirm the appointment, otherwise the team sent an appointment letter to the patient's home address.
- Patients were able to self-refer to some of the services available at Spire Norwich; there were seven consultants who would accept these referrals.
- A recent general practitioner (GP) survey, which received 93 responses, had reported that 83% of GPs had found Spire Norwich's referral process 'very easy' with the remainder finding it 'quite easy'.
- Patients said that they had not experienced long waiting times for clinics within the outpatient department. One patient said that they had been called back on the day of inspection as they and some other patients had to wait for equipment they required to be repaired. On the day of the hospital's inspection this patient reported that they had had to wait over an hour to see their consultant, but advised that this was the only appointment in the history of over fifteen years of appointments where this had occurred.
- Examples of comments received from patients and relatives included; "The promptness is particularly impressive.", "we have had no difficulties at all…"
- The outpatient manager explained that when a new consultant joined the hospital, they would meet with them and ask how long the consultant would like for both new and follow up appointments. Waiting times were monitored on a daily basis within clinics for individual consultants and if a trend was noted the outpatient manager would approach the consultant and suggest amended clinic appointment times to minimise patient waiting time.
- The NHS process was consultant led and the consultants list all their own patients. The patient is seen initially at the local NHS trust and if appropriate for surgery at Spire the consultant sends the referral to the hospital. When the notes arrive these are checked against the notification list added to a spreadsheet and sent for preassessment check. If patients do not fit the admission criteria and SLA arrangements then they are rejected. Administration staff log all this information on a spreadsheet and the hospital director has direct oversight, by way of a weekly report, to ensure the hospital delivers the agreed service. The weekly report includes details such as number of cases referred, booked, breach dates and numbers rejected.
- The referral to treatment time for non-admitted patients beginning treatment within 18 weeks of referral from an NHS referrer were above the target of 95% in 2015 with a rate of 98.3%.
- The inter-provider transfer process in the 2015 to 2016 contract requires that Spire Norwich accepts NHS patients anywhere along the 18-week pathway (including post-breach) and because of this, an agreed contract variation has been agreed whereby the hospital will not be penalised for breaches where the time remaining after the transfer was less than 12 weeks.

Meeting people's individual needs

- Matron advised that there was a bariatric support group meeting which was held within the hospital once a month, which provided patients with clinical support.
- 'Dementia friend's' training was planned for the end of May 2016. A Healthcare Assistant said they would like to attend this training, and we saw that there were two or three training sessions offered each month between until August 2016 to become a dementia friend.
- Staff told us that they did not see many learning disabilities patients within the outpatient or diagnostic imaging services, but if they attended clinics staff would make reasonable adjustments such as allowing relatives or carers to attend with the patient for support, or additional time for a consultation to allow questions to be raised and answered.
- Matron and one of the outpatient managers were the nominated 'dementia leads' acting as a point of contact for staff requiring more information about dementia issues. Nurses and heath care assistants knew of both of the contacts for these lead roles.
- Nursing staff confirmed that they did not have many patients with learning difficulties attending the outpatient department, and there was no flagging

system for these patients as they said that they would not necessarily be alerted to the patient's condition before they arrived for clinic. Individuals may require additional time for an appointment to ensure that they fully understood the decisions they were making about their care, and without prior warning a consultant's clinic may have been fully booked with no flexibility to accommodate these patient's requirements.

- The main waiting room areas were organised for adults with magazines, a television in the second waiting area outside the consultation rooms and drinks available.
- Spire Norwich hospital aimed to provide freshly prepared nutritious food to aid patient recovery, and offered a range of food menus to suit individual patient choice such as; diabetic, vegetarian, vegan, ovo-lacto vegetarian, gluten free / coeliac, halal, and lactose free.
- The hospital provided patients with access to wifi to enable them to make contact with their families or use social media.

Learning from complaints and concerns

- The hospital had "please talk to us" patient leaflets detailing how to make a complaint if patients were unhappy with an element of their care they had received.
- There was a good process in place for the management, and subsequent learning, of complaints. We reviewed complaint files and the process was explained. The hospital aimed to resolve complaints as soon as possible in a face-to-face situation, giving patients the opportunity to raise their concerns directly with hospital staff at the time.
- We reviewed a complaint from a patient about a procedure they had at the hospital which necessitated a return visit. This patient was not local to the hospital and the hospital offered to cover the cost of the patient's fuel to return to the hospital and finalise the procedure. This was accepted by the patient, and consequently the hospital received a letter of thanks.
- Changes in practice or process in response to patient complaints received by the outpatient department included; updating the outpatient breast clinic service leaflet with charges so patients could make informed decisions, and a tracker sheet was implemented so that referrals between outpatients and radiology could be traced.
- The Spire Norwich had been asked to share their complaints documentation and follow-up practice with other hospitals in the Spire group.

