# Spencer Private Hospitals Margate

# Hospital Directors

# Annual Report

# 2023 – 2024

Spencer Private Hospitals Margate (SPH) is currently registered with the Care Quality Commission under the following regulation activities:

- Treatment of Disease, Disorder or Injury
- Surgical Procedures
- Diagnostic and Screening Procedures

These services are provided in the following facilities:

- 22 en-suite patient bedrooms
- Five outpatient consulting rooms
- One treatment room
- One audiology room

In addition to the facilities provided in SPHs, there is a formal Service Level Agreement with East Kent Hospitals University Foundation NHS Trust (EKHUFT) for the following services to be provided in NHS facilities.

- Operating Theatre Services (including recovery facilities)
- Intensive Care Unit Services
- Medical Imaging
- Pathology Services
- Cardiology Services
- Endoscopy Services

Facilities Management Services (maintenance, supply of utilities etc) are provided by 2gether Support Solutions (2GSS).

## 1. Activity

In the year 2023-2024, Spencer Hospitals Margate completed the following activity in line with regulated activity:

### 1.1 In-Patient Activity:

3,564 patients were admitted during 2023-24 (3,581 in 2022-23). Average Length of Stay (ALOS) for year was 1.99 days.

The ward area continues through its SLA to support EKHUFT with 10 beds weekdays, and 6 beds at weekends to assist with the local NHS pressures by providing patient care.

### 1.2 Day Case Activity:

2023-24 saw an increase of 9% in day case activity - 1,392 patients received day case stays in comparison to 1,278 in the previous year.

### 1.3 Occupancy:

Effective occupancy was 71.2%. These statistics do not take into account activity where beds are used more than once in a day.

### 1.4 Out-Patient Data:

27,675 patients received out-patient services. 10,217 of these were patients receiving eye injections in the treatment of Wet AMD and associated disorders to prevent loss of sight.

The dept saw an overall activity growth of 4% over the year.

### 1.5 Theatre Procedures:

2,414 theatre cases were completed in the year of 2023-2024: a 10% increase from 2,190 the previous year.

This increase can be attributed to the improvements in monitoring of theatre utilisation following the implementation of weekly bed meetings.

### 1.6 Year End Performance:

Income for the Margate site was £11.83 million which was 5% below budget. In the main, this was due to a slow start to the year and the increase in assistance with beds for EKHUFT Trust patients. (The bed income differs from SPH CAB income budgeted). Income has also not been received for NHS TTOs drugs for transferred EKHUFT patients. This is being addressed at the time of writing this report.

Overall site costs have been well managed.

Theatre staffing remains under review as changes to cross charging which occurred during the year has affected year end staff costs and subsequent P&L.

**Margate Site was 71% of total company EBITDA .**

## 2. Patient Experience:

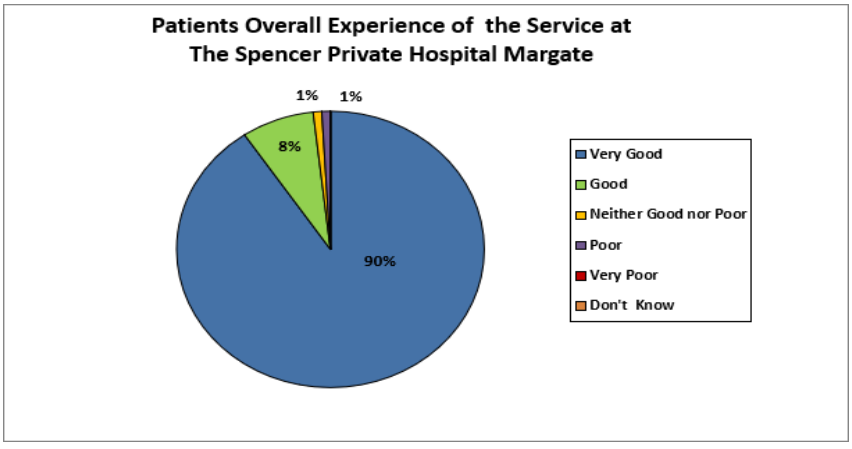
All patients are encouraged to complete a patient experience questionnaire upon discharge. Any required improvements are recorded through our surveys and complaints process and are fed back to the appropriate staff to ensure the required improvements are made.

Friends and Family (FFT) data is collated and fed back to the CQC, ICB, Board of Directors, and all staff throughout the hospital at departmental meetings along with being included in the organisations staff newsletter 'The Spencer Digest'.

### 2.1 Friends and Family Outcomes (FFT) 2023-24:

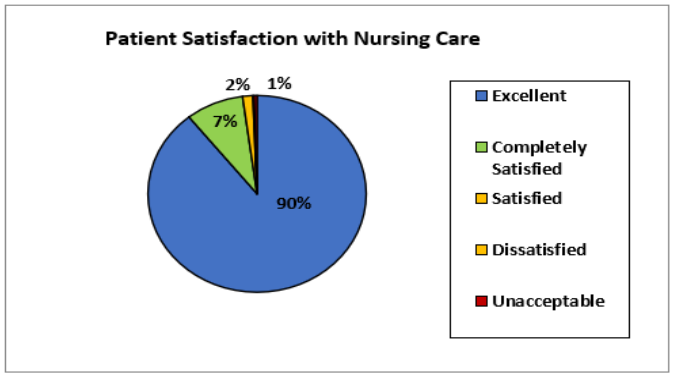
| Overall experience of our service | Very Good | Good | Neither Good nor Poor | Poor | Very Poor | Don't Know |
|---|---|---|---|---|---|---|
| | 90% | 8% | 1% | 1% | 0% | 0% |

