Spire Hesslewood Clinic

Quality Report

Nightingale House
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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

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Hesslewood Clinic is operated by Spire Healthcare Limited. The clinic primarily serves the communities of the East Riding of Yorkshire and Hull. It also accepts patient referrals outside of this catchment area.

Spire Healthcare Limited acquired Spire Hesslewood Clinic in 2014. After a six-month commissioning period Spire Hesslewood Clinic began caring for patients from February 2015 on a 'walk in, walk out' basis. There are two theatres, where minor procedures were performed under local anaesthesia and outpatient consulting rooms at the clinic, which offered dermatology, Botox, chronic migraine, dietetics, podiatry, orthotics, rheumatology and outpatient ophthalmology services. The clinic operates as a satellite to the main site, Spire Hull and East Riding Hospital. The hospital is located approximately one and a half miles north of the clinic. The clinic is under the same management structure. Staff are 'flexed' across the two sites, which also share the same medical advisory committee, senior management team, a single medical records storage site, policies and procedures. The two sites also have a combined data collection process and clinical dashboard, meaning that data was not available at a site-specific level for Spire Hesslewood Clinic.

Services were provided to children and adults of all ages (0 to 75+) and were offered to NHS, insured and privately funded patients. The service had six consulting rooms at the Hesslewood clinic.

We inspected this service using our comprehensive inspection methodology. The inspection was unannounced (staff did not know we were coming) and took place from 18 to 20 September 2018.

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

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

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

Services we rate

Our rating of this service stayed the same. We rated it as good overall.

- Staffing was managed safely across all services. We found there were enough staff with the appropriate skills, experience and training to keep patients safe and to meet their care needs. The clinic was visibly clean and well maintained. Incidents were reported and the quality of root cause analysis (RCA) investigations was more robust. Mandatory training compliance was at or above trajectory including safeguarding of vulnerable adults and children.
- Patients, including children and young people were cared for effectively using evidence based best practice guidance. Policies were mostly developed nationally. Staff across the services had received an up to date appraisal and had the right knowledge and skills to care for patients. Consent to care and treatment was obtained appropriately. There were clinical performance indicators which were monitored and compared across the company through a clinical scorecard. We saw effective multidisciplinary working between staff of all grades. All staff caring for children and young people were required to have completed paediatric competencies and have up to date training in safeguarding level three and life support, appropriate to their role.

Summary of findings

- Patients were cared for in a kind, caring and compassionate way. Patients and relatives, we spoke gave consistent feedback without exception. We observed positive interaction of staff with patients. We found that the services received positive feedback for the Friends and Family Test. Staff told us they took practical steps to maintain privacy and dignity and to minimise anxiety of children and young people. Staff we spoke with demonstrated a sensitive and supportive attitude to children and young people, parents and carers. Private consulting rooms were available
- The services were planned and managed to meet demand. In the twelve months from August 2017 to July 2018 referral to treatment (RTT) data for July 2017 to August 2018 showed that 100% of patients commenced treatment within 18 weeks. This meant the clinic had consistently exceeded the standard of 90%. There was personalised, patient-centred care provided for patients living with a learning disability and dementia. There were dementia link nurses in place. Complaints were managed and overseen by the hospital director and clinical complaints specifically overseen by matron. The reduction of avoidable cancellations was a priority and processes and systems within the pre-operative assessment team were under review. Registered children's nurses worked at both Hesslewood clinic and the main Spire Hull and East Riding hospital site as required to support children and young people attending outpatient appointments and procedures at Hesslewood, as required. Staff told us appointments and admissions were planned flexibly to meet children and young people's needs. The service had received no complaints from families of children and young people relating to Hesslewood clinic.
- The clinic had a clear management structure in place with clear lines of responsibility and accountability. The manager had the right skills and abilities to run a service providing high-quality sustainable care. Staff of all grades told us leaders and the senior management team were extremely supportive, visible and approachable. Staff of all grades spoke positively about the culture and told us they were passionate about their roles and the organisation. Professional relationships between all staff promoted the clinic values and staff said they felt valued and worked well together. There was a robust clinical strategy action plan in place. Although, there is no requirement for independent healthcare providers to have a freedom to speak up guardian (F2SUG), a member of staff had been appointed to this role. We found that governance processes had improved and were more robust. Minutes of the MAC meeting were detailed and included comprehensive governance information. Consultants were utilised under practising privileges and these, with appraisals were reviewed every year by the senior management team. The governance of the children's and young people's service was now clearly defined and linked to the governance processes for the whole service. A children and young peoples (CYP) clinical score card system had been introduced to support structured monitoring of quality, performance and patient outcomes. There was a positive culture across all staff involved in the delivery of children and young people's services. All staff spoke highly of the support they received from the children and young person's lead nurse. The CYP service had identified its risks and had taken action to mitigate them. The service lead had developed links with the local safeguarding networks and visited the regional transfer team.

However, we also found the following issues that need to improve:

- There was no separate waiting area for children, toys and activities provided were located on the main route into the clinic. Action plans following audits were often documented as single actions without detailing any subsequent actions or cooperation by other departments or disciplines. Whilst policies and guidelines were evidence based we found out of date paper versions of policies and protocols held in a reference file in the clinic area. There were up to date versions on the staff computer server. The friends and family test (FFT) feedback was positive however response rates were low. There were high numbers patients affected by cancelled and rearranged clinics. We did not see a comments book or other ways for children and families to give feedback on the service at the Hesslewood clinic. It was unclear whether the CYP service was sufficiently represented at senior level to influence and support strategic developments involving children and young people. The planned children and young people's service staff steering group was still in development.

Following this inspection, we told the clinic it should make some improvements, even though a regulation had not been breached, to help the service improve.

Ellen Armistead

Summary of findings

Deputy Chief Inspector of Hospitals (North Region)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity at the clinic. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was safe, effective, caring responsive and well-led.
Services for children and young people	Good 	Children and young people's services were a small proportion of the clinics activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. We rated this service as good because it was safe, effective, responsive and well led. We did not observe any children or young people being cared for at the time of our inspection therefore we were unable to rate caring.
Outpatients	Good 	We rated this service as good because it was safe, caring responsive and well-led. We do not rate effectiveness for outpatients.

Summary of findings

Contents

Good

Spire Hesslewood Clinic

Services we looked at:
Surgery, Services for Children and Young People and Outpatients.

Summary of this inspection

Background to Spire Hesslewood Clinic

Spire Hesslewood Clinic is operated by Spire Healthcare Limited. The clinic primarily serves the communities of the East Riding of Yorkshire and Hull. It also accepts patient referrals outside of this catchment area.

Spire Healthcare Limited acquired Spire Hesslewood Clinic in 2014. After a six-month commissioning period Spire Hesslewood Clinic began caring for patients from February 2015 on a 'walk in, walk out' basis. There are two theatres, where minor procedures were performed under local anaesthesia and outpatient consulting rooms at the clinic, which offered dermatology, Botox, chronic migraine, dietetics, podiatry, orthotics, rheumatology and outpatient ophthalmology services.

The clinic operates as a satellite to the main site, Spire Hull and East Riding Hospital. The hospital is located approximately one and a half miles north of the clinic. The clinic is under the same management structure. Staff are 'flexed' across the two sites, which also share the same medical advisory committee, senior management team, a single medical records storage site, policies and procedures. The two sites also have a combined data collection process and clinical dashboard, meaning that data was not available at a site-specific level for Spire Hesslewood Clinic.

Services were provided to children and adults of all ages (0 to 75+) and were offered to NHS, insured and privately funded patients. The service had six consulting rooms at the Hesslewood clinic.

The two sites are registered separately with CQC.

Our inspection team

The team that inspected the service comprised a CQC lead inspector Kerri Davies and three other CQC inspectors. There were also three specialist advisors with expertise in governance, surgery and children and young peoples services. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Why we carried out this inspection

We inspected this hospital as part of our independent hospital inspection programme. There were no special reviews or investigations of the hospital ongoing, by the CQC, at any time during the 12 months before this inspection.

How we carried out this inspection

During the inspection we visited the Hesslewood clinic outpatient areas and theatres. We observed the environments, checked equipment and looked at patient information. We also reviewed performance information.

As part of the inspection process, we spoke with five members of staff. Staff we spoke with included managers, nurses, doctors, and support staff.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during the 12 months before this inspection.

Summary of this inspection

Information about Spire Hesslewood Clinic

The clinic had outpatient consulting rooms and two theatres, where minor procedures were performed under local anaesthesia. The clinic offered dermatology, Botox, chronic migraine, dietetics, podiatry, orthotics, rheumatology and outpatient ophthalmology services and operates as a satellite to the main site, Spire Hull and East Riding Hospital.

The service has been inspected once before, in September 2015, at that time we rated the clinic as good overall. We issued one requirement notice in relation to Regulation 17 HSCA (RA) Regulations 2014 good governance. We were provided with an action plan, which was regularly reviewed by CQC, to provide us with assurance that the clinic had met the requirements.

The clinic is registered for the following regulatory activities:

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

Activity (August 2017 to July 2018). Spire Hull and East Riding Hospital and Spire Hesslewood Clinic have a combined data collection process and clinical dashboard, meaning that data was not available at a site-specific level for the clinic.

- There were 38140 outpatient total attendances in the reporting period. Data given below includes the outpatient and physiotherapy services provided at Spire Hull and East Riding Hospital, Lowfield Clinic, the Diadem outreach clinic and Hesslewood Clinic unless otherwise stated.
- From August 2017 to July 2018, there were 38,140 outpatient and physiotherapy attendances, 830 (around two per cent) of these were children's outpatient attendances; four appointments were for children aged 0 - two years, 607 were for three -15 years and 219 were for 16-17 years.
- From August 2017 to July 2018, 85% of patients seen were NHS funded and 15% were private patients. During this period, 8,736 NHS and 2,046 private patients attended for first appointments and 23,496 NHS and 3,862 private appointments were follow-ups. New to follow up ratios were 1 to 2.7 for NHS funded patients and 1 to 1.9 for privately funded patients.
- The hospital and clinic employed 238 surgeons, anaesthetists, physicians and radiologists across the two sites under practising privileges. There were also264 wte staff employed by the hospital and clinic at the time of the inspection, 476 staff in total including bank staff. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety

- There had been no reported never events, at the clinic, in the period August 2017 to July 2018.
- From July 2017 to June 2018 there had been 828 clinical incidents across Spire Hull and East Riding Hospital and Spire Hesslewood Clinic, the majority (705) were reported as no harm, 57 were low harm, 61 were moderate harm, one was severe harm. There had been four deaths reported and 27 serious incidents requiring investigation.
- The clinic had no reported incidents of healthcare acquired Methicillin-resistant Staphylococcus aureus (MRSA), healthcare acquired Methicillin-sensitive staphylococcus aureus (MSSA), healthcare acquired Clostridium difficile (C. diff) or healthcare acquired Escherichia coli (E-Coli).
- There had been 79 complaints across both the hospital and the clinic from August 2017 to July 2018.

Services accredited by a national body:

- Société Générale de Surveillance(SGS) Accreditation for Sterile Services Department.
- British United Provident Association (BUPA).
- United Kingdom Accreditation Service (UKAS).
- Macmillan (Level 5).

Services provided under service level agreement:

- Clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Laser service
- Laundry
- Maintenance of medical equipment
- Non-clinical waste removal
- Occupational health
- Pathology and histology
- Radiation protection

Summary of this inspection

- RMO provision
- Staff agency
- Blood Transfusion

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were enough skilled staff to deliver the service. Including provision for children and young people, for example children's nurses would come to the Hesslewood clinic as required, for example if a child or young person was having a surgical procedure or pre-assessment.
- Mandatory training compliance was at or better than the planned level for the time of year.
- Staff understood their responsibilities in relation to safeguarding children and vulnerable adults and knew how to raise a concern.
- Risk assessments had been undertaken in relation to patient safety, the environment and staff safety. The service had a Laser Protection Adviser and was compliant with safety requirements.
- The departments and equipment were clean, well maintained and suitable for their use.
- Incidents were reported, managed appropriately and learning was shared.

Are services effective?