Are outpatients and diagnostic imaging services well-led?

Good

We rated outpatients and diagnostic imaging for well-led as good because:

- Individual staff members reported feeling included, listened to and a valued part of the team.
- Staff felt supported by senior management and spoke of them being approachable and visible.
- There was a cohesive group of staff, in an open, learning environment.
- There was an open transparent attitude to serious incidents which involved both duty of candour to the patient, but also an open learning environment for staff with the support from senior management.
- Staff were keen and proud to develop internally, and share their knowledge with their peers via the form of internal training.
- Governance processes were well established such as incident management, risk management and learning from complaints and information flow between key committees was well documented.
- There was a robust system for ensuring that consultant's practising privileges were monitored and managed via the medical advisory committee (MAC).

Vision and strategy for this this core service

- The vision for Spire Norwich was; "To be recognised as a world class healthcare business." This vision was underpinned by six values; caring, teamwork, driving excellence, integrity, delivery on promises and the ability to 'keep it simple'.
- The radiology manager was very passionate about the new department. Medium term plans for the department were being worked towards. This included building a multi-skilled workforce to allow for cross-cover. Some external training had been identified for a member of staff keen to develop knowledge within mammography, and once completed; this member of

staff would be dual trained. There were a number of staff members completing the Spire training for magnetic resonance imaging (MRI) scanning, which would build additional flexibility within the department's workforce.
- The outpatient manager's plans were to use the hospital administration system to look at room utilisation for the 120 consultants working in the department, and they had identified that a more private room was required for patients post-procedure such as women who had just received gynaecological treatment.

Governance, risk management and quality measurement for this core service

- At the time of our inspection, consultant's practising privileges database demonstrated 99% compliance with practising privileges requirements for the 218 Consultants working at the hospital.
- November 2015 medical advisory committee (MAC) minutes confirmed that within the biennial review of practising privileges all relevant matters were taken into consideration. There was evidence of the year's rolling programme for speciality review in order to renew consultants practising privileges. Recording of evidence was managed by the hospital director and matron. This was a robust and thorough process.
- MAC meetings were held quarterly with an additional annual general meeting. Each medical/surgical speciality had representation at the meetings.
- The MAC chair attended the clinical governance committee and was active in monitoring improvements within the hospital. The operations manager had worked with the Spire corporate team in February 2016 to establish a hospital wide risk register. They had also been working with the heads of departments (HoDs) to review local risks, and create a risk library to compliment the risk register. This work had been achieved as part of the key priorities for 2016 action plan.
- The outpatient's manager told us that the three main risks for the department were – the need to supply intermediate paediatric safeguarding training for staff and four of the five registered general nurses had dates booked for 2016. The second risk was using clinical space efficiently to free up space for clinics; the third was the need for provision of a 'recovery space' for outpatient day procedures such as for gynaecology. However, none of these risks were present on the departments risk register so we could not be assured they were being managed and mitigated effectively.
- The hospital director confirmed that there were three members of the consultant body who were members on both the clinical governance and MAC meetings which aided in medical insight at the governance meetings, cross cover and key issue information flow.

Leadership / culture of service

- Within a mixed staff focus group (not purely outpatients and diagnostic imaging) of approximately 24 staff held on the day of inspection, staff said that the management team were pro-active at acting upon both good and negative feedback.
- February 2016 governance committee minutes demonstrated that there was a good reporting culture in relation to both clinical incidents and risk adverse events, as low, no-harm and near miss examples were reported for organisational learning.
- Outpatient's staff said that any inappropriate behaviour would be dealt with immediately, and any whistleblowing concerns were managed by the hospital director.
- Staff within the outpatient department told us that matron would visit the department and be accessible if a department manager was away.
- We observed warm and engaging working relationships, as well as very professional and caring attitudes displayed towards patients. Staff spoke of the supportive teamwork culture, support from senior managers and theirindividual responsibility to ensure that patient's received the best possible care.

Public and staff engagement

- The hospital held regular HoD and departmental meetings to share staff experiences and cascade information.
- The February 2016 MAC minutes reported on the consultants and staff survey of 2015 which demonstrated that Spire Norwich was exceeding the Spire group's figures in terms of consultant and staff feedback with a 92% response rate.