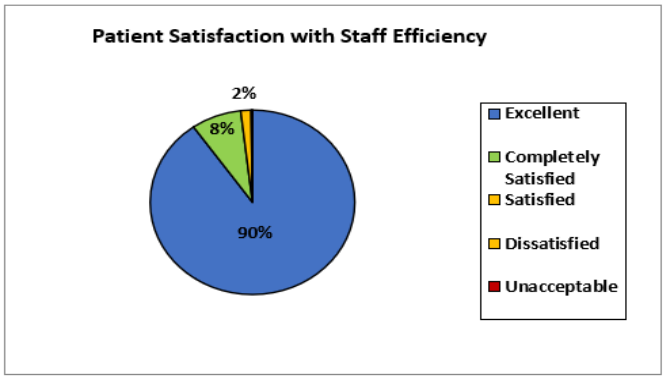
**In-Patient Survey:**

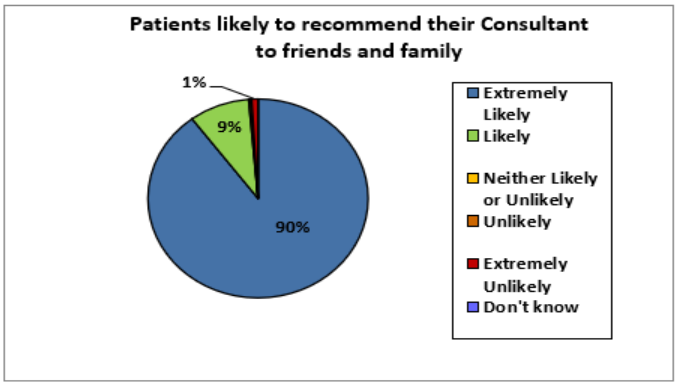


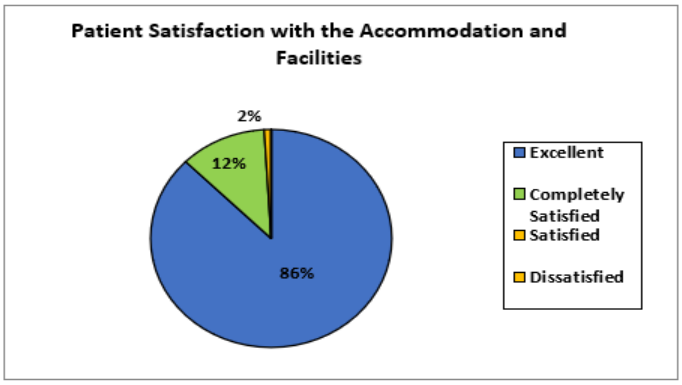
**The overall FFT was very positive with a 98% recommendation of the hospital to family and friends.**

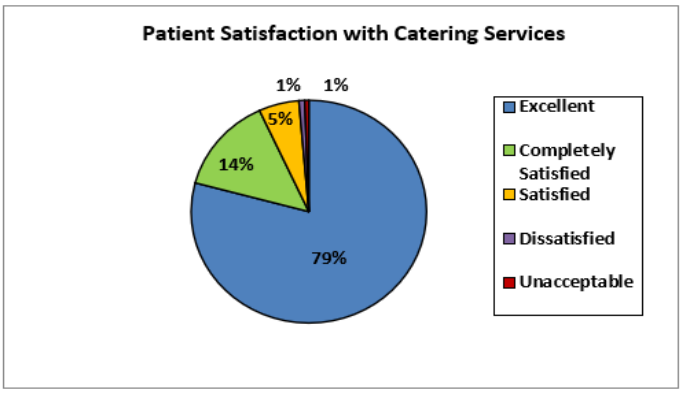
## Individual Dept Information:

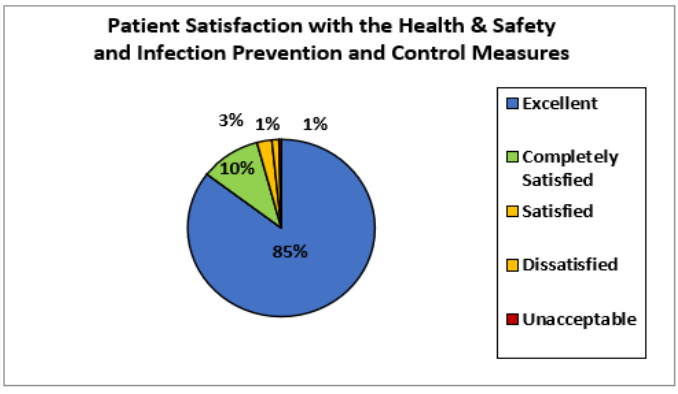


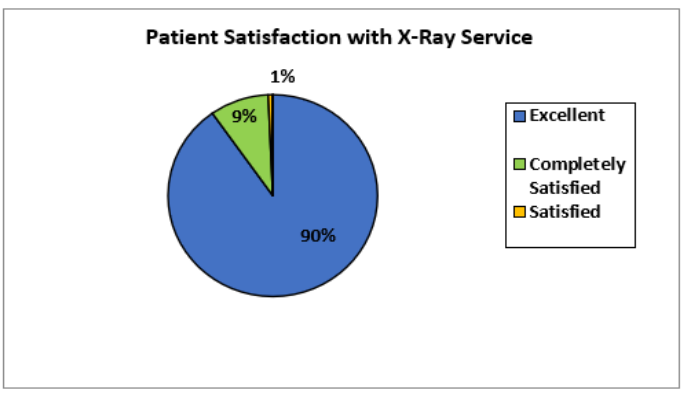



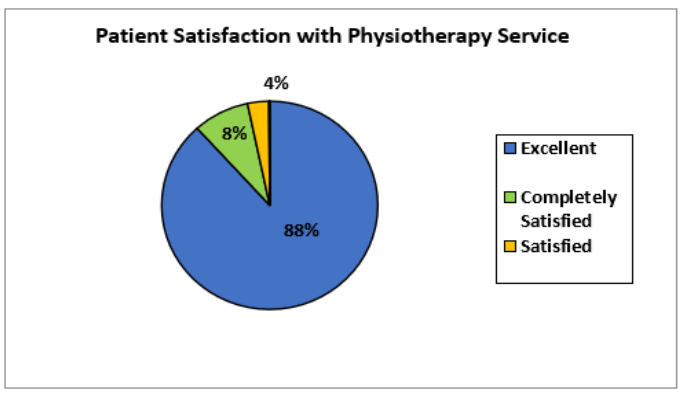



**Patient feedback:**

*"Everyone very friendly and accessible. Medical staff - excellent. Consultant - I was so glad I had him, superb, straight talker, brilliant surgeon."*

*"Staff are a credit to you."*

*"The food was excellent - well prepared, always hot where necessary and well presented. There was a very good choice at all meals. The catering staff I met were all very friendly and helpful."*

*"First class overall. What a team; my sincere thanks to you all."*

*"The professionalism and quality efficiency reflects on skilled teamwork. All staff were very kind and willing to go the extra mile to make my stay comfortable, safe and enjoyable. They gave me praise when walking without aids, this encouraged my confidence."*

*"All staff came across kind, caring and showed empathy during my stay. Friendly and reassuring. A big thank you for taking care of me during my stay. Great team!"*

*"The staff deserve praise for their work; always smiling. The staff and nurses were excellent, friendly and extremely helpful. Staff like these are not easy to find and a credit to the service."*

*"The staff at all levels from Director to most junior staff were excellent."*

*"The last time I tasted food like this was at the Hilton Hotel Park Lane."*

*"I could not fault anything, especially the staff. I was very anxious and emotional, but everyone was there to reassure me, explain everything and used positive distraction. Thank you."*