Good

We rated effective as good because:

- Policies and protocols for adults and children were based on evidence-based guidance and were easily accessible to staff.
- A separate clinical scorecard, had been introduced, to monitor the effectiveness of care and treatment for children and young people including patient outcomes.
- Staff completed a specific programme of quarterly audits of children's services which underpinned the clinical scorecard and used the findings to benchmark against other similar services and improve services.
- Staff measured patients pain before during and after treatments to determine progress and effectiveness.
- The clinic used data from patient outcomes and audit to adapt patient care and improve patient experience.
- Staff were competent and received regular performance reviews.
- All staff caring for children and young people were required to have completed paediatric competencies and have up to date training in safeguarding level three and life support, appropriate to their role.

Summary of this inspection

- Staff demonstrated knowledge and understanding of the Mental Capacity Act and consent.

However, we also found the following issue that the service needs to improve:

- Action plans following audits were often documented as single actions without detailing any subsequent actions or cooperation by other departments or disciplines.
- Whilst policies and guidelines were evidence based we found out of date paper versions of policies / protocols held in a reference file in the clinic area but there were up to date versions on the staff computer server.

Are services caring?

Good

We rated caring as good because:

- Staff were passionate about providing the best possible service and experience for their patients.
- Patients reinforced their positive experience this by telling us that 'it was a really good experience using services at the clinic and that all staff were always polite and helpful.'
- Staff involved patients in decisions about their care and treatment and were given time to ask questions and to make sure they understood what was to happen.
- Staff told us they took practical steps to maintain privacy and dignity and to minimise anxiety of children and young people.
- Staff we spoke with demonstrated a sensitive and supportive attitude to children and young people, parents and carers. Private consulting rooms were available.

However, we also found the following issue that the service needs to improve:

- FFT feedback was positive however response rates were low.

Are services responsive?

Good

We rated responsive as good because;

- Service planning was responsive to the needs of local people and supported delivery of services offered by local NHS trusts.
- There was a wide range of services offered and they were available to NHS, self-funding and insured patients.
- The staff worked hard to meet people's individual needs and to improve access and flow.
- Staff had access to interpreter and translation services when needed.

Summary of this inspection

- The service took complaints seriously and responded in a timely manner. There were examples where improvements had been made because of complaints.

However, we also found the following issue that the service needs to improve:

- There were still high numbers patients affected by cancelled and rearranged clinics.
- There was no separate waiting area for children, toys provided were located on the main route into the clinic.
- We did not see a comments book or other ways for children and families to give feedback on the service at the Hesslewood clinic.

Are services well-led?

Good

We rated well-led as good because:

- The clinic had a clear management structure in place with clear lines of responsibility and accountability.
- Staff spoke highly of their immediate line managers and the hospital leadership team and felt they were listened to and engaged in the organisation.
- Staff had been involved in developing a vision for their own areas of work.
- Staff described the culture as open and there were governance processes in place that supported management of risks, issues and performance and ensured shared learning from incidents and complaints.
- The service took patient feedback seriously and had a desire to learn and improve.

However, we also found the following issue that the service needs to improve:

- It was unclear whether the CYP service was sufficiently represented at senior level to influence and support strategic developments involving children and young people.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Not rated	Good	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

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

Mandatory training

- The service set target for mandatory modules of 95% for all staff by the end of the calendar year. We were told all staff must complete annual mandatory training, both on line and face to face as appropriate. Staff said they had undertaken all mandatory training required for their role.
- Information provided showed the target had been met for all mandatory training modules at the end of 2017, for example equality and diversity (98%), fire safety (98%), infection control (97%), safeguarding adults levels one and two (97%) and safeguarding children levels one and two (96%).
- All staff had undertaken safeguarding training and there were safeguarding leads for the clinic in place.
- We reviewed mandatory training compliance rates at the time of inspection when it would be expected that approximately 75% of staff would have completed mandatory training, in line with the calendar year training programme.
- All modules of training were ahead of trajectory to achieve the expected level of 95% by the end of the year. For example, health and safety (84%), manual handling (90%), safeguarding children levels one and two (82%) exceeded trajectory.
- The registered manager was responsible for monitoring compliance with training by clinicians working under practising privileges and who had received mandatory training from their substantive employer.
- During review of personnel documents we received assurance this monitoring was being undertaken for medical staff, mandatory training records were completed and checked with substantive employers.

Safeguarding

- There was a safeguarding adults policy (October 2016) and a safeguarding children policy (June 2017) in place at the clinic and these were supported by clinical, departmental, safeguarding and education strategies. The policies identified the responsibilities for the safeguarding responsible manager (hospital manager) and the safeguarding responsible person (clinical lead).
- We saw information relating to safeguarding displayed at the clinic.
- The clinic provided adult safeguarding training and children safeguarding training to all staff which included Deprivation of Liberty Safeguards (DoLS) and counter terrorism training (PREVENT). This was mandatory at level two for every member of staff.
- The safeguarding lead for adults and children and young people across both sites was the clinical lead. The clinical lead was able to clearly define their responsibilities in relation to safeguarding adults and children.
- The clinical lead attended the Local Safeguarding Children Board (LSCB). These are a multi-agency body set up in every local authority.Where necessary we were told the lead would also liaise with the clinical commissioning groups.

- All safeguarding incidents at the clinic were reported through the electronic incident reporting system, all immediate actions taken to safeguard the individual were logged and a referral sent to the local authority safeguarding team.
- All consultants at the clinic, who wished to have practicing privileges to deliver care and treatment, were required to undertake safeguarding training.
- All children's registered nurses, support staff involved in the care of children and consultants registered to provide services to patients under the age of 18 had received safeguarding children training at level three.
- The clinic was in the process of ensuring all safeguarding training at level three was delivered in accordance with 'Adult Safeguarding Levels and Competencies for Healthcare, Intercollegiate guidance (2016)'.
- Staff we spoke with had a clear understanding about what constituted abuse and the action to report and record allegations of abuse.
- Information provided showed there had been no safeguarding concerns raised at the clinic in the three months before inspection.

Cleanliness, infection control and hygiene

- The matron was the director of infection prevention and control (DIPC) and had an appropriate post graduate accredited qualification. In addition, the service had appointed a lead nurse for IPC.
- The IPC team were able to access help and support from a designated consultant microbiologist employed corporately on a service level agreement basis. In addition to this the lead nurse told us they had positive working relationships with the microbiology team at the local acute trust.
- The clinic was visibly clean and tidy. We saw cleaning and the relevant checklists being completed.
- The hospital and clinic's infection prevention and control manual (November 2015), policies and procedures were based on Department of Health and Social Care's codes of practice on the prevention and control of infections.
- The manual included guidance on hand hygiene, the decontamination of reusable medical devices, the use of personal protective equipment (PPE) and the management of the spillage of body fluids.
- The service carried out hand hygiene audits and the outcome and action plans were shared with staff through team meetings. Across surgery there was above 90% compliance from January to June 2018. We saw that staff adhered to 'arms bare below the elbow' policy in clinical areas and used PPE as appropriate.
- Specialised ventilation is a statutory requirement in operating departments and a clinical requirement to reduce surgical site infections. Increased health risks to patients will occur if ventilation systems do not achieve and maintain the required standards. The link between surgical site infection and air quality is well established (Health technical memorandum 03-01: specialised ventilation for healthcare premises).
- The 'Health Act 2006: code of practice for the prevention and control of healthcare associated infections', sets out criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment and where the risks of infection are kept as low as possible. This applies because the services care for NHS patients.
- We reviewed ventilation verification reports and noted theatres at the clinic achieved greater than 75% of the original design parameters as required in 4.16 HTM 03-01-part B.
- Access to theatres was restricted and there were separate clean and dirty utility areas to reduce the risk of infection.
- Antibacterial hand gel dispensers were available at the entrance and within clinical areas. We saw staff used these and washed their hands between patient contact.
- All surgical patients were screened for MRSA pre-operatively. Information provided by the hospital did not indicate compliance rates for screening. However, we noted from minutes from the IPC committee meeting that outcomes were documented, the minutes showed one patient had their surgery delayed to allow for suppression therapy. A further 27 patients had been given suppression therapy pre-operatively and their surgery carried out as planned.
- Staff followed guidance (Sharp Instruments in Healthcare) Regulations (2013) on sharps management and bins were clearly labelled and tagged to ensure appropriate disposal and prevent cross infection.
- The main hospital had an onsite sterile services department which was accredited by SGS, where all reusable equipment was processed. The service was subject to regular inspections, the most recent being at

the time of our inspection. There were policies, work instructions and risk assessments linked to the management of the service, which were approved by SGS and used nationally across the Spire group.
- Water testing processes were in place and governed by policies.

Environment and equipment

- The environment was tidy and clinical areas were well maintained, bright, secure and welcoming.
- We saw that clinical and non-clinical waste was segregated, stored and disposed of appropriately.
- Daily checks of all resuscitation equipment were carried out and records of these were seen during the inspection.
- We saw that all equipment used during surgery had been checked, calibrated and serviced; records of these checks were kept.
- Staff confirmed they had all the equipment they required to carry out their role.
- We reviewed patient led assessment of the care environment (PLACE) audit results across the surgical service and noted that the environment was scored at 87%, the same as the national average.

Assessing and responding to patient risk

- The clinic followed clear admission criteria. All patients were referred for treatment by their GPs or self-referred.
- Pre-operative assessment was undertaken, information shared with patients and diagnostic investigations were undertaken prior to any decision on whether surgery would be offered. This took account of high risk patients, for example such as those with higher body mass index.
- The World Health Organisation (WHO) surgical safety checklist (five steps to safer surgery) is guidance to promote safety of patients undergoing surgery. This sets out what should be done during every surgical procedure to reduce the risk of errors.
- We were provided with results of WHO audits (99% compliance) and also observed surgeons worked well with the theatre team to ensure that the WHO recommendations for theatre safety were followed and that there was emphasis on the management of specific risks.
- We saw that staff were fully engaged in the process and patients were also involved as appropriate.
- Following surgery patients were provided a 24-hour helpline for advice and this included direct access to the surgeon. Following surgery, consultants gave patients their contact details and patients told us they felt reassured that help was available if needed.
- The services had protocols for transfer to the local NHS trust for patients whose condition deteriorated and required acute care and support.
- Venous thromboembolism (VTE) screening rates were good across the surgical service with 99% of all patients screened in the last twelve months.
- There was a recommended two-week cooling off period for cosmetic surgery patients, however, we were told that if patients wish to go ahead to surgery within two weeks they could sign a disclaimer. The audit covering the period from January 2018 to March 2018 showed full compliance with the cooling off period requirement. Most cosmetic surgery patients were referred to Spire by their GP. The cosmetic policy had recently been revised and included the need for psychological assessment and liaison with GPs if felt necessary for self-referring patients.

Nursing and support staffing

- Staffing was managed across the main hospital site and the clinic. During the inspection we saw that staffing at the clinic was appropriate to meet the needs of patients. We were not provided staffing figures by site therefore were unable to report specific data for the clinic.
- Information provided showed the service employed 0.8 registered nurses (17.5 whole time equivalent (wte)) for every registered operating department practitioner and healthcare assistant employed (22.7 wte) within theatres across both sites.
- An average of 6% bank and agency registered nurses were used within theatres over the six months before inspection.
- Information provided also showed 14% bank and agency operating department practitioner and healthcare assistants were used within theatres over the six months before inspection.
- At the time of inspection there was approximately six wte vacancies in theatres.
- From August 2017 to July 2018 there was a staff turnover rate of 24% for theatre nurses and 46% for operating department practitioner and healthcare assistants.

- All surgical procedures were planned and the clinic did not provide emergency care; referrals were made to the local NHS trust when needed.
- We saw there were adequate and safe numbers of skilled staff in all areas and this was confirmed by patients, relatives and carers.

Medical staffing

- The hospital and clinic employed medical staff under practising privileges approved under comprehensive policies and procedures by the medical advisory committee (MAC).
- The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services
- The MAC provided medical supervision and was responsible for reviewing and monitoring clinical practices for the service.
- The organisations process for granting practising privileges included checks with the disclosure and barring service (DBS), General Medical Council (GMC) registration and appropriate qualifications.
- A contact list was maintained for all doctors with practising privileges and the consultant surgeon was responsible for ensuring alternative anaesthetic cover if their usual anaesthetist was not available.