Good

Outpatients and diagnostic imaging

- Consultants had their own lounge however they chose to take their breaks in the same coffee lounge area as other staff. Staff told us that consultants were approachable and joined in social activities outside of work.
- The department/ward performance scorecards were used in a friendly competitive manner amongst staff. The scorecards were also reviewed within the MAC meetings as an element of performance monitoring.
- The outpatient department provided patients with a satisfaction survey upon discharge from their treatment, to monitor the effectiveness of the care provided, though the findings of these surveys were not discussed within this forum. The December 2015 HoD action points stated that patient satisfaction was to be a focus, and this action was completed by the hospital business development manager who developed an action plan to improve outcomes.

Innovation, improvement and sustainability

- The pharmacy manager gave an example of patients reported frustrations about trying to speak to a member of staff about medication once they had been discharged home. Because of this the pharmacy team had devised a small business card entitled "Questions about your medication", which detailed the pharmacy contact telephone number. This meant that patients could speak directly to the team. Feedback received by the team had been that this had been well received by patients as they had a single point of contact and ease of access for any medication queries they may have.
- The November 2015 clinical governance minutes note the recent radiology protection audit which was completed, with suggested amendments of documentation processes and recording of local audits. The radiology manager had developed an action plan following this feedback and no significant concerns.
- Spire Norwich held 13 educations seminars for the general practitioner (GP) community in 2015 and 51 GP practice-based educational events. The education events were free events and could be used to build continued professional development (CPD) credits. Topics examples were a 'radiology and urology update' which was an hour's evening session and a lunch and learn training session delivered by a consultant urologist.

Outstanding practice and areas for improvement

Outstanding practice

- Diagnostic imaging services used two software packages to allow both internal and external based staff the ability to view imaging and reports. There was a web based secure connection for consultants and radiographers to access imaging and reports whilst not located in the hospital. This software allowed secure access to documentation and images via iPad and mobile phones.
- There was a robust system and database in place which was used to record and monitor consultants competencies, completion of mandatory training, continued professional development, personal development review, indemnity, and revalidation. This information was considered as part of a rolling programme within the medical advisory committee (MAC) meetings, before being signed off by the hospital director and matron in order to re-establish consultant practising privileges.
- There was an exceptional senior management team leading the hospital. The Hospital director, matron and MAC chair had clear oversight on the running of the hospital. They were all aware of the key risks and challenges as well as united in the future of the hospital. Staff had nothing but praise for the management team, stating they were visible, approachable and promoted an open culture.

Areas for improvement

Action the provider MUST take to improve

- Adopt a single patient record system, ensuring that all patient records are up to date, contain relevant information, include medical and nursing notes, patient risk assessments and administration pathway records. The hospital must have a robust system of monitoring the quality of records.
- Ensure that all staff that care for children complete level 3 safeguarding children training, in line with the intercollegiate document published by the Royal College of Paediatrics and Child Health. Ensure that there are suitably trained staff on duty, at all times, when children are seen and treated.

Action the provider SHOULD take to improve

- Ensure that all staff have access to major incident training and drills.
- Ensure staff understand the requirements and practice of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- Review governance processes to ensure a greater level of management oversight with regards to oncology services.
- Consider participation in national audits related to cancer services where possible.
- Ensure that the quality of records, including consent forms, is improved to ensure documentation is clear, legible and accurate.
- Ensure that all departments are aware of risk management policies and procedures for the hospital. Furthermore, the provider should satisfy itself that all relevant risks to the safety and wellbeing of staff and patients have been identified and are being managed.
- Ensure that the medicines cupboards are locked at all times.
- Review preoperative fasting arrangements for patients and ensure regular monitoring to evidence improvement.
- Ensure there is a clear and well understood service specification for the provision of enhanced recovery care.
- Ensure auditing of RMOs awake periods during the night to assess safety of 24/7 working pattern and compliance to the European working time directive.
- Ensure that there is a system in place which allows people with specific needs, for example people with learning disabilities or dementia, to be identified prior to admission and flagged to appropriate staff so that additional needs can be considered.
- Review the safeguarding training and procedures to ensure that all staff are aware of what would constitute a safeguarding concern.

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
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1)(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance** How the regulation was not being met: Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. We found gaps in some of the patient records we reviewed. Not all patient notes were retained by the hospital, risk assessments had not been completed in some instances and records were not always available in outpatient clinics. Documentation, including consent forms, were not always legible.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Regulation 13(1)(2)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safeguarding service users from abuse and improper treatment

How the regulation was not being met:

Clinical staff, directly caring for children within outpatients and diagnostic imaging had not received safeguarding training to level 3. There was a risk that children could be seen and treated without a member of staff on site with the appropriate level of training.