*"Best hospital experience I have ever had all staff were amazing. Thank you."*

*"The catering staff are so helpful and willing to accommodate any dietary needs."*

*"I could not fault any member of staff. They are a credit to the hospital."*

*"Thank you to all on the Spencer Ward. You've made my stay a great experience considering it's a hospital."*

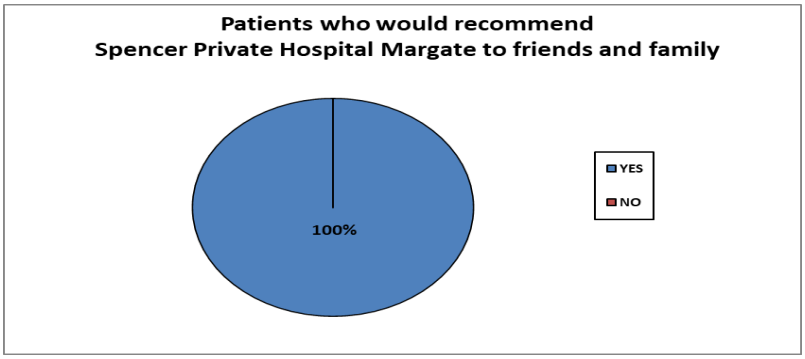
*"Cleanliness was of an exceptional standard."*

*"Lovely & professional staff."*

## 2.2 Patient Experience – Ophthalmology Wet AMD Service.

Ophthalmology surveys are undertaken at every clinic held. These are reported quarterly and distributed to all required staff for feedback and learning and are discussed at the ophthalmology meetings.

**Survey results for this service are excellent – 100% would recommend the service to family and friends.**




**Patient Feedback:**

*"Staff are very professional and kind."*

*"Friendly atmosphere."*

*"Lovely helpful staff."*

*"Nice to have a laugh with staff."*

*"Fantastic"*

*"Staff are always kind and helpful."*

There was one area of concern highlighted during the year relating to the new criteria implemented by G4S for eligibility for patient transport services. No communications were held with SPH as the service provider prior to the changes being made. The amended criteria affected a number of patients who were advised they no longer met the criteria to qualify for the service which impacted on their ability to attend the hospital for their treatment. The Hospital Director met with the ICB and G4S to discuss the matter and the criteria was amended to ensure all patients attending SPH were offered their required transportation.

### 2.3 Focus for improvement in 2024-25.

The increase of the survey responses is an area in need of improvement in the coming year which supports the CQCs new inspection framework where patient experience is a key driver of evidencing quality. The Hospital Director has requested the implementation of an IT solution to streamline patient feedback processes which sits within SPH's digital transformation strategy.

## 3. Complaints.

Effective complaints management is an integral component of high-quality governance. SPH's Quality and Safety framework is underpinned by excellent governance at all operational and organisational levels and the organisation as a whole works as a team to deliver person-centred care. This includes putting patients and their families at the centre of our decision-making processes.

SPH are committed to delivering the best possible patient experience to every single patient, every single time. It is a key aspect of our leadership commitment to our customers and is a part of the hospitals wider quality management system. This aligns with the organisations Values and Mission Statement.
SPH has a clear focus on enhancing customer satisfaction and experience. As part of this process we listen, take seriously, and respond promptly and openly to any complaint we receive. This

approach assists us to work hard to ensure patients feel confident in raising any issues or concerns they may have and enables us to help our staff to feel supported to respond to patients who experience issues or concerns.

### 3.1 Duty of Candour.

SPH's approach to complaints management is in line with the CQC's Regulation 20 – Duty of Candour, which ensures as a health care provider we are open, honest, and transparent with staff, patients, the public and regulators when things go wrong with their care and treatment.

### 3.2 Complaints Management.

Complaints are reviewed at our weekly Closing the Loop Meetings, Quarterly Clinical Quality and Safety Governance Meetings. These are then fed back at Quarterly Medical Advisory Committee meetings (MAC).

Complaints are additionally discussed at Board Meetings attended by SPH Directors, Senior Management Team Meetings (SMT), Heads of Department Meetings, and Individual Departmental Meetings to ensure that staff learn from patient experiences.

The patient guide in all patient rooms, as well as the Statement of Purpose, contains information on how to make a complaint. The Patient Guide and Statement of Purpose was updated in January 2024. The SPH website also displays information on how to make a complaint.

Complaints management is constantly monitored and managed through the organisations Datix Management System. Weekly closing the loop meetings are undertaken to ensure responses and resolutions are completed in a timely manner. This has continued to improve staff engagement and feedback is provided to staff through the Datix system and the organisations monthly Spencer Digest newsletter. Improvements to this will continue in the coming year utilising a new IT solution to capture patient responses.

### 3.3 ISCAS.

SPH are members of the Independent Sector Complaints Adjudication Service (ISCAS) and follow the process below for the completion and escalation of all complaints. The link for the ISCAS guide can be found on the organisation's website:

https://iscas.cedr.com/patients/complaints-process/

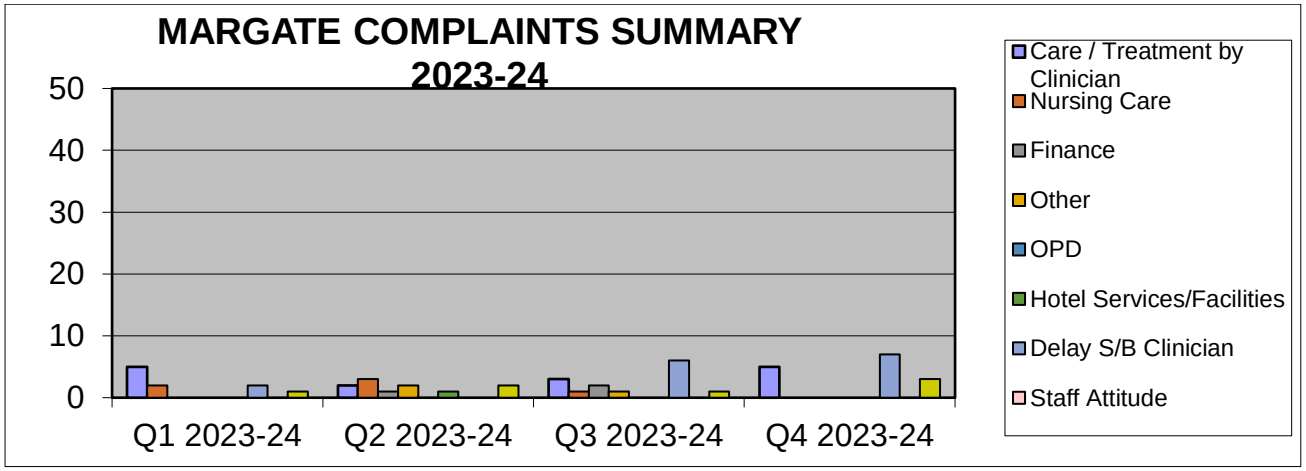
### 3.4 Complaints.