Records

- Patients' records were kept in paper format and stored securely and complied with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). The hospital and clinic were registered with the Information Commissioner's Office.
- The surgical register in the operating theatre was completed and recorded procedures undertaken, names of surgeon and scrub nurse, the time each patient entered and left theatre, the patient's name and unique identifier as well as implants and swab counts.
- Administrative staff ensured patients' records were available for clinics. The clinic confirmed 100% of patients were seen with all relevant medical records available in the three months before inspection. Staff confirmed there had not been any instance of records not being available.

Medicines

- Access to pharmacy services was available at the Spire Hull and East Riding Hospital site.
- Medicines were stored safely and securely and processes were in place to ensure these were safe for use. These included the recording of receipt, storage, use and reconciliation of medicines.
- We carried out checks of medicines and found these were in date and entries in the control drug (CD) register were completed appropriately with two staff members' signatures in compliance with policy.
- All medication cupboards were appropriately locked and keys held by nursing staff. Intravenous fluids were stored in locked cupboards and CDs were stored securely in wall mounted cabinets.

Incidents

- Policies and procedures for incident reporting were available to staff and they were confident in using the system to report and record these.
- There had not been any never events in the last twelve months at the clinic. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had received training and had a good knowledge of the procedure to follow.
- The organisation reported 828 clinical incidents, across both sites from July 2017 to June 2018. Of these 823 resulted in no harm, low harm or moderate harm. During the same period the hospital and clinic reported 189 non-clinical incidents.
- All incidents and near misses were reported onto the electronic system and investigated with serious incidents requiring investigation (SIRI) subject to root cause analyses (RCA).
- There were mechanisms to ensure lessons learned were identified and improvements made were necessary. We saw that RCA were undertaken for all serious incidents requiring investigation and lessons learnt, recommendations and shared learning formed part of the root cause analysis.

- Five staff had completed RCA training in 2018 to ensure the quality and management of RCA investigations.
- Incidents were discussed at the medical advisory committee (MAC) and learning was shared locally through staff meetings. Incidents discussed at the MAC were raised with the relevant surgeons by the registered manager.

Emergency awareness and training

- The clinic was not a receiving area for major incidents.
- The hospital and clinic had a business continuity plan in place which provided the organisation with recovery procedures to re-establish business operations following a major business interruption, leading up to a total loss of premises.
- The plan identified roles and responsibilities of all staff in an emergency situation, the composition of the internal emergency response team and the local response and recovery team.
- The plan also identified incident alert and escalation procedures, evacuation procedures during working hours and the emergency response outside working hours.
- The plan had been tested through resuscitation and paediatric scenarios.
- The organisation had a contract in place with a private company to urgently deliver blood if required.

Are surgery services effective?

Good

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

Evidence-based care and treatment

- The service used a range of tools to monitor and benchmark performance against other hospitals in the group. These included, for example, the national clinical scorecard, children and young people's dashboard, and national audit programmes for effective management of cancer patients.
- The service used evidence-based care pathways as commissioned and developed by the company's head office. Care pathways were based on clinical guidelines from established and recognised bodies, for example The National Institute for Health and Care Excellence (NICE) and covered a range of procedures.
- The service had a clinical audit programme and clear approach to policy management. The services completed national and local audits and discussed these at relevant governance meetings.

Nutrition and hydration

- The service collected and reported patient feedback on nutrition and hydration, as well as a number of other measures, through the patient feedback form.
- Patients' were offered drinks, biscuits and sandwiches, free of charge, to meet their individual needs.
- Diabetic patients were identified at pre-operative assessment and an individual care plan developed with the surgeon and anaesthetist.
- Malnutrition universal screening tool (MUST) assessments were completed during pre-assessments.

Pain relief

- Patient feedback on pain relief was benchmarked against other hospitals within the company and showed the services were above the national group average.
- Patients' pain was assessed during and after procedures. Pain scores were checked with patients and documented by staff and appropriate pain relief provided.
- We saw nursing staff provided patients with advice on pain relief when preparing patients for discharge.
- Local audits showed 100% of patients had pain scores recorded within their notes in the six months before inspection.
- Patients consultants were available to provide advice if patients complained of pain after surgery.

Patient outcomes

- A number of patient outcomes were measured and reported through the company's clinical scorecard. The clinical scorecard was used to benchmark the services against company comparators for key performance indicators.
- Data sets included returns to theatre, readmissions, transfers, surgical site infections, VTE, falls and pressure ulcers. Data was combined for the clinic and the hospital site and there was an action plan to address any concerns. We were provided evidence of improvement over time with scorecard measures.
- The organisation submitted data to national audits to allow results to be monitored and benchmarked.

- Performance was reviewed at the clinical audit and effectiveness committee, clinical governance committee and at the MAC. We saw actions were taken to reflect outcomes and performance.

Competent staff

- Records showed that 100% of nursing staff and operating department practitioners in post more than six months had their registration validated in the last twelve months.
- Newly appointed staff underwent an induction process including a supernumerary period at the start of employment.
- Bank staff had a longer induction and agency staff also went through a standardised induction checklist delivered by the senior nurse on duty.
- Data provided showed that 100% of theatre staff had received an appraisal within the last twelve months.
- Consultants worked at the clinic through practising privileges which were reviewed every year by the senior management team and the MAC. This review included appraisal and performance.
- All consultants limited their practice to those sub-specialist areas that they also practice in the NHS. Any patient who presented with a condition outside of their sub-specialist expertise was referred on to an appropriate clinician.

Multidisciplinary working

- We saw effective multidisciplinary working between staff of all grades at the clinic. Professional relationships between all staff promoted the values of the hospital and the clinic. Staff said they felt valued and worked well together.
- All consultants had a good working relationship with the theatre teams and followed common processes.
- There was an established process for multi-disciplinary team discussion of all cancer and cardiology patients prior to commencement of treatment. Local audits showed 100% of cancer patients had evidence of multi-disciplinary team discussion recorded within their notes.
- Treatment was well co-ordinated between theatres and other departments, patients confirmed their treatment was seamless when transferred between departments.
- Access to physiotherapy, imaging services and pharmacy provision was available from the main hospital if needed.

Seven-day services

- Services at the clinic took place from Monday to Saturday. Evening clinics were also available to support patients who were unable to attend during the day due to work or other commitments.
- Theatres had the potential to function six days a week as service demanded.
- Access to consultants in charge of care was available 24 hours a day. Should a surgeon be on leave, cover was locally agreed with another consultant with practising privileges.
- The hospital and clinic had service level agreements in place for 24-hour access to pathology, sterile supplies, supply of blood and blood components, pharmacy, haematology malignancy diagnosis and critical care transfer of adult and paediatric patients with local NHS trusts.

Health promotion

- The hospital and clinic had negotiated a health promotion commissioning for quality and innovation (CQUIN) with the local clinical commissioning group (CCG) to monitor smoking and alcohol consumption.
- The clinic had provided training to staff to provide relevant advice to patients.
- Information provided showed the clinic had provided advice and the respective CCG leaflet to 100% of smokers and 54% of patients with alcohol intake.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The clinic gained consent in a two-step process. Patients were given a full explanation of their proposed procedure and associated risks at a pre-operative assessment up to two weeks before surgery. On the day of surgery patients signed and dated the consent form to confirm they understood their procedure and risks and wanted to continue.
- Local audits had been introduced to monitor compliance with consent procedures and evidence of consent in patient notes. These showed 100% compliance with consent requirements.
- We reviewed patient notes and confirmed consent was discussed at pre-operative assessment, on the day of surgery and recorded appropriately.
- We saw that clinicians confirmed consent had been obtained and discussed treatment with the patient.

Patients confirmed they were given clear information about their treatment options and that consultants had discussed the benefits and risks of surgery and answered their questions before giving consent to proceed.

- The services had a policy and associated procedures for consent which complied with the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Staff understood their responsibilities in obtaining informed consent and the process to determine best interest decisions. Capacity to consent was assessed as part of pre-operative assessment.
- Staff confirmed that all patients considering cosmetic surgery were given a 'cooling off period' to consider treatment options.

Are surgery services caring?

Good

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

Compassionate care

- We saw that patients were treated with care, compassion, and respect by all staff. During the inspection we observed patients were greeted professionally on their entrance to the clinic and directed to the relevant service.
- The clinic promoted privacy and dignity for patients, particularly when they were transferred from trolleys and chairs.
- Friends and Family test (FFT) audits of patient feedback provided showed that 98% of patients said they would recommend the clinic to a friend or relative. However, the response rate was low (between 10% and 24%).
- We saw there were high levels of patient satisfaction, evidenced through surveys and compliments.
- Patient led assessments of the care environment (PLACE) showed that privacy, dignity and well-being was scored at 85% compared to a national average for all acute providers of 83%.
- We saw that consultants greeted patients in a warm and friendly manner for their appointments and patients confirmed they had built up good relationships with their consultant.

Emotional support

- We saw staff explaining treatments and procedures to patients and saw that all questions were answered and patients given time to understand the responses given. Consultants confirmed they would give additional time to any patient who needed a longer discussion.
- Patients confirmed staff had supported them when they arrived for their procedure and felt reassured following discussion with staff and were well prepared for treatment.

Understanding and involvement of patients and those close to them

- Patients told us they were fully involved in their care and treatment and they felt able to ask for further details and explanation about any aspect of their treatment.
- They told us treatment had been explained and their questions were answered fully by both nursing and consultant staff.
- Patients said they had been involved in their discharge planning.
- All patients said their privacy and dignity needs were respected.
- We saw that patient notes recorded pre-operative discussion, confirmation of consent and contact during admission and post-operatively to provide support and information.
- Patients received information including the cost of surgery in writing prior to their appointment.
- Written information about post-operative care was given to all patients and we saw staff talk to patients about their aftercare.
- Dementia champions were in place across the service and one to one nursing in place where required. The service had adopted 'John's campaign' and 'Barbara's campaign' (campaigns to ensure staff have the skills to nurse dementia patients with sensitivity, compassion and empathy and support carers with compassion and respect).

Are surgery services responsive?

Good

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

Good

Surgery

Service delivery to meet the needs of local people

- The services at the clinic were planned to meet the needs of the local population.
- The clinic had a policy which outlined the inclusion and exclusion criteria for surgical patients.
- Patients were referred to the surgeon of their choice where possible and seen by that consultant throughout their treatment ensuring continuity.
- The clinic offered surgery and outpatient appointments on certain days of the week and in the evenings and weekends where possible; appointment and treatment times were undertaken at a time suitable to the patient when possible.
- Pre-admission assessment appointments were provided which were convenient to the patient where clinically appropriate.

Meeting people's individual needs

- Patients were provided with information leaflets regarding risks and benefits of surgery and were able to review these before their procedure.
- Toilets, including disabled access facilities were available throughout the clinic for patients, carers and relatives.
- The clinic offered access to translation services for patients where English was not their first language.
- The services used the Spire Healthcare Limited consent policy which gives advice for staff on when an interpreter is required and clearly notes that; 'it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English.' Family members should not be used as interpreters in any clinical matter. We saw that information was displayed advising of this. We discussed our concern with the senior team who acknowledged this and advised that they would raise the concern about the wording in the policy with the Spire corporate team.
- We were told that a patient experience committee was in the process of being established and that patient forums had been introduced and scheduled.

Access and flow

- Patients were referred to the clinic by their GP, self-referral or NHS referral.
- Referral to treatment (RTT) data for July 2017 to August 2018 showed that 100% of patients commenced treatment within 18 weeks. This meant the hospital had consistently exceeded the standard of 90%.
- There was a process in place for patients who missed or did not attend their appointments as planned. Staff would contact them by phone and patients would be offered alternative dates as appropriate.
- Patient records confirmed staff completed appropriate discharge summaries and these were communicated to GPs in a timely manner.

Learning from complaints and concerns

- Complaints were managed and overseen by the hospital director and clinical complaints specifically overseen by matron. The tracking of complaints was managed by the governance administrator who ensured documentation was uploaded to the electronic system, shared with relevant staff involved in the investigation and that timescales were met.
- Complaints data and learning was presented at the MAC, clinical governance committee, clinical audit and effectiveness committee and relevant complaints were discussed in team meetings.
- For shared learning, complaints were discussed at safety huddles, team meetings, the clinical governance committee, the audit and effectiveness committee, the medical advisory committee and also shared with all staff through the governance newsletter.
- Patients were able to raise complaints through the hospital and clinics website, through patient feedback forms, patient forums, social media, verbally to any member of staff as well as in writing and by email. Patients spoken with did not raise any areas of concern.
- 'Please talk to us leaflets' explaining the complaints process were available throughout the clinic. We saw 'You said, we did' displays which demonstrated learning from feedback and complaints and the changes made in response. Feedback had been used to provide positive feedback for staff and to improve services.
- Feedback was also used for consultant appraisals to inform their feedback with any complaints shared with their appraiser.

Are surgery services well-led?

Good

Surgery

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

- The service was led by a head of department for the Hesslewood clinic which covered the outpatient clinics, the surgical bed area and the operating theatre. This had been a recent change and the manager was looking forward to having a clearly defined area of responsibility and being able to develop services within their remit.
- The manager had the right skills and abilities to run a service providing high-quality sustainable care.
- The clinic had a clear management structure in place with clear lines of responsibility and accountability. The hospital's senior management team (SMT) consisted of a hospital director, matron, operations manager, business development manager and a finance and commercial manager. A governance and clinical lead were line managed by the matron.
- The matron was new in post however they had been employed by Spire, in another location for more than 18 years. Staff we spoke with were aware of the new appointment. The former matron had taken up the role of clinical lead. The matron told us they were being supported by staff at all levels including her predecessor.
- Within the organisation there were national, corporate leads in place to support the local leads, for example there was a corporate head of clinical education who supported the local lead for education and development. Corporate training days had been attended by the risk champion, in addition this member of staff had a monthly conference call with other risk champions and the corporate lead was also available for support.
- Staff of all grades told us the senior management team were extremely supportive, visible and approachable. Staff also told us the hospital director had an open-door policy.
- We spoke with the hospital director who was able to outline the key changes that had been implemented since our last inspection. This had included reconfiguration of some services, staffing changes including heads of departments and scaling back some services to ensure patient safety. In addition, the oncology and children and young people's services had been improved to enable increased activity.

Vision and strategy

- We looked at the organisation's strategy. This was in the form of a jigsaw and appeared to contain mission statements from all departments, rather than strategic objectives. We discussed this with the hospital director who explained that the purpose of the document was to engage clinical teams in their own strategic vision. The version in use at the time of our inspection was the first draft and this was being developed further, in conjunction with each service, in quarter four of 2018.
- The hospital and clinic had a robust clinical strategy action plan, this included actions and measures to minimise avoidable harm, to provide a positive experience for all patients under their care, to communicate more efficiently, effectively and courteously with everyone, to strengthen nursing and shape professionalism and leadership, to employ excellent staff who feel valued and empowered to perform the best of their abilities and to empower staff to speak up when they have concerns about patient care.
- The hospital and clinic had an education and training lead person who had developed the education strategy. The aim of the strategy was to ensure the development and commitment to clinical education to enhance staff's skills and knowledge.

Culture

- Professional relationships between all staff promoted the values of the service and staff said they felt valued and worked well together.
- There is currently no requirement for independent healthcare providers to have a freedom to speak up guardian (F2SUG) however the service had appointed a member of staff to this role in February 2018. The role of the F2SUG is to ensure that staff have the capability to speak up effectively and are supported appropriately. We saw a poster displayed at the clinic promoting the role of the F2SUG however we could not find any documentation to guide practice. We discussed this with the senior leadership team who told us the whistle blowing policy was being revised to incorporate the requirements.

- We spoke with the F2SUG who told us they had promoted the role by sending a global email to all staff and attending team meetings. In addition, October 2018 was freedom to speak up awareness month and they were planning to do further promotional work. However, they had not dealt with any cases since the role had been introduced. The guardian felt this was partly due to the approachability of senior staff.
- We saw that the F2SUG details including a photograph were displayed at this site.
- We looked at the whistle blowing policy and found that this was being reviewed and updated to include the information regarding the F2SUG.
- The lead for education and development told us the company invests heavily and are supportive of ideas for staff development.
- Staff of all grades spoke positively about the culture within the clinic and told us they were passionate about their roles.
- Staff told us they were proud to wear the Spire badge, of where they 'were and where they were going', one recent recruit told us 'it was the best place they had ever worked'.
- The chair of the medical advisory committee told us they were proud of the services provided and was honoured when they were asked to take on the role of the chair of the committee. The chair described the senior leadership team as having a 'can do attitude'.
- The newly appointed matron spoke positively of their first impressions and described staff as being immediately welcoming, willing and receptive.

Governance

- At our inspection in 2015, we found that whilst there were governance structures in place for the provider and locally within with the hospital and clinic, these were not effectively implemented. We found there was a high element of trust and a low assurance culture.
- At this inspection we found that governance processes had improved and were more robust. There was a quarterly clinical governance committee, an audit and effectiveness committee also met every six weeks. To improve governance and oversight a weekly rapid response meeting had been introduced as well as daily safety huddles.
- All incident reports within the previous 24 hours were discussed at the safety huddle at the main hospital, this would include any incidents reported by staff at the clinic, to provide assurance that immediate actions to mitigate further risks had been undertaken. Following this any incidents requiring escalation would be discussed in greater depth with the relevant head of department at the rapid response forum. Due to the rapid response meeting being recently introduced, it was not possible to report of the effectiveness of the process.
- We spoke with the newly appointed governance lead, who told us they had concerns that previously the mechanisms for ensuring the actions to mitigate the risks, following serious incidents, were not always completed effectively or there was limited evidence of actions. The lead described this as being a priority for them but acknowledged they were not assured about the processes at the time of the inspection. However, they saw this as a priority. The lead told us that staff were encouraged to report all incidents including near misses so that any themes and trends could be identified.
- We reviewed the minutes of clinical governance committee meetings and found it was difficult to assess the effectiveness of the meeting, as the minutes referred to papers presented on topics and general points on the topic. There was no evidence of analysis, challenge or assurance.
- We asked senior staff we spoke with about the governance framework for their services. Each service lead was able to clearly define the arrangements and the reporting processes.
- At our inspection in 2015, there was a lack of effective oversight and action to ensure that incident investigations were of a high standard and root causes identified. We spoke with the MAC and clinical governance chair about root cause analysis and lessons learned following serious untoward incidents and were assured that the process had improved and was more robust.
- Since the previous inspection staff undertaking root cause analysis investigations had attended training. All serious incidents were investigated by the relevant head of department and the lessons learned shared at the senior management team meeting, MAC and clinical governance as well as the relevant departments team meeting.
- The MAC chair provided assurance that clinical safety was a priority. They described some of the changes to processes that had occurred as a result of national high

profile cases and from our previous inspection and gave several positive examples including the work to embed the WHO checklist procedure, RMO cover, the anaesthetic rota, the improvements in surgical pre-assessment now being in line with American Society of Anaesthesiologists (ASA) physical status classification system, the introduction of a safer staffing acuity tool and the audit and assurance processes.

- At our inspection in 2015, we found that attendance at the medical advisory committee was around 50%. At this inspection the chair of the committee confirmed that attendance was similar at around 50-70% however, we were told that representatives from each speciality did attend the meetings. The chair described the purpose of the meetings as being 'the critical friend' and was able to describe how practice had changed because of the committee. We were told that new procedures were discussed at the meetings, all clinical incidents were also reviewed and any learning shared. The chair gave an example of a recent never event, that had had occurred in theatres, which was reviewed by the group.
- We reviewed minutes of the MAC meeting and found these were detailed and included comprehensive governance information. These were saved with restricted access to key staff on the hospital's shared drive as they contained some sensitive information, for example the details of doctors whose practising privileges were suspended.
- The MAC chair and the chair of the clinical governance committee, had a shared sense of purpose and a good working relationship.
- The MAC meeting and the clinical governance committee meeting were held on the same day and ran concurrently so that issues raised at the governance meeting could be shared at the MAC later the same day.
- At our inspection in 2015, the company policy was for staff to have a DBS review every 10 years. However, during inspection, on review of 10 personnel records, this did not always occur.
- At this inspection, we spoke with the local human resources (HR) contact, this was a member of the administration team whose role included supporting the senior team and heads of departments with staff performance issues, recruitment, complaints and the maintenance of the electronic systems used to monitor compliance with nursing and medical staff recruitment checks and professional body registration.
- We were not able to review any nursing personal files as these were off site at the time of our inspection and being uploaded on to an electronic system to meet the General Data Protection Regulation 2016/679 (GDPR). This is a regulation in European Union (EU) law on data protection and privacy for all individuals within the EU and the European Economic Area (EEA). It also addresses the export of personal data outside the EU and EEA areas.
- We looked at the system used to check that all registered nursing were compliant with revalidation for registration with the Nursing and Midwifery Council (NMC). We saw that this was a robust system which was checked each month.
- Medical consultants were utilised under practising privileges (authority granted to a physician or dentist by a governing board to provide patient care); these, with appraisals and other recruitment checks were logged on an electronic system. At this inspection we reviewed the system and saw that a robust checking process was in place. This included recording of recruitment processes, disclosure and barring (DBS) records, references, mandatory training and appraisals.
- Consultants who failed to provide evidence of their NHS appraisal or mandatory training had their practising privileges suspended until these were provided. We saw evidence of this documented in the medical advisory committee meetings.
- A biennial review of activities undertaken, behaviours and clinical appraisal information (complaints, incidents, compliance with documentation) was completed for each consultant's practice by the hospital director, matron and MAC representative. This was completed annually for consultants treating patients under 18 years.
- At our inspection in 2015, we found systems to ensure compliance with IPC standards required improvement. Previously the governance lead was also the designated IPC lead, however they had no formal qualification for this role. At this inspection the matron was the director of inspection prevention and control (DIPC) and had an appropriate post graduate accredited qualification for this. In addition to this the service had internally appointed a lead nurse for IPC. This staff member did not have any formal qualification but was due to

commence degree level accredited study in January 2019. We discussed the concerns from the previous inspection and were assured that changes had been made to improve IPC measures.

Managing risks, issues and performance

- At our inspection in 2015, staff we spoke to expressed that their biggest worry was staffing levels and recruitment. We also had concerns that the risk register required improvement.
- We found that the current risk register still had some long-standing risks, for example risks that had been on the register for two years and also some that had little or no evidence of actions to mitigate the risk.
- We met with the risk champion who described their role and the actions taken since taking up the role. This member of staff was approached by the senior team to become the risk champion earlier this year. At that time there were more than 200 risks on the risk register, many were no longer relevant, had not been reviewed or did not have any actions to mitigate the risk. This was in line with our findings in 2015.
- The risk champion explained that with support from the corporate head of risk, they had stripped back the risk register in line with the corporate policy and ensured that the remaining risks were in line with the corporate policy. Clinical risks were rated in line with the national patient safety agency (NPSA) risk matrix guidance. Other risks included risks preventing the services from meeting objectives, reputational and financial risks. The risk champion explained that this was still a work in progress.
- All risk registers were created within the electronic reporting system, each service had their own risk register. Risks graded from one to six were managed locally by heads of departments, risks graded six to 12 were reviewed by the relevant member of the SMT and discussed at the clinical governance, SMT and the health and safety committee meetings.
- Each month heads of departments received a copy of their risk registers which they were able to display and to use for discussion at team meetings. Spire Hull and East Riding Hospital and Spire Hesslewood Clinic had a shared outpatients risk register. The manager at the clinic was aware of the risks that applied across both sites.
- The risk champion had arranged to meet with heads of departments and attend team meetings to explain the risk registers and how these should be reviewed and updated in line with completion of the actions to mitigate, on the electronic system. The risk lead was responsible for monitoring compliance with this and sending reminder alerts to the heads of departments where necessary.
- We were told that the senior team had access to a dedicated HR business partner who visited once a week and was available to contact on an ad hoc basis at all other times. In the event of a head of department needing advice in relation to a staff performance issue, the administrator was able to signpost to policies and advise of previous similar cases which could be referenced. We had some concerns that staff who were not trained in HR processes had this level of responsibility.

Managing information

- The services used a clinical scorecard with quality measurements. This was submitted to the local commissioners on a quarterly basis and was used to benchmark against other Spire providers.
- Accessible information standards posters were on display at the clinic. This informed patients to let staff know if they had communication support needs.
- All staff had access to the intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Minutes from meetings and important documents such as the risk register could be accessed by staff on the intranet.
- Staff could access patient information such as x-rays, medical records and physiotherapy records appropriately through electronic and paper records.
- Compliance with information governance training for all staff was 78%, this was better than the September 2018 trajectory of 75%.
- We found that patient records were stored safely and securely away from patients and that there was a secure transport system in place for transferring records from one site to another.