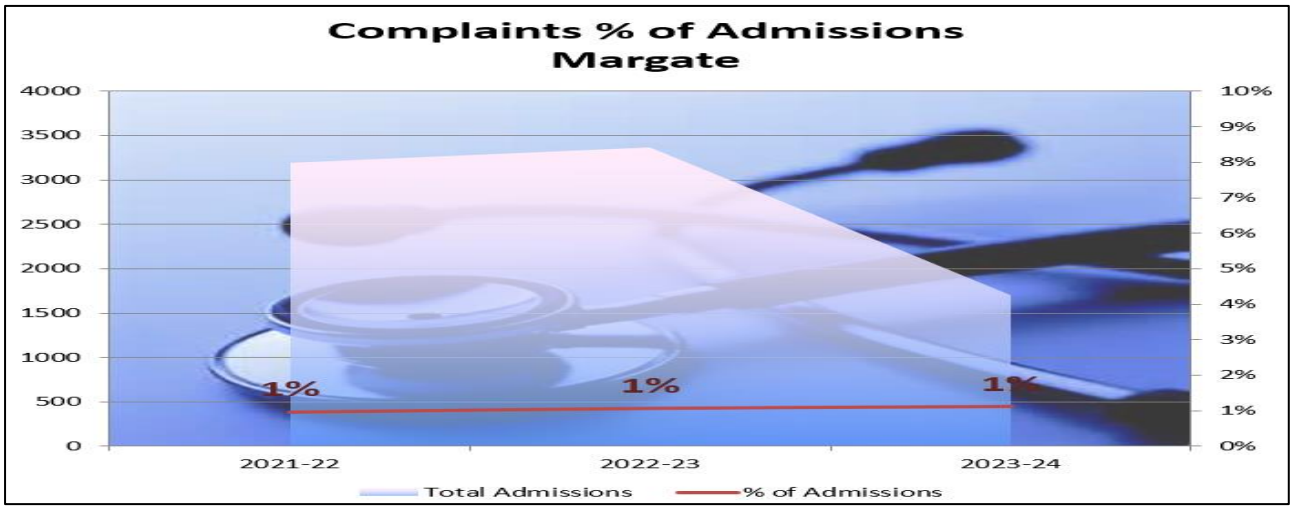
There were 50 complaints recorded in 2023-24, equating to 1.40% of patient admissions.

#### 3.4.1 Patient complaints adjudication service for independent healthcare – ISCAS.

**There were no complaints to ISCAS in 2023-24.**

| Complaint Category | 2021-22 | 2022-23 | 2023-24 |
|---|---|---|---|
| Care/Treatment by a Clinician | 12 | 15 | 15 |
| Delay in being seen by a Clinician | 4 | 6 | 15 |
| Staff Attitude | 0 | 2 | 0 |
| Nursing Care | 10 | 9 | 6 |
| Finance | 4 | 5 | 3 |
| Outpatients (OPD) | 0 | 0 | 0 |
| Bookings/Administration | 5 | 12 | 7 |
| Hotel Services/ Facilities | 0 | 1 | 1 |
| Other | 0 | 1 | 3 |
| **TOTAL** | **35** | **51** | **50** |



**Preventative Measures / Lessons Learnt Following Complaints:**

**Care / Treatment by Consultants / Clinician:**

- Around one third (30%) of the complaints related to Consultant behaviour and manner. The Consultants involved all offered their sincere apologies to patients for any upset or distress caused as this was not their intention. The Hospital Director has met with required Consultants to ensure communication with patients improves.

- Communications have been held with Consultants regarding their timekeeping to ensure they are not late for their clinics, nor do they overrun.

- Requests have been made to Consultants to ensure they advise the administration team of all booked annual leave to prevent cancellation of clinics.

**Delay in Treatment and Waiting Times:**

- Around one third (30%) of the complaints were related to a delay in patient treatment, either through cancellation of procedures or outstanding wait times following the pandemic which continues to impact on the scheduling of procedures. The bookings and administration teams do their utmost to minimise occurrences of cancellations and have worked hard to address RTT waiting times. Meetings to review the RTT continue monthly, and outcomes are reported to the ICB at the regular contractual meetings.

**Administration / Bookings:**

- Around 14% of the complaints received were in relation to errors in the booking and administration process. All of the complaints have been discussed with the Head of Customer Services who has ensured that additional staff training has been provided where required, and that staff are informed of patient feedback, both positive and negative in order to improve administrational practices and communication skills.

**Nursing Care:**

- Registered Nurses have attended refresher courses on cannula care and the administration of IV medications.

- Registered Nurses have undertaken re-training in administration of Controlled Drugs.

- The procurement of pharmacy medicines for planned discharges has been reviewed to ensure timely discharging is maintained.

- Discussions have taken place with the nursing team to ensure effective communication is maintained with patients.

- Discharge protocols have been reviewed with clinical staff to ensure full compliance is met.

- Discussions have taken place with the nursing staff to assist with improvement in patient care and patient communications.

- A review has been undertaken with Canterbury Christ Church University relating to the supervision of student nurses.

- Pre-assessment processes, including the triaging of patients, have been reviewed and improved. This included the implementation of LifeBox which is a digital preassessment process. The system has streamlined process and improved pre-operative patient safety.

- Shared Governance meetings with EKHUFT have continued throughout 2023-24 to discuss and review clinical incidents and clinical practice along with learning from complaints received relating to the transfer of patients.

**Finance:**

- Communications have been held with the finance team to ensure due diligence is undertaken with patient paperwork, particularly with regards to patient insurance claims and making sure cover has been agreed by the insurance company prior to surgery.

**Facilities:**

- All required facilities maintenance has been undertaken. The site supervisor has reviewed the organisations planned maintenance programme to ensure any issues are identified in a timely manner.

- Menus and beverage services have been reviewed and improved. The Site Supervisor is collaborating with 2GSS on all aspects of the food provision service.

- Communications have been held with the facilities team to ensure all patients are regularly reviewed throughout the day to establish nutritional requirements. The team are to ensure they attend daily huddles.

## 4. Health and Safety.

This section of the report reflects SPH's compliance with the organisations overall Health & Safety Policy Statement, which requires those responsible for health and safety within the premises and during activities to:

1. Comply with health and safety legislation.

2. Implement health and safety arrangements.

3. Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies.

4. Develop partnership working and to ensure health and safety arrangements are maintained for all.

To ensure that the health and safety agenda is embedded and embraced throughout the organisation using a variety of monitoring methods, including:

- Quarterly Health and Safety Committee meetings
- Monthly Site Health and Safety Walk Rounds
- Regular 'Drop in' clinics held by the Hospital Director
- Discussing Health and Safety at Board Level
- Monthly Senior Management Team Meetings (SMT)

- Quarterly Heads of Department Meetings.
- Monthly Individual Departmental Meetings - ensuring that staff learn from any incident / accident.
- Monthly published staff newsletter that is shared with all staff.
- Datix Incident reporting system with feedback provided to staff.

The overall responsibility for the organisations Health and Safety remains with the CEO with the day-to-day management delegated to the Hospital Director, assisted by Facilities Site Supervisor and Matron.

The Plant Room area within the SPH Margate continues to be managed, monitored, and maintained by 2GSS. A plant room risk assessment is undertaken and actioned by 2GSS in line with their risk assessment processes.

Services purchased from 2GSS are continuously monitored; these include the checking of water supplies, LOLER (lift maintenance), medical gases, fire equipment, fire plans and weekly fire tests.

Health and safety reports are reviewed at Management Review Meetings as part of SPH ISO processes and at quarterly Clinical Governance and Safety meetings. These are then fed back at Medical Advisory Committee meetings (MAC).

Health and Safety reports are additionally discussed at Board Meetings attended by SPH Directors, Senior Management Team meetings, Heads of Department meetings, Health and Safety meetings and Individual Departmental meetings to ensure that staff learn from any incident / accident.

### 4.1 Staff Health and Safety Information.

Health and Safety information for staff and patients is placed on dedicated health and safety information boards in the ward and staff areas. Safety updates have been provided to staff utilising the monthly staff newsletter, the organisations People HR system, and departmental meetings.

### 4.2 Health and Safety Committee.

The committee continues with its corporate structure to ensure a consistent safety approach across all sites. Meetings have taken place every quarter although membership changes with staff changes. The committee meetings have been chaired by Lynn Orrin / Cheryl Lloyds, and consist of representatives from each site, individual departments, as well as specialist representatives with specific responsibilities.

Quarterly reports and graphs have been produced and are discussed at the committee meetings throughout the year.

Dashboards for care hours per patient day (CHPPD), never events, staff days lost through injury and patient harm events continue to be utilised to enhance transparency and improve on communication channels for both nursing staff and patients to enhance transparency and improve on communication channels for both nursing staff and patients. These reports are accessible to both staff and patients.

### 4.3 Health and Safety Drop-in Clinics.

Health and Safety / Hospital Director ‘drop-in clinics’ have continued during 2023-24 to improve staff engagement. TEAMS has been utilised for staff working from home.

Feedback from staff regarding organisational management of health and safety issues has overall been very positive. All staff receive face to face H&S guidance at Corporate Induction Days.

### 4.4 Safe Staffing.

SPH have a duty of care to ensure that all patients are cared for by appropriately qualified and experienced staff within a safe environment. To support this objective, the organisation continued to utilise its Nursing Dependency Analysis Tool to ensure safe staffing levels are maintained.

Safe Staffing metrics, and quality measures have continually been reviewed over the past year and monitored, including Datix Incident Reporting, Harm Free Care statistics, Complaints, Patient Experience Surveys, and Friends and Family feedback. (Please see full Safe Staffing Report).

**There were no red flag events reported in 2023-24.**

**The CHPDD metric has been maintained throughout the year.**

### 4.5 Annual Harm Free Care Report.

During 2023 - 2024 there were 3,564 patients admitted at Margate. The number of incidents against patients admitted is 0.30%.

1. **Falls.**
   There were 11 incidents of Falls during 2023-24.

2. **Pressure Ulcers.**
   There were no incidents of Pressure Ulcers during 2023-24.

3. **VTE.**
   There were no incidents of a VTE in 2023-24.

4. **Urinary Infection.**
   There were no incidents of Urinary Infections in 2023-24.

**Goal:**
The National Standard for Harm Free Care is set at 95% for all four harms.

**Outcome:**

In 2023-24, we exceeded the National Standards by achieving:

99.69% Harm Free Care recorded for Falls.

100% Harm Free Care recorded for Pressure Ulcers.

100% Harm free Care recorded for VTE.

100% Harm Free Care recorded for Urinary Infections.

SPH statistics are recorded from every day of the year.
(Please see Annual Clinical Governance and Safety report for full details of all HFC related incidents and actions taken to mitigate risk).

**Actions / Lessons Learnt from falls incidents.**

All patient falls were fully investigated to ascertain if any improvements to practice could be identified. All risk assessments had been undertaken for patients involved. All incidents were either no harm or low harm events. All required protocols were followed in all cases. The trend identified related to patients wishing to be independently mobile without wishing to ask for assistance. Communications were held with patients to minimise risk. Call don't fall signs are in place and patients are regularly reminded to ask for assistance where indicated. Hourly walk rounds are undertaken daily to minimise risk.

### 4.6 Freedom to Speak Up (FTSU) Guardian.

Alex Aucutt-Ford is SPH's Lead Freedom to Speak Up Guardian and took on the role in 2023 following the retirement of the previous Guardian. Since then, Alex has recruited 2 more Guardians in Jen Whitehead (PMO) and Cheryl Styles (Bookings).

The F2SU Team hold a key role within SPH to provide a confidential method of raising concerns and to support staff. Alex has ensured all F2SU processes have been reviewed and actions taken to ensure best practice is maintained including:

- Encouraging staff to speak up utilising a dedicated email for staff to use to confidentially raise concerns.
- Completing training in the F2SU area
- Raising the profile of F2SU
- Networking with other F2SU Guardians

There were 3 F2SU concerns raised during 2023-24 which were investigated by the relevant department and feedback provided accordingly. The FTSU policy was ratified by SMT in November 2022 and has a 3 yearly review date set for July 2025.

### 4.7 Safeguarding.

Safeguarding remains a key priority for the Organisation. In line with The Health and Social Care Act 2012 and CQC regulations, the organisation has policies and systems in place to safeguard the people who use our services.

During 2023-2024 the organisation continued with its on-going programme of on-line training in relation to safeguarding Adults and Children for both clinical and non-clinical staff. Training has been undertaken through the Kallidus on-line training system. Both level 1 and level 2 training are delivered in this way. Level 3 face to face training has been re-established and clinical staff are completing Level 3 as required.

The organisations Safeguarding Lead, Cheryl Lloyds has undertaken level 4 training. An appropriate deputy is completing level 4 training in 2024.