Engagement

- At our inspection in 2015, senior staff recognised that improving staff and consultant feedback was an area requiring improvement.
- At this inspection we were told that the organisation completed anonymised staff surveys twice a year. The

data collection was completed nationally by the corporate team. Heads of departments received feedback on the results from their staff groups and completed action plans to address any concerns.

- Staff were seen to be passionate about their roles and invested in the success of the clinic. Staff we spoke with were engaged in the future of their services and the desire to be excellent providers of care. Some of the staff we spoke with were proud to have received recognition from their colleagues and managers for long service and or good work and achievement.
- All staff we spoke with felt valued by the company, their line managers and the senior management team. Staff gave examples of engagement activities and rewards offered these included; an annual staff party, a free birthday lunch, long service awards and inspiring people awards.
- Staff said the hospital director was 'always around and knows every body's name', that managers had an open-door policy and were very approachable.
- Other staff told us that work life balance was respected and that the investment in their training made them feel valued.
- We saw that where a staff member had a led on a piece of work such as reviewing, updating or writing a policy or treatment protocol they were clearly recognised for that work by being a named author on the document.
- The hospital director held a daily safety huddle for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle to their own teams.
- Patient engagement occurred in several ways, for example, patient feedback was encouraged, and surveys were undertaken regarding patient experience and waiting times. Compliments were also collected and shared with staff and or used in appraisal and revalidation. All feedback was shared to promote improvement from a patient perspective and improvements were displayed on 'You said we did' boards in the outpatient waiting areas. Patient experience surveys showed a high level of satisfaction.
- We saw that staff valued patient feedback. Managers told us that patient feedback had been used to inform developments such as the new physiotherapy gym, increasing outpatient clinic capacity, developing evening services and improving car parking.
- The lead for training and development told us they worked with other hospitals within the company to support training delivery and gave an example of how they had worked with the training and development lead at another hospital within the company to support the delivery of children acute illness management training.

Learning, continuous improvement and innovation

- The lead for training and development told us they were able to access support and share information through the national clinical educators group. This group met every three months.
- The hospital held a sepsis awareness update during our inspection. This included a sepsis survivor attending to talk to staff about their experience.
- Staff we spoke with told us they felt the introduction of a champion for patients living with dementia was an improvement which had resulted in the development of more robust admission criteria and planning for vulnerable patient groups.
- The clinical lead told us they were the first independent hospital to use 'Johns story' to promote the importance of care for people living with dementia.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

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

Mandatory training

- For our detailed findings please see the Surgery report.
- The standard modules for mandatory training included training in safeguarding children.
- We reviewed mandatory training information across the children's service with the clinical lead. We saw that contracted staff were up to date with mandatory training, in all except one module. We saw that some bank staff were on maternity leave at the time of inspection. However, two bank staff who had started at the end of 2017, had only completed three modules each and managers told us this was because they were relatively new to the organisation.

Safeguarding

- For our detailed findings please see the Surgery report.
- The Spire Healthcare Limited procedure for safeguarding children and young people in Spire Healthcare, issued June 2017, review date 2020, provided staff with guidance about safeguarding children and young people. The procedure followed relevant national legislation and guidance, for example the Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children published in 2018. It also included relevant and current information about female genital mutilation (FGM), child abduction, child sexual exploitation (CSE) and human slavery and trafficking. The policy contained relevant guidance about the national PREVENT strategy. PREVENT is part of the government's counter terrorism strategy.
- All consultants, including anaesthetists, who wished to have practicing privileges to deliver care and treatment to children and young people were required to complete level three safeguarding children and young people training. All registered children's nurses (including bank and agency registered children's nurses) were required to have completed level three safeguarding children's and young people's training.
- The services used a dashboard of performance indicators to monitor performance of the children and young people's service. This showed that 100% of consultants who treated children and young people were up to date with level three training in safeguarding. It also showed that 83% of staff had completed level two training (quarter two 2018) and 67% of staff had completed level three training (2017 scorecard).
- Records provided indicated that all registered children's nurses, including bank registered children's nurses, had completed level three safeguarding training.
- A list of all medical staff with practicing privileges and who had completed level three safeguarding children and young people's training was held by the governance lead.
- The children safeguarding lead was the clinical lead. One of the consultants with practising privileges was the named children's and young people's safeguarding lead doctor. The CYP lead nurse was the safeguarding champion and had completed level four safeguarding

children and young people's training. All staff we spoke with knew who the safeguarding lead was and said they would contact the CYP lead nurse in the first instance for advice if they had any concerns.

- Staff we spoke with demonstrated an understanding about safeguarding children and young people processes. A safeguarding information poster was displayed at the clinic with a photograph and the contact details of the safeguarding lead and information about the actions they must take in the event of a safeguarding concern.
- Staff completed a safeguarding children's admission checklist as part of their care pathway. This included identifying if there were any active safeguarding concerns about the child or identification of any risk factors that could indicate safeguarding concerns. Any potential restricted access visitors were also recorded in the care pathway.
- Spire Healthcare Limited policy required all children to be chaperoned by their parent or a registered children's nurse at all times.
- There was a local emergency procedure which set out action staff should take in the event of a missing child and staff were aware of the process to follow.
- There was a local procedure which set out what action staff should take if a child was not brought to an appointment and we saw an example of where this had been followed.
- The service had made one safeguarding referral in 2018 and we saw this had been completed and reported as an incident, in line with Spire policy.
- The CYP lead contributed to the East Riding Safeguarding Steering Group.

Cleanliness, infection control and hygiene

- For our detailed findings please see the Surgery report.
- Processes were in place for infection prevention and control. The clinic provided some toys and books for children to play with in the outpatient waiting area. Toys we looked at were visibly clean. We saw staff signed daily checks lists to evidence they had cleaned the toys. Alternatively, some toys and activity books were single-use; given to children as a gift which they took home at the at the end of their visit.
- Staff carried out infection control risk assessments on all children and young people as part of their preadmission assessment process. This included detail about any recent illnesses, hospital admissions and childhood illnesses, and whether childhood immunisations were up to date.
- At our inspection in 2015, there were gaps in assessing and auditing of infection prevention and control procedures such as observational hand hygiene audits.
- At this inspection, we saw the service carried out hand hygiene audits to monitor CYP staff compliance with the hand hygiene policy. We were provided with an example of a recent observational hand hygiene audit (Sept 2018), which showed 100% compliance with the hand hygiene policy by the staff member observed.
- We saw hand gel dispensers including child height gel dispensers in waiting areas.
- Staff used an infection and prevention audit tool specifically for children and young people's services. This audit tool assessed hand hygiene facilities, the general environment, the patient's immediate environment and bed space, isolation processes, dirty utility, waste disposal, sharps safety, storage areas, clean utility and treatment room, equipment and clinical practices. We reviewed completed audits which indicated 100% compliance had been achieved in all areas at this site in June 2018.

Environment and equipment

- For our detailed findings please see the Surgery report.
- At our inspection in 2015, the clinic had not identified or sufficiently mitigated some of the risks the environment posed to children and young people. At that time there was no separate waiting areas for children and assessments did not identify all risks posed to children, for example ligature risks from window blind cords.
- At this inspection, we saw staff carried out risk assessments of the clinic environment for children and young people attending outpatient's appointments. A weekly health and safety checklist was completed which included consideration of environmental risks to children.
- We saw that there was no designated children's waiting area at Hesslewood. The toys provided were located near to the main entrance and in the main route into the building. Adult patients could also use this area. Staff recognised the limitations of the environment and told us there were plans to introduce wall-mounted play equipment to bring this site in line with Spire Hull and East Riding hospital. Managers explained there was a

longer-term ambition to incorporate a dedicated children's area when the reception and waiting area was redesigned, although there was no agreed timescale for this.

Assessing and responding to patient risk

- For our detailed findings please see the Surgery report.
- The procedure for the care of children and young people in Spire Healthcare (issue date April 2017, next review April 2021), set out the safe and agreed criteria for the admission of children. The procedure took account of national guidance from the Royal Colleges and the National Institute for Health and Care Excellence (NICE). The consultant was personally responsible for assessing children for suitability, working with the CYP team.
- Staff told us no interventional procedures were carried out on children at Hesslewood, including injections and there was no sedation of children at Hesslewood, only local anaesthetic cream was used.
- The clinic would see children from 12 months old, for outpatient medical appointments. Staff told us paediatric outpatient bookings could only be made with consultants who were appropriately trained for the age-group and the booking system would flag if not. The most common appointments for children were for the dermatology clinic.
- The CYP lead nurse reviewed all bookings for under 18-year olds and all children and young people undergoing any procedure, either with general or local anaesthetic, attended a pre-assessment clinic. The preadmission assessment document was comprehensive and supported staff to identify and mitigate against any issues, health, social or emotional, that had the potential to increase the risks factors to the child during their admission.
- We saw from patient records that the assessment was completed by a registered children nurse and gave the opportunity for a visual assessment of the patient as well as discussing their forthcoming treatment and obtaining relevant past medical history. Parents and guardians were strongly encouraged to bring their child for a face to face pre-assessment and staff arranged appointments to make this convenient for families.
- Staff told us the resuscitation lead facilitated four emergency scenarios per year. We saw that a training scenario relating to a children's emergency had been completed at Hesslewood clinic within the last 12 months.
- In the event of an emergency involving a child at Hesslewood clinic, staff would call 999 and request an ambulance.
- The procedure for the Care of Children and Young People in Spire Healthcare included requirements for resuscitation training. The policy included the training requirements for different staff groups employed by the clinic. All registered children nurses (RCN) were required to have successfully completed either the European Paediatric Advanced Life Support (EPALS) or the Advanced Paediatric Life Support (APLS) course. RCN were required to have completed paediatric acute illness management training (AIMS) with annual PILS update. Other clinical staff were required to have successfully completed the Paediatric Intermediate Life Support (PILS) course.
- The CYP lead explained that only registered children's nurses who had completed EPALS were rostered to work independently at Spire Hesslewood as it was a small stand-alone clinic.
- We found staff in outpatients were also trained in paediatric life support; nine of 12 staff allocated PILS training had completed this and the remaining three staff members were booked to attend the training. Two of the 10 staff allocated to complete paediatric basic life support (PBLS) had completed this and the remaining eight had booked training.

Nurse staffing

- At the previous inspection in 2015, the CYP lead nurse employed at that time did not work full time. This meant there was not always a registered children's nurse identified and available with responsibility and accountability for the whole of the child's pathway.
- Following that inspection, the provision of children and young people's services were reviewed and a family-nurse model was adopted. The local lead nurse for CYP now had allocated accountability for children's services across both sites, including outpatient services and radiology services. This was in line with Royal College of Nursing guidance on defining staffing levels for children and young people's services. This stated there must be a registered children's nurse identified

and available with responsibility and accountability for the whole of the child's pathway, including their pathway through outpatient departments. The local lead nurse for CYP was supported by a national lead nurse role for children and young people's services at Spire Healthcare Limited, who also had operational responsibility at another Spire location.

- At this inspection, we found the staffing model was designed to be agile with staff working across the clinic and at Spire Hull and East Riding hospital. There was one contracted employee leading the children's team (12 hours per week) supported by a second part-time contracted nurse (one day per week) and five registered children's nurses (RCNs) who were employed as regular bank workers.
- The service intentionally recruited bank staff who also held other areas of employment in the acute children and young people sector, usually with the NHS. This provided a workforce with a larger skill set and specialist skills from their other areas of employment and meant the service did not work in isolation. Staff had been chosen to match skills to the needs of children and families to meet the growing needs of the service. For example, two registered children's nurses who already worked in theatres could support the pre-assessment clinics, a school nurse who could support the clinic's work with children looked-after and; a nurse with expertise in supporting young people in transition between child and adult services. All RCNs worked at Spire Hull and East Riding and at Hesslewood clinic, as required. The service had recently recruited to the bank, recognising that the CYP lead nurse needed additional nursing support to deliver a safe service, with regular bank staff on maternity leave and an expanding service.
- The CYP lead told us the service had revised its booking processes so all bookings for children and young people under 18 years old, were now flagged to the lead nurse weekly to ensure appropriate staffing was in place. The CYP lead nurse told us they reviewed all bookings for under 18-year olds, including outpatients; that children and young people would be rebooked if appropriate staff were not available, and that agency nurses were not used at this location.
- There was a risk-based approach to nurse staffing for young people aged 16 to 18 years old. Pre-admission assessment identified whether the young person was appropriate to follow the adult pathway. This meant they would be cared for by adult nurses who had completed relevant competency assessments or registered children's nurses. This process included considering the wishes of the young person.
- Staff said they had access to an external play therapist employed by Spire Healthcare Limited, who they could refer to for additional support for example for a child assessed as being highly anxious about their admission during the preadmission assessment process. The lead CYP nurse also had experience in this area.