Safeguarding incidents are included in the organisational Quarterly Clinical Governance and Safety reports which are shared from Ward to Board.

There were two safeguarding concerns reported in 2023-24. All processes were followed and adhered to.

### 4.8 Health and Safety Policies.

The Health and Safety Policy and Health and Safety Policy Statement for Margate was updated in January 2024.

### 4.9 Health and Safety Risk Register – 4 Risk.

SPH continued to utilize the 4Risk Information Management System during 2023-2024. The Risk Register is currently under review.

### 4.10 DSE Assessments.

DSE assessments have been undertaken for all required staff members including those working from home. Any required actions are addressed.

### 4.11 RIDDOR.

There were no reportable incidents in 2023-2024.

### 4.12 Legionella Testing

Monthly testing undertaken by 2GSS in line with the organisations SLA.

### 4.13 Environmental Risk / Legal Compliance Register.

The Legal Compliance register was updated in February 2024 in line with ISO 14001:2015 accreditation.

### 4.14 Controlled Drugs (CD) Management.

CD Management is discussed monthly at SPH Clinical Governance and Safety, Pharmacy, Corporate H&S meetings, SMT and Heads of Dept and Departmental meetings to ensure best practice and shared learning.

The RAG rated CD Reporting System is embedded within the organisation which has assisted the organisation to maintain a consistent reporting approach.

The clinical areas where CDs are stored are audited monthly by the nursing team and at three monthly intervals by EKHUFT pharmacy personnel. Daily CD checks are maintained by two registered Nurses.

The Home Office undertook their compliance visit on 6th April 2023. The inspection went very well, and no concerns were raised regarding the management of CD's.

The CD licence was renewed in September 2023 – Next Due September 2024.

Accountable Officer Training was undertaken by Lynn Orrin, Hospital Director on 19th-20th April 2024.

The Home Office annual return for 2023-24 was completed and submitted by EKHUFT as the supplier to SPH.

(Please see Full CD annual Report)

### 4.15 Unannounced Environmental Health Inspection.

An unannounced EH inspection took place on 23/01/24. The top 5* rating was achieved.

### 4.15.1 Basic Food Hygiene Certification.

All required staff have completed Basic Food Hygiene training.

### 4.16 Fire Management.

SPH continues to work within the agreed Service Level Agreement with the Trust / 2GSS to provide fire risk management. Any records required can be obtained from the Trust. Fire equipment has been checked as a part of the SLA. The fire policy was updated in March 2023.

### 4.1.6 External Fire Audit by ATC.

The annual external fire audit was undertaken on 14/11/24. There was one remedial action relating to free standing O2 cylinders which has been actioned. A copy of the report was sent to 2GSS and the CEO.

Bespoke fire site staff training was undertaken on 14/11/24.

### 4.17 NJR Reporting.

The NJR introduced a new 3 tier initiative during 2023-24 to rate organisations gold, silver or bronze level.

**SPH Margate reporting at year end was 99.02 % submission rate which was Gold Standard.**

SPH received an Outlier Alert from the NJR relating to 10-year data findings for knee revision. The Hospital Directors worked with all relevant Consultants and MAC members to review all NJR data provided. The findings identified one Consultant, who although he was not individually outside the parameters within his own practice, his revision rate did place SPH in the outlier position (still within green level.) An action plan was sent to the NJR outlining findings and actions taken.

Trust MDT processes have been reviewed and improved. SPH knee revision patients are included in this review process. Since this has commenced, in the last two years, only three cases have required revision surgery.

The Consultant identified no longer works within SPH. Information was shared with the SMT, the Board, MAC members and relevant orthopaedic Consultants throughout the review process.

### 4.18 Datix Incident Reporting.

Datix continues to be utilised for oversite of incident reporting. Weekly ‘Closing the Loop’ meetings have continued throughout the year to assist with the day-to-day management of incidents and to ensure all required processes are followed and all lessons learnt are shared throughout the organisation.

### 4.18.1 Slips, Trips and Falls.

The falls risk assessment tool continues to be used on all admissions and patient leaflets continue to be given to patients at pre-assessment.

Slip, Trip and Fall incidents have remained low since the implementation of hourly nurse walk rounds. The continuance of the 'Harm free Care' monitoring system have evidenced the organisation continues to exceed the National Required Standards.

There were 11 reported cases of a patient slip, trip and fall during 2023-24 (Please see HFC section in the report).

### 4.18.2 Cuts.

There was one reported case of a cut in 2023-24.

- INC1849: Cut (reported 20/05/23) – low harm sustained.

  A patient caught his left forearm on the catch of the door upon entry which resulted in two small skin tears and some bruising to the skin. Appropriate care was provided to the patient.

### 4.18.3 Needlestick Injury.

There were two needlestick related incidents in 2023-24.

- INC1907 and INC1908: Needlestick Injury - Faulty Syringe (reported 02/07/23) – low harm sustained.

Both incidents were low harm incidents. All protocols were followed. Once incident required yellow card to be completed.

### 4.18.4 COSHH.

There were no COSHH related incidents in 2023-24.

### 4.18.5 Injury from fixtures:

There was one reported injury from fixtures during 2023-24.

- INC1894: Injury from Fixtures (reported 25/05/23) – low harm sustained.

  A staff member banged her head whilst undertaking her duties. All relevant protocols followed at time of incident. Staff to ensure that they maintain situational awareness and observe their surroundings whilst undertaking their duties. No sick time was reported following injury.

### 4.18.6 Equipment Failures.

There were 10 reported equipment failures during 2023-24, the majority of which related to the OCT scanner and the ophthalmology IT system. The failures were reported as per protocol and fully addressed at the time of the incidents. The incident references are below, further details of which can be found in the quarterly quality reports. No harm was sustained from these failures.

SPH continues to liaise with external parties regarding replacement scanners and future systems to replace the current ophthalmology centre.

1. INC1820: Equipment Failure – OCT Scanner (reported 27/04/23) – no harm sustained.
2. INC1821: Equipment Failure – Ophthalmology Centre (reported 27/04/23) – no harm sustained.
3. INC1826: Equipment Failure – OCT Scanner (reported 04/05/23) – no harm sustained.
4. INC1884: Equipment Failure – OCT Scanner (reported 16/06/23) – no harm sustained.
5. INC1983: Equipment – Dictation software (reported 26/08/23) – no harm sustained.
6. INC2162: Equipment Failure – OCT scanner (reported 28/12/23) – no harm sustained.
7. INC2183: Equipment failure – OCT Scanner (reported 06/01/24) – no harm sustained.
8. INC2190: Equipment failure - Dictation software (reported 13/01/24) – no harm sustained.
9. INC2216: Equipment failure – Dictation software (reported 23/01/24) – no harm sustained.
10. INC2340: Equipment error (reported 25/03/24) – no harm sustained.

### 4.18.7 Manual Handling.

There were no Manual Handling related incidents in 2023-24.

### 4.18.8 Environmental Aspect incidents.

There were 4 reported environmental incidents reported in 2023-24. The incident references are below, further details of which can be found in the quarterly quality reports.

1. INC1843: Environmental (reported 15/05/23) – no harm sustained.
2. INC1923: Environmental – Car Park Barrier Incident (reported 11/07/23) – low harm sustained.
3. INC1949: Environmental - Sharps Incident (reported 03/08/23) – no harm sustained.
4. INC2036: Near miss - Fire Risk (reported 11/10/23) – no harm sustained.

All required processes were followed.

### 4.18.9 Other:

There were 16 reported ‘other’ incidents during 2023-24. These were due to the following:

1. INC1893: Other - Security – Entrance Doors (reported 21/06/23) – no harm sustained.
2. INC1853: Other – Consultant late clinic (reported 22/05/23) – no harm sustained.
3. INC1832: Other – IG (reported 10/05/23) – no harm sustained.
4. INC1947: Other – Consultant Late (reported 01/08/23) – no harm sustained.
5. INC1952: Other – Consultant cancelled clinic (reported 04/08/23) – no harm sustained.
6. INC2023: Other – Consultant Clinic Delay (reported 25/09/23) – no harm sustained.
7. INC2026: Other – Staff member collapse (reported 28/09/23) – low harm sustained.
8. INC2030: Other – Consultant clinic cancellation (reported 30/09/23) – no harm sustained.
9. INC2048: Other – Cleaning Standards (reported 18/10/23) – no harm sustained.
10. INC2096: Other – Consultant Clinic Over-ran (reported 20/11/23) – no harm sustained.
11. INC2120: Other – Consultant Clinic Over-ran (reported 30/11/23) – no harm sustained.
12. INC2160: Other – Staff accident (reported 19/12/23) – low harm sustained.
13. INC2222: Other – Patient Behaviour (reported 03/02/24) – no harm sustained.
14. INC2228: Other – Staff incident – vasovagal event (reported 05/02/24) – no harm sustained.
15. INC2292: Other – Staff incident – company van collision (reported 29/02/24) – no harm. sustained.
16. INC1919: Manual Handling – Staff scald (reported 09/07/23) – low harm sustained.

Full reports have been provided throughout the year to SMT, the Board and all staff across the organisation.

### 4.19 Staff Wellbeing and Resilience.

Staff Wellbeing has continued to be at the forefront of all strategic and operational decisions and additional support has been provided for staff with:

- Free access to counselling.
- Welfare checks where required.
- Mental Health First Aiders across the organisation.
- Training of Trauma Risk Management Practitioners (TRIM).
- Weekly meditation sessions.

### 4.20 Transition to PSIRF.

The organisation is cruelty reviewing processes for the transition to PSIRF. This is being led by Cheryl Lloyds, Hospital Director for Ashford and Canterbury. Meetings remain on-going with the Kent and Medway Patient Safety Team at the time of writing this report.

## 5. Training.

### 5.1 Organisational Training - Meeting the Demands of a Changing Healthcare Landscape.

SPH understands that staff training, including health and safety training, is not just about compliance - it's also about driving the organisations performance improvement and its organisational impact. Investors In People (IIP) accreditation continued in 2023-24, however, this will not be continued next year. There will remain a clear focus on the training and development of staff.

### 5.2 Kallidus Learning Management System (LMS).

The Kallidus LMS was launched on the 26/07/2023 which replaced the organisations Relias training platform. The Learning and Development (L&D) team were able to upload all learning history from Relias and no data was lost. This prevented any additional repeat training.

Kallidus is an easy-to-use system, with a high level of engagement due to a variety of interactive blended learning approaches. All content is viewed by learners to successfully pass courses allocated to them. Kallidus does not allow skipping onto the next section, until all tasks or questions set have been answered to the set pass mark. This ensures there are no gaps in the knowledge that has been provided and ensures learners are trained to the correct standards and that the required quality outcomes are achieved.

**Key Benefits of Kallidus:**

**Organisational:**

- Impacts on our business results, such as our quality of care and patient satisfaction / experience.

- Assists us to review and build staff development programmes to help improve recruitment and retention.

- Cost effective - by providing consistent high-level training accessible to staff 24/7.
- Promoting a strong culture that successfully navigates change.
- Gives Managers insight into their teams' compliance rates updated in real time.

**Learning and Development:**

- Fulfils the organisations mandatory training requirements.
- Assists to evidence compliance and improve inspection results.
- Improved internal induction training processes.
- Helped to improve career development plans for contracted staff.
- All training that has been completed has the option for learners to review the materials without having to complete the course over again.
- Has an optional library for learners to improve their personal continued development above and beyond mandatory training.
- Aids in the administration of our bespoke Management Learning and Development Programme. Enables notification of dates available and online booking to stream the process that was previously completed manually.
- Allows the L&D function to add monthly focus topics to aid both professional and personal growth of all colleagues.
- Able to upload our own recorded video content to enhance the learning experience of individuals, teams and the organisation.
- External training can be uploaded by the individual learner to show continued CPD, including the amount of time and certificates if available.

**Clinical:**

- Assists with delivering consistent training and skills across the organisation.
- Developed specialised programmes focused on specific needs of the organisation.
- Fostered engagement with staff.
- Able to download training information for revalidation.

Policies and procedures and training videos continue to be added to the learning management system as well as evaluation of training being completed through Kallidus; to assist with clear communication and compliance across the organisation whilst reducing the use of paper and other relevant documentation. This aligns with our internal ISO 9001:2015 and ISO 14001:2015 - Quality and Environmental Management systems.

### 5.3 Mandatory Training for 2023-2024.

Specific training requirements for representatives continue to be met on an individual basis. New staff member training remains ongoing. Staff on long term sick are not included in statistics.

Training has been delivered through the following methods:

- Company Induction programmes
- External national training programmes
- Kallidus training system
- One to one discussions / coaching

**Mandatory training through Kallidus - Site Compliance rates**

| | |
|---|---|
| **BLS** | **97%** |
| **Equality and Diversity** | **94%** |
| **Fire Safety** | **94% (statistic does not include staff who have undertaken bespoke site training by ATC as this is not uploaded to Kallidus.** |
| **GDPR** | **96%** |
| **Information Security** | **94%** |
| **Health and Safety** | **91%** |
| **Moving and Handling.** | **94%** |
| **Safeguarding Children** | **100%** |
| **Safeguarding adults** | **89% (statistic does not yet include staff who have undertaken level 3 face to face as this is yet to be uploaded to Kallidus.** |

New staff members are included in the above statistics and their training remains on-going at the time of writing this report.