Medical staffing

- For our detailed findings please see the Surgery report.
- The service had processes in place to ensure medical staff had the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Information provided showed there were 35 consultant surgeons and seven anaesthetists with paediatric practicing privileges listed on the paediatric register (quarter two June 2018). Staff told us the booking system would now prevent appointments being booked if the consultant was not listed on the paediatric register.
- Consultants were required to complete annual paediatric basic life support training (PBLS) and safeguarding children level three training. If these were not completed, the consultant was suspended from carrying out treatment on children until they evidenced they had completed the training. We saw examples of medical staff being temporarily suspended from the paediatric register if this were the case.
- All consultant surgeons, paediatricians and anaesthetists had to complete an application for paediatric admitting rights. This considered their experience in carrying out named procedures for children of a specific age range. This information was used by the management team to determine whether the person had the required skills and experience to carry out paediatric treatments. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges.
- The policy for the care of children and young people stated that to be considered for practising privileges for children under three years old, consultant surgeons and physicians would need to provide evidence they were providing services for children at a specialist NHS unit.

Good

Services for children and young people

Records

- We were unable to review patient records for children at Hesslewood clinic as only one child was due to attend during our visit for a first appointment and other records were stored off site.

Medicines

- For our detailed findings please see the Surgery report.
- At our inspection of Hesslewood clinic in 2015 we found the required pregnancy test records for a specific dermatology treatment were not well-maintained, which meant there was a risk that patients may have been inappropriately prescribed medication when they were pregnant. There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.
- At this inspection, we found that there was a specific policy in place for pregnancy testing of children and young people which gave guidance and information for staff to follow and made specific mention of the dermatology medicines where pregnancy testing was important. We saw that prompts about pregnancy checks were incorporated into CYP day case and inpatient pathway documentation which staff used to plan and deliver care. Staff audited whether the CYP pre-assessment questionnaire was completed appropriately and scored 100% compliance from April to June 2018, however pregnancy testing was not specifically included.

Incidents

- For our detailed findings please see the Surgery report.
- The service had a good track record regarding incidents. There had been no serious incidents and no never events involving children.
- At Hesslewood clinic, there had been one no harm incident reported for children and young people's services in the year preceding the inspection, relating to a safeguarding concern.
- Staff we spoke with, who cared for children and young people, had a clear understanding about incident reporting. They knew how to report incidents and the types of incident that needed to be reported. Staff said they received feedback for reported incidents and learning was shared.
- The CYP lead nurse and the Spire Healthcare national CYP lead nurse received and reviewed all incidents involving anyone under 18 years old. This had started in April 2018, following learning from an internal clinical review (February 2018).We saw that incidents were recorded in the CYP quarterly clinical governance report which was submitted to the clinical governance meeting.

Safety Thermometer

- The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. The tool focusses on: deterioration, IV lines, pain and skin integrity.
- Spire Hull and East Riding hospital had begun to contribute to the safety thermometer on a monthly basis, which included data from Hesslewood clinic, and this was reviewed at the clinical governance meeting. No harms were identified. We saw information displayed in the waiting area on the performance against the children's safety thermometer.

Are services for children and young people effective?

Good

We did have not have sufficient robust evidence to rate effective at our inspection in 2015, therefore we cannot compare our new ratings directly with previous ratings.

Evidence-based care and treatment

- For our detailed findings please see the Surgery report.
- At our inspection in 2015, there was very little evidence provided to indicate whether they used the National Institute for Health and Care Excellence (NICE) or other specific national guidance for children's services and no specific audits of children and young people's services were carried out.
- At this inspection, we saw that policies reflected national guidance and specific children and young people's service had been introduced to drive service improvement.
- We saw that most policies and procedures took account of national guidance. For example, the resuscitation policy referenced the Resuscitation Council Guidelines 2015 and the procedure for the care of Children and

Young People in Spire Healthcare policy included references to the United Nations Convention on the Rights of the Child 1989 and guidance from the Royal College of Nursing.

- There was a national lead for children and young people's services at Spire Healthcare Limited, who was leading a review of national policies, with the aim to incorporate CYP into central policies, as they were reviewed. They also supported the local CYP lead and completed twice annual clinical reviews of the CYP service at Spire Hull and East Riding, although this did not specifically include Hesslewood Clinic.
- At the previous inspection the service did not have an identified audit plan in place specifically for paediatric care, which meant that learning from formal clinical audits, benchmarking or tracking clinical outcomes did not take place.
- At this inspection, we found there was a planned audit programme, the results of which fed into the paediatric clinical score card. The audit programme included audits of documentation, health and safety, infection control and safeguarding and included repeated audits to identify and monitor improvements in the delivery of the service. The paediatric clinical score card compared Spire Hull and East Riding hospital and the clinics performance against those of other Spire Healthcare hospitals that delivered children's services. The use of the clinical score card meant the service was now able to learn from formal clinical audits and benchmarking to improve the service and ensure the service was delivered in line with national guidance.
- The clinical score card monitored a range of indicators across Spire Hull and East Riding hospital and Hesslewood clinic. Indicators relevant to Hesslewood included; completion of consent forms, and the percentage of staff compliant with safeguarding training. For the period 1 Jan 2018 to 30 June 2018, the CYP service met its targets for 100% completion of consent forms and 83% against a target of 50% or more for staff who had completed safeguarding training. We noted that the service did not currently score itself against the indicator; 'Fully completed risk assessment for all interventional procedures in OPD present in patient record'.

Nutrition and hydration

- We saw water and hot drinks were provided in the waiting area, this was free of charge and away from the toys.
- Staff said they could refer either to a dietician at the local NHS trust, or to a dietician employed by Spire Healthcare Limited, for additional support.

Pain relief

- We saw that care pathways included an assessment of the child's pain on admission and during their admission.
- The service audited whether patient's pain scores were recorded with every set of observations and the service scored 100% compliance from January to June 2018.

Patient outcomes

- For our detailed findings please see the Surgery report.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- At our inspection in 2015, staff told us patient outcomes were good; however, we did not see any evidence to show that patient outcomes for children and young people's services were routinely monitored. At that time, children and young peoples' outcomes were not measured separately, which meant they could not demonstrate how effective the children's and young people's service was.
- At this inspection, we saw measured outcomes for children and young people using a planned audit programme and the paediatric clinical score card. Results were reported in quarterly governance reports prepared by the lead nurse.
- Data from the paediatric scorecard showed that there had been no known surgical site infections and no avoidable cancellations on the day of surgery from January to June 2018.
- The service did not take part in any external audits and staff explained this was mainly due to low numbers of children and young people seen.

Competent staff

- For our detailed findings please see the Surgery report.
- At our inspection in 2015, the children and young people's service cared for low numbers of patients and had low numbers of nursing staff; these staff maintained competencies in their roles within other organisations, usually within the NHS, which also employed them.

Good

Services for children and young people

- At this inspection, numbers of young people being cared for, had increased and a similar model was in place, however all staff caring for children were also required to have completed paediatric competencies and have up to date training in safeguarding level three and life support, appropriate to their role. The clinical lead confirmed that no staff should look after an under 18-year-old without paediatric competencies.
- An internal clinical review (February 2018) had highlighted; incomplete CYP competencies in outpatients and diagnostics.Information provided, at the time of our inspection, demonstrated improvement. All CYP staff (100%) had completed the competencies. In addition to this some diagnostics and pharmacy staff had undertaken the competencies despite this not being a requirement of their role. In total we found 56% of all staff who did not require the competencies had undertaken them. This included 92% of outpatients staff, 81% of physiotherapy staff, 45% of theatres staff and 19% of ward staff.
- At our inspection in 2015, when we asked about phlebotomy for children and young people the matron told us, the number of children and young people needing blood tests on-site was low. The matron told us three or four phlebotomy staff were booked to attend a paediatric phlebotomy course.
- At this inspection, we found the Spire Healthcare Limited procedure for the care of children and young people defined that only staff with specific paediatric venepuncture competencies could take blood from children and young people in the outpatient's department. The CYP lead nurse confirmed that only registered children's nurses with these competencies took blood.
- The clinical lead was responsible for completing an appraisal with the CYP lead nurse twice a year. Although appraisals were not formally required, the CYP lead completed informal appraisals with bank staff. Some bank staff were on maternity leave at the time of inspection and some were too new to the organisation to have yet had an appraisal but reported positive induction discussions about development.
- A self-assessment against the 'You're Welcome' criteria across the service had identified clinical supervision as an area for improvement. An action was identified to ensure that formal clinical supervision took place, although timescales and accountability were not yet identified for this.

Multidisciplinary working

- For our detailed findings please see the Surgery report.
- All staff we spoke with told us staff across the two sites worked as a team to support children and young people.
- All registered children's nurses working at Hesslewood clinic were also working in other roles for example in the local NHS or the local authority, which meant the service could easily access a variety of skills and expertise.
- **Seven-day services**
- For our detailed findings please see the Surgery report.
- Staff told us children's clinics were often scheduled on a Friday afternoon, although children could access appointments at other times including Saturday mornings.
- The clinic did not have an on-site pharmacy, pathology or radiology service; these services were provided at the Spire Hull and East Riding Hospital site.

Health promotion

- For our detailed findings please see the Surgery report.
- Although there was no formal health promotion programme for children and young people admitted as inpatients, staff told us they took opportunity to discuss healthy lifestyles where appropriate with children, young people and their parents.
- We saw a children's information and education leaflet; 'Helping to keep you safe from infection' which included hand hygiene tips and infection prevention measures, available in the waiting area.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- For our detailed findings please see the Surgery report.
- Staff used the Spire Healthcare Limited consent policy (Jan 2016, review Jan 2019) which included guidance for staff on consent and children and young people including parental responsibility and Gillick competency and consent for 16 and 17-year olds. Staff used a specific consent form for children and young people. Staff we spoke with were aware of their legal responsibilities.

Good

Services for children and young people

- Patient records we viewed at the main Spire Hull and East Riding showed consent for procedures was obtained. We saw there was space on the form for children to sign if they were able to consent to their treatment.
- The service audited whether consent forms were fully completed and the service scored 100% compliance from January to June 2018.

Are services for children and young people caring?

Not sufficient evidence to rate

We did not see any care provided to children or young people during our inspection therefore we did not have sufficient robust evidence to rate caring at our inspection.

Compassionate care

- Staff worked at Hesslewood clinic and at the main Hull and East Riding hospital site. We observed caring interactions between staff and children and young people and their families at the main Spire Hull and East Riding site.
- Staff told us they supported children to reduce anxiety during appointments. Children's nurses recommended appropriate video clips and online resources to familiarise themselves with their procedure, as part of the pre-assessment process.
- Private consulting rooms were available. Staff told us they maintained dignity of patients, for example weighing them in the privacy of a consulting room.
- Staff at Hesslewood clinic told us they put the TV on in the waiting room, so that conversations in consulting rooms could not be overheard.

Emotional support

- Staff we spoke with demonstrated a sensitive and supportive attitude to children and young people, parents and carers.

Understanding and involvement of patients and those close to them

- Children's nurses also recommended appropriate video clips and emailed online resources to families. There was an information leaflet; 'Your visit to hospital – a guide to coming into hospital' which the bookings team sent out to families. This included information on what to expect and how to prepare.

Are services for children and young people responsive?

Good

We did have not have sufficient robust evidence to rate responsive at our inspection in 2015, therefore we cannot compare our new ratings directly with previous ratings.

Service delivery to meet the needs of local people

- For our detailed findings please see the Surgery report.
- Services at the clinic were planned to meet the needs of children and young people. The service had increased in capacity since our last inspection.
- Children and young people attended Hesslewood clinic for minor surgical procedures and pre-assessment and for outpatient medical appointments. Following national guidance, inpatient surgical services were only offered to children age three and above. All procedures were planned.
- Children and young people attended the clinic as privately funded, insured or as NHS patients. The service was also commissioned to provide health assessments for children and young people looked after by the local authority.
- At our inspection in 2015, there were no separate areas for children and young people to wait and/or be seen in the outpatient's department. There were no toys available; when we asked about this, we were told colouring books and crayons were available on request.
- At this inspection, the service had begun to identify and develop identified a space for children in the clinic.
- Staff told us that they would switch the waiting area televisions to children's channels when there was a children's clinic booked, to create a more relaxing environment.

Meeting people's individual needs

- For our detailed findings please see the Surgery report.
- From July 2016, all organisations that provide NHS care must have fully implemented and conform to the

Accessible Information Standard - to identify, record, flag, share and meet information or communication needs relating to a disability, impairment or sensory loss. We saw that communication needs, including a need relating to a disability or mental health issue, were considered in the pre-assessment process and this was then available to the children's nurse for follow-up appointments.

- The service used the Spire Healthcare Limited consent policy which gives advice for staff on when an interpreter is required and clearly notes that; 'it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English.'Family members should not be used as interpreters in any clinical matter. We saw that information was displayed advising of this. We discussed our concern with the senior team who acknowledged this and advised that they would raise the concern about the wording in the policy with the Spire corporate team.
- Staff knew how to obtain an interpreter as required and records showed that they were used.
- The child's individual needs were discussed during the preadmission assessment process and information was used by staff to plan individual care and treatment. The assessment considered communication needs and contact with child and adolescent mental health services(CAHMS) or other mental health needs. If, during the preadmission assessment process, staff identified the service could not meet the child or young person needs, staff referred the child to alternative health care providers who could support the child and their parent.
- The clinic provided some toys and books for children to play with in the outpatient waiting area. Alternatively, some toys and activity books were single-use; given to children as a gift which they could take home at the at the end of their visit.

Access and flow

- For our detailed findings please see the Surgery report.
- Although there was no formal monitoring of referral to treatment times for children's services, staff told us they usually saw children within two weeks of referral or sooner if the child's condition was urgent or the parents were worried.
- Parents and children, we spoke with in other outpatient waiting areas, told us they were usually seen on time for appointments.
- Staff had reviewed outpatient waiting times for children and young people in January 2018 and found five out of six (83%) patients were seen within five to 19 minutes.

Learning from complaints and concerns

- For our detailed findings please see the Surgery report.
- The CYP service had received two complaints in the previous 12 months which had been responded to in a timely and appropriate way. No complaints related specifically to Hesslewood clinic.
- Staff provided examples where they had made changes to practice in response to comments from parents of children and young people. This included introducing a dedicated email address and mobile telephone number for parents to contact the CYP nurse on duty with any questions, following some difficulties in contacting relevant staff. Staff told us feedback was positive as families liked that they could also send a text message to the same number.
- We did not see a comments book or other ways for children and families to give feedback at the Hesslewood clinic.

Are services for children and young people well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

- For our detailed findings please see the Surgery report.
- The outpatients service for children and young people was based within the existing outpatients service and overseen by the CYP lead. Staff spoke highly of the support they received from the children and young person's lead nurse who worked across Spire Hull and East Riding hospital and Hesslewood clinic.
- The CYP lead nurse (a registered children's nurse) reported to the clinical lead. There was a lead paediatric consultant, a lead paediatric anaesthetist and a team of surgical and anaesthetic consultants experienced in the surgical management of children and young people.
- An internal clinical review, in February 2018, had noted that although there was a CYP lead, they were not designated as head of department (HOD), as required for a standalone service by Spire Healthcare Limited

policy. The review noted that representation at HOD level was important to ensure the service has a qualified paediatric representative at an appropriate level to influence strategy and advise on any developments and how they may impact on CYP. We observed that the CYP lead managed on-call responsibilities as well as another role within the Spire Hull and East Riding hospital and at the local NHS trust. The lead attended the daily HODs safety huddle meeting with the hospital director when available, providing an update via the ward manager where attendance was not possible. They were supported by the CYP national Spire lead.

Vision and strategy

- For our detailed findings please see the Surgery report.
- At our inspection in 2015, staff were unable to describe a vision or strategy for children's services.
- At this inspection, staff we spoke with, understood the service aims to develop and increase the number of children and young people seen at the clinic. Staff appreciated that recent work to recruit a diverse skill mix within the CYP team and the new children's ward area, was central to this.
- The children and young people's lead had a vision for what they wanted to achieve which was supported by the Spire Healthcare Limited lead nurse for CYP.
- We noted that the internal clinical review in February 2018 highlighted that CYP does not feature as part of the strategy display.

Culture

- For our detailed findings please see the Surgery report.
- Leadership of the children and young people's service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- There was a positive culture across all staff in the delivery of children and young people's service. All staff spoke highly of the support they received from the children and young person's lead nurse.
- The lead nurse reported increasing engagement from senior leaders at Spire for CYP services. Both lead nurses noted that being heard was important for a growing service.
- The Spire Healthcare lead CYP nurse commented on the strength of the CYP lead in developing a flexible staff team, with a variety of skills and experience and believed the time was now right to expand and develop the children and young people's service.

Governance

- For our detailed findings please see the Surgery report.
- At the previous inspection in 2015, governance processes did not support quality monitoring of the children and young people's service.
- At this inspection, we found governance of the children's and young people's service had been established, linked to the governance processes for Spire Hull and East Riding hospital. A CYP clinical score card had been introduced and the CYP lead reported on this quarterly to the clinical governance meeting. The lead paediatrician represented the CYP service in the Medical Advisory Committee (MAC) meetings. There was a lead CYP anaesthetist who oversaw the anaesthetic services for children, meeting the guidance on the provision of paediatric anaesthesia service 2015 published by the Royal College of Anaesthetists.
- The lead CYP nurse was fully engaged in the planning and development of the children and young people's services. An annual steering group for children and young people's services was in development to guide the future development of the service.

Managing risks, issues and performance

- For our detailed findings please see the Surgery report.
- At our inspection in 2015, we did not find any evidence of audits, risk management or quality assurance for children and young people's services. While audits of patient records took place, there were no specific CYP audits.
- At this inspection, we found there was a specific audit plan, clinical score card and risk register for the children and young people's service which were used to manage risks, monitor and improve performance and quality.
- The audit plan included specific audits of infection prevention and control and patient records for children and young people. Audit results fed into the clinical score card which compared performance with other Spire locations nationally.
- The management of the risks, issues and performance relating to children and young people was owned by the

CYP service and managed by the CYP lead nurse. The CYP lead nurse had full oversight of the service including all risks to the service and reviewed all incidents involving children and young people.

- The CYP service held its own risk register. Review of the risk register showed there were four risks identified across the CYP service. Items on the service risk register matched the risks staff spoke about, including risks to children associated with the new ward environment bathroom area, and risks related to the running of the service, such as staffing levels and recruitment of bank staff and EPALS competency of the RMO.

Managing information

- For our detailed findings please see the Surgery report.
- Staff had identified the review and management of information for children and young people as an area for improvement, following the 'You're Welcome' self-assessment.

Engagement

- For our detailed findings please see the Surgery report.
- Staff told us children and their families could give feedback using; 'how was your visit to hospital' survey forms although it was unclear how this was used.
- The service engaged with local stakeholders. For example, the CYP lead nurse had held two presentations for local GPs to inform them about the CYP services provided.
- CYP and other staff we spoke were engaged with the CYP service and spoke positively about the CYP lead nurse. Staff said they could contact them at any time for support and advice.

Learning, continuous improvement and innovation

- For our detailed findings please see the Surgery report.

Good

Outpatients

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Are outpatients services safe?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Mandatory training

- For our detailed findings please see the Surgery report.
- The mandatory training programme covered all appropriate topics including; general health and safety, adult and children safeguarding, moving and handling, information governance and infection control. There were clear expectations about frequency and type of training in the training policy and what groups of staff each module applied to. Some of the training modules such as compassion in practice, managing violence and aggression and Mental Capacity Act were once only modules and would be covered as part of induction. Induction and mandatory training was given to all staff including bank staff. Training provided was a combination of e-learning and face to face training.
- Data provided showed compliance with mandatory training for outpatient, pharmacy and reception staff was near or better than the expected target of 75% at September 2018 for almost all modules across all staff groups. At the time of our inspection clinic appointment staff however were below target for all modules. Following our inspection, the hospital provided data to show that this had been acted upon and the compliance levels had improved. Pharmacy and nurse admin staff were also below target for the 'anti-bribery, gifts and hospitality module.'
- Staff we spoke with in outpatients confirmed they were up to date with mandatory training.
- Staff in outpatients were trained in both adult and paediatric life support. Paediatric life support (PILS) training was reported separately from the mandatory training above as this was role specific training. In outpatients nine of 12 staff allocated PILS training had completed this and the remaining three staff members had booked training.Two of the 10 staff allocated to complete paediatric basic life support (PBLS) had completed this and the remaining eight had booked training.

Safeguarding

- For our detailed findings please see the Surgery report.
- Staff we spoke with were aware of their responsibilities to safeguard adults and children and knew whom to contact in case of any concerns.
- We saw evidence of children's and adults' safeguarding policies and procedures.
- Adult and children's safeguarding was a part of mandatory training. Staff told us they were up to date with mandatory training. Registered nurses and physiotherapists we spoke with told us their safeguarding training was at level three and that they were up to date.
- Data provided by the hospital showed; outpatients, physiotherapy, reception and admin teams had compliance levels at or better than the expected target of 75% for September 2018. The clinic appointment staff had been below compliance at 14% at the time of our inspection. However, following our inspection, the hospital provided updated evidence to show this had been acted upon and staff had achieved100% compliance for adult safeguarding and children's safeguarding training by the end of October 2018.

- Staff confirmed they had completed safeguarding training and that they were expected to undertake an annual refresher. Managers told us that clinical staff in outpatients were trained to level three in safeguarding which was above the training policy requirement.
- Whistleblowing posters were visible in staff areas and staff expressed confidence that they could speak to managers about any concerns they had about services or other staff.
- All staff felt well supported by senior staff who were readily available if they needed to escalate any safeguarding concerns.
- The service had a safeguarding responsible manager and a safeguarding responsible person, staff knew who they were and how to contact them if they needed support.
- There was easily accessible information for staff to escalate safeguarding concerns or contact local authorities when necessary.
- Staff gave us examples of when they had discussed safeguarding concerns with the local spire safeguarding lead, when referrals to local authorities had been made and what the outcome of their actions was.
- The paediatric clinics were managed and staffed by a registered sick children's nurse (RSCN), further detail can be found in the children's service section of the report. The outpatient manager told us that it was policy that young people under 18 years were only seen if there was a person with parental responsibility with them.
- There were local protocols in the department which were clear around children being accompanied by a person with parental responsibility. A child's main carer could leave a list of other approved adults who could accompany their child, such as named grandparents.
- Staff told us they considered safeguarding implications and took actions when necessary, if it was a child who had missed an appointment.

Cleanliness, infection control and hygiene

- For our detailed findings please see the Surgery report.
- The areas we visited were visibly clean and we saw evidence that waiting areas, clinic rooms, and equipment were cleaned regularly. Checklists and cleaning schedules were in use for the outpatient areas we visited.
- The clinic rooms were carpeted which makes cleaning difficult from an infection control perspective. There were cleaning schedules in place and the floors were visibly clean. We were told these rooms were only used for consultations and that any dressing changes would be undertaken in the treatment room, which was not carpeted.
- The manager told us that they used a specific room for dirty wounds such as leg ulcers to minimise the risk of cross infection.
- We saw staff following "bare below the elbow" policy in clinical areas and hand hygiene policy. Soap dispensers and hand gel were readily available for staff, patients, visitors and the public to use. Dispensers were clean and well stocked.
- We observed staff using the correct hand washing technique, using personal protective equipment (PPE) appropriately.
- The department manager told us that hand hygiene audits were carried out by the infection, prevention and control lead.
- The hand hygiene audit of outpatients at Hesslewood showed 92% compliance for quarter one. The quarter two audit showed and improvement and achievement of 100% compliance. The area of non-compliance in quarter one was staff not using a no-touch technique to turn off taps following hand washing.
- Equipment in outpatients was visibly clean and stickers were in place to show that cleaning had been carried out and that the equipment was ready for use.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- There was an infection prevention and control link nurse network in operation, with an identified link practitioner for the Hesslewood clinic.
- Housekeeping staff had received infection prevention and control training and adhered to a colour coded system for using the correct cleaning equipment for each of the clinical areas.

Environment and equipment

- For our detailed findings please see the Surgery report.
- There was enough comfortable seating available in waiting areas with TVs magazines and health promotion literature available for patients.
- Curtain changes were recorded and consumable items were in date.
- Not all equipment was labelled to show when it was last serviced or maintained. However, we spoke with the

manager for the engineering and services management and were told there was a planned maintenance programme in place. In addition to this, compliance reports were submitted locally and nationally for environmental safety testing, for example water safety testing, fire risk assessments and air safety tests.

- There were contracts in place with specialist companies to undertake emergency repairs of equipment and maintenance. Staff told us external contractors responded quickly when equipment faults were reported. A recent problem with a piece of laser eye equipment had been resolved within 48 hours.
- The service had a service level agreement in place with a company to provide a Laser Protection Advisor (LPA) and safety assurance regarding the use and maintenance of laser eye equipment. The last inspection was in February 2018 and the service was fully compliant with requirements.
- The resuscitation trolley was checked every day to ensure it was in good working order. We looked at resuscitation trolley checklists and found them to be checked and signed daily. Drawer locks were in place. The trolleys were clean and tidy and all consumables were within the use by date. The oxygen cylinder was also checked and within date
- The department manager told us that if consultants wanted to use their own equipment there was an expectation that they kept maintenance and cleaning records and they signed a formal documented agreement to ensure equipment was safe to use.
- The staff had been trained by the supplier or manufacturer for each piece of equipment, where appropriate. For example, training had been provided to all staff in the use of the laser-eye equipment.

Assessing and responding to patient risk

- For our detailed findings please see the Surgery report.
- There were policies, procedures and processes in place to protect patients and staff.
- Risk assessments had been undertaken in relation to patient safety, the environment and staff safety. The manager undertook paediatric environmental risk assessments and completed weekly checks. Internal audits showed these assessments were carried out and the areas were compliant with the requirements.
- Staff in outpatients told us they were all trained to basic life support level for adult and paediatric patients. Staff had also received training in acute illness management. For the outpatient team based at Hesslewood the emergency response was to call 999.
- There were emergency call bells in outpatient rooms and toilets.
- Medical staff assessed patient referral information to see if they were suitable for consultation and or interventions at the Hesslewood Clinic. Higher risk, complex cases were referred to the local NHS trust.
- We attended the daily safety huddle which was attended by all departments. This gave an opportunity to facilitate multidisciplinary working and a service wide approach to patient safety.

Nurse staffing

- For our detailed findings please see the Surgery report.
- Staff and patients, we spoke with, as well as our observations confirmed that there was enough staff available to meet patient's needs. The manager told us that staff were now dedicated at the Hesslewood site and this was a positive change for continuity and would facilitate the development of the service.
- Within outpatients, staffing levels were based upon several factors including the number of patients expected to attend and the number, type and complexity of clinics to be held. Managers told us that activities such as dressings were audited in relation to patient waiting times and that this information was also used to inform planning of clinic staffing. The outpatient manager told us that the minimum staffing in the department was one RN and two HCAs.
- At 1 July 2018 there were 13 (11 whole time equivalent (wte)) registered nurses (RNs) employed within the outpatient department.
- At 1 July 2018 there were six (4.7 wte) healthcare assistants (HCAs) employed within the outpatient department. There was one full time and one 30-hour registered nurse vacancies at the time of our inspection. Recruitment was planned and the manager of the department told us that recruitment was not too difficult.
- The RN staff sickness rate from August 2017 to July 2018 was less than two per cent for eight of the twelve months however October 2017 and March 2018 showed peaks of 67.3% and 54.1% respectively.

Good

Outpatients

- The HCA staff sickness rate from August 2017 to July 2018 was less than two per cent for eight of the twelve months however October 2017 and February 2018 showed peaks of 12% and 7.4% respectively.
- Staff told us that the peaks of sickness had been covered by staff working extra shifts, use of bank staff, the manager had worked more of her time clinically and staff from the ward area had also supported when needed.
- From August 2017 to July 2018, as a share of total staff bank registered nursing staff used in the outpatient department ranged between 7.8% and 21.5% from August 2017 to July 2018. The number of shifts covered by bank RNs from May to July 2018 averaged 26 shifts a month.
- From August 2017 to July 2018, as a share of total staff, bank healthcare assistants used in the outpatient department ranged between 0% and 6.9%. The number of shifts covered by bank HCAs from May to July 2018 averaged three shifts a month.
- The Spire Hesslewood Clinic and Spire Hull and East Riding Hospital had their own bank of staff to call on when needed, to cover short notice absence. Outpatients had recently recruited two members of bank staff. There was no reported use of agency staff in outpatient areas in the last 12 months. There were no unfilled shifts from May to July 2018.
- Staff turnover in the department from August 2017 to July 2018 was 5.9% for outpatient RNs and 11.1% for HCAs.

Medical staffing

- For our detailed findings please see the Surgery report.
- Medical staff in outpatients had practising privileges with the hospital and clinic and held clinics for both NHS and self-funding patients. All clinics were consultant led.
- There were 238 doctors (more than six months in post) with practising privileges, all had their registration confirmed in the period from August 2017 to July 2018. From August 2017 to July 2018, 101 doctors with practising privileges had carried out no episodes of care, 36 had carried out one to nine episodes of care, 73 had carried out 10 to 99 episodes of care and 39 had carried out more than 100. During this time one doctor had their practising privileges removed and had been referred to the General Medical Council.

Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Medical notes and referral letters were not held electronically.
- All patients attending the clinic had a full set of medical records stored on site for a maximum of a four-month period. After this, they were transferred to an off-site storage facility.
- All clinic notes were arranged 24 to 48 hours in advance, which meant patients should never attend clinic without medical records being available.
- Staff reported that records were usually available in a timely manner for clinic appointments and the department estimated that records were unavailable less than 1% of the time. For the three months before the inspection 0.15% of patients were seen without a full medical record being available across both site
- In the event of records being unavailable for a patient's appointment, a temporary set of records was created, with the referring GP letters attached which included relevant medical history. Managers told us that in all cases, the patient would be risk assessed to determine whether temporary records or rearranging the appointment would be the most appropriate action. Staff told us that it was extremely rare for a patient to attend without records being available.
- Managers told us that any patient records which are off site are requested prior to the appointment and are available on next day delivery. There was a process in place to ensure medical records were transported securely between sites and stored securely when not in use.
- The policy was that consultants did not take medical records out of the clinic. However, there was a requirement that all consultants were registered with the Information Commissioner's office and were personally accountable for the protection of information.
- Records were stored securely away from waiting patients.
- We saw that records audits were part of the routine audit programme.

Medicines

- For our detailed findings please see the Surgery report.

Good

Outpatients

- We were told that medicine stocks were checked regularly and a more formal stock take was completed twice a year. We checked medicine cupboards and found that all medicines were in date.
- Prescription pads were locked in the medicine cupboard and nursing staff gave these to Consultants on an individual patient basis. Records were kept of who had used each prescription.
- There was no onsite pharmacy at Hesslewood; if patients needed a prescription then they needed to go to the Spire Hull and East Riding Hospital to pick it up. Prescription charges were covered as part of the packages of care commissioned for NHS outpatients.
- Prescription charges for private outpatients were added to, or included in, consultation fees depending on the treatment plan bought. Improvements had been made to ensure charges were made clear to patients before they attended for their first outpatient appointment.
- Medicines requiring refrigeration were stored appropriately. We saw that fridge temperatures were monitored daily and were within the recommended range.
- Flu vaccines were available to patients and staff and were administered in the outpatient department, under a patient group directive (PGD). The nurses administering flu vaccines had received training from the occupational health nurse.

Incidents

- For our detailed findings please see the Surgery report.
- There was a process in place to enable reporting of all incidents and near misses. Managers told us incidents were subject to a risk-appropriate level of investigation with serious incidents needing investigation (SIRI) using a root cause analysis method.
- There were mechanisms in place to ensure learning from incidents and improvements made where necessary. Staff told us that they received information (which included lessons and actions) regarding serious incidents from local services and from other hospitals in the Spire group.
- Managers and staff were familiar with duty of candour requirements and the need to be open with patients when things went wrong.
- From August 2017 to July 2017 there were no never events or serious incidents relating to this service.
- The service had reported 104 clinical incidents and 22 non-clinical across both sites from July 2017 to June 2018. The largest number of incidents reported was in relation to missing information / mis-labelled specimens, surgical site infections detected at follow up appointments and cancellations the majority of which were patients who did not attend for appointments.
- The manager told us they could filter incidents to their own department and generate their own reports.
- There had been no incidents in the last 12 months that had triggered a formal duty of candour response.
- A member of staff we spoke with told us they had not received any feedback after reporting an incident. They said they felt this would have been beneficial. The incident related to an administration error which had resulted in a patient from out of the area, arriving on the wrong day. The staff member felt that their actions had prevented the patients from making a formal complaint, as they had dealt with the incident immediately and de-escalated the patient's complaint.

Safety Thermometer (or equivalent)

- Safety information such as surgical site infections and incidents was on display in the outpatient areas.

Are outpatients services effective?

We do not rate the effectiveness of outpatient services

Evidence-based care and treatment

- For our detailed findings please see the Surgery report.
- Most of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- Policies and protocols were available on the IT system in the 'book of knowledge' we saw that some protocols and a small number of policies had been printed for staff to access more easily in the department.
- The policy folder we looked at in had some out of date policies / procedures. This created the risk of staff following outdated guidance.
- Findings of audits and inspections were discussed at team meetings so all staff were aware when any changes to practice were needed.

Nutrition and hydration

- Patients had access to tea and coffee and water while waiting in the outpatient areas.

- Patients told us staff offered them refreshments when they arrived and offered to bring them to patients who needed help.

Pain relief

- Pain relieving medications and local anaesthetics were used for minor procedures in the department.

Patient outcomes

- For our detailed findings please see the Surgery report.
- The service had made some improvements to how they used audit data in outpatient services.
- Spire outpatient departments had a comprehensive audit programme that included; clinic utilisation and waiting times audits, a range of IPC, environment and equipment audits, documentation, patient satisfaction and a cosmetic cooling off period audit.
- Consultants working in outpatients were involved with research and monitoring effectiveness of the treatments they offered. For example, a number of studies had been carried out including outcome data from patients attending a migraine clinic at Hesslewood as part of a larger study involving patients in the Hull and York network. Findings from these studies had recently been shared at a national symposium.
- Patient outcomes relevant to outpatients were also monitored through complaints and cancellations, which were included on a clinical scorecard with quality measurements for other areas. This was submitted to the local commissioners on a quarterly basis and was used to benchmark against other Spire hospitals. For example, the service audited the percentage of eligible females who have a pregnancy test documented in their medical records prior to treatment or surgery with results reported following a local audit of 20 sets of patient notes per quarter. The Spire Hull result for the last two audits was 100% which was better than the Spire average of 99%

Competent staff

- For our detailed findings please see the Surgery report.
- Staff we spoke with told us that induction was thorough and structured. New starters, which included bank staff, were given a "buddy" and were given a three-month induction and probationary period.
- The outpatient manager told us that staff competence was maintained through on-going training and assessment of core competencies which were signed off. Core competencies had been revised during the last 12 months and all staff in outpatients had been signed off as being competent.
- Staff were attending a sepsis awareness update during our inspection. HCAs had received further training in phlebotomy, suture removal and wound care. Staff moving and handling competence was assessed by members of the physiotherapy team.
- The service had a process in place to assure itself that consultants, providing outpatient services, held current indemnity, GMC registration, had an annual appraisal and to confirm revalidation where necessary.
- The appraisal year ran from January 2018 to December 2018 and the target for completion was 75% by September 2018. More than 90% of outpatient staff, across the two sites, had received an annual appraisal by July 2018.
- Staff told us that they had been supported with training relevant to their role and career development. Support with learning had been supported by immediate line managers and the hospital director as well as more specialist support and support networks available through the wider Spire group. Staff could access training regarding to lead or link roles or management and leadership. Staff had recently received update training about customer care which had been identified as a learning need through the analysis of themes from complaints.
- Staff had been trained in the use of the specialist eye equipment within the department and were assessed as