Non-compliance of mandatory training is being addressed by the departmental Managers.

**Improvements to be implemented in 2024-25.**

- Recommencement of in-house practical Manual Handling training.
- Review of departmental induction programmes to ensure they reflect department process changes.
- Freedom to Speak Up - Staff training to be included in the orientation of new staff members to raise the profile of the Guardian role and to ensure staff how to raise concerns.

## 6. External Governance Review.

The organization took the opportunity to undertake an external governance review during 2023. The Hospital Directors and SMT are currently working alongside Catherin Pelley to review and number of governance processes.

## 7. ISO Accreditations.

The organisation has continued with both ISO accreditations during 2023-24 which assists with dedicated time to ensure daily staff practice meets with required regulatory and company processes.

### 7.1 ISO 9001:2015 Quality Management System.

- The Quality Management System was fully managed and updated in 2023-24.
- Organisational charts have been updated to reflect staff changes.
- The audit schedule and matrix were agreed for 2024 – internal audits remain on-going.
- The Quality Statement and Policy have been updated.
- The Quality manual has been reviewed and updated.

#### 7.1.1 External Audit.

The external audit was undertaken on 11 April 2023. A full pass was achieved with no non-conformances identified.

### 7.2 ISO 140012:2015 Environmental Management System.

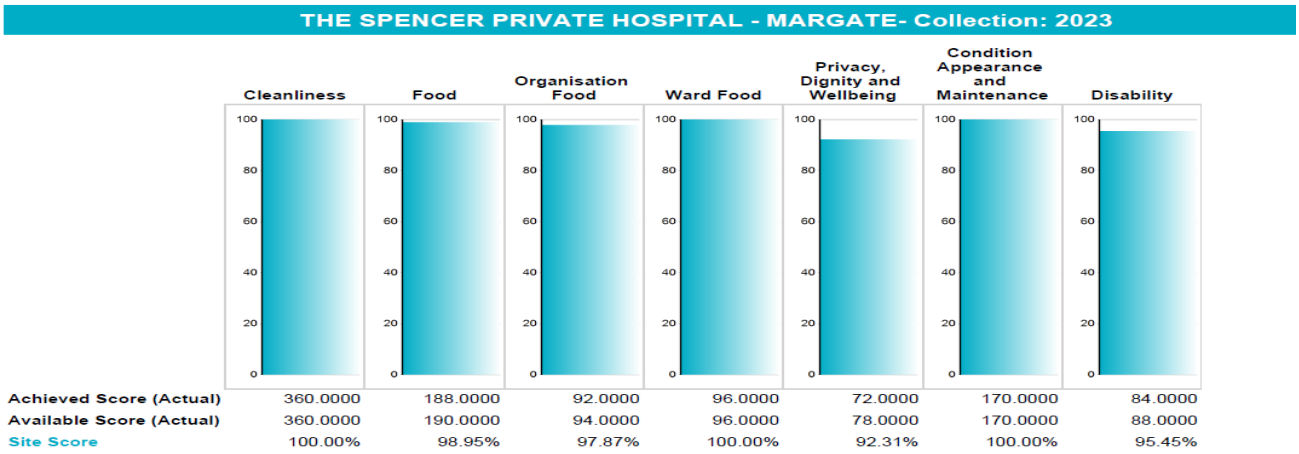
- The Environmental management system was fully managed and updated in 2023-24:
- The environmental manual has been reviewed and updated.
- The Environmental Policy has been reviewed, updated, and displayed on the lower ground floor.
- The Legal Compliance Register has been reviewed and updated.
- The Recycling Policy has been reviewed and updated.
- The Environmental Aspects program has been set 2024 – Audits remain on-going.

#### 7.2.1 External Audit.

The external ISO audit was undertaken on 15 May 2023. A full pass was achieved with no non-conformances. We were commended for the management of the accreditation.

## 8. PLACE Inspection.

The PLACE inspection took place on 09 November 2023. 5 external auditors undertook the audit accompanied by 3 internal staff members. The audit team included 2 EKHUFT independent external verifiers. Inspection findings were submitted to NHS Digital.




## PLACE Benchmarking:

| Organisation Name | Cleanliness Score % | Food Score % | Privacy, Dignity, Wellbeing Score % | Condition, Appearance and Maintenance, Score % | Disability Score % |
|---|---|---|---|---|---|
| SPENCER PRIVATE HOSPITAL - MARGATE | 100% | 98.95% | 92.31% | 100% | 95.45% |
| BMI - THE CHAUCER CANTERBURY | 98.87% | 98.42% | 93.75% | 99.44% | 96.48% |
| EKHUFT- KENT & CANTERBURY | 98.16% | 93.13% | 87.11% | 97.09% | 85.46% |
| EKHUFT - QEQM | 98.54% | 91.44% | 83.04% | 97.54% | 74.15% |
| EKHUFT - WILLIAM HARVEY | 99.62% | 89.74% | 81.36% | 98.09% | 84.60% |
| KIMS | 100% | 92.80% | 88.53% | 100% | 96.40% |
| NUFFIELD TUNBRIDGE WELLS | 92.21% | 97.02% | 88.06% | 97.08% | 79.05% |
| SPIRE TUNBRIDGE WELLS | 98.59% | 95.88% | 72.29% | 93.41% | 48.28% |
| THE HORDER CENTRE | 100% | 94.78% | 93.33% | 96.11% | 86.30 |

| | National Average % | Spencer Private Hospital Scores % |
|---|---|---|
| ➢ Cleanliness | 98.1% | 100% |
| ➢ Food | 90.9% | 98.95% |
| ➢ Privacy, Dignity and Wellbeing | 87.5% | 92.31% |
| ➢ Condition Maintenance and appearance | 95.9% | 100% |
| ➢ Disability | 84.3% | 95.45% |

## 9. Practicing Privileges / Medical Advisory Committee.

The MPAF has been continually monitored throughout the year with improvements made to compliance processes. Monthly monitoring continues to identify areas of non-compliance which have been addressed.

Compliance has been discussed at SMT and Board meetings throughout the year.

## 10. Summary.

Margate has had a successful year with a real focus on quality improvement, recruitment and retention and staff wellbeing. Collaborative working with EKHUFT has developed and improved which has benefited EKHUFT, SPH and the patients who have received care at the hospital.

The Board of Directors are asked to receive this paper for information and assurance.

**Lynn Orrin**
**Hospital Director**
**2nd May 2024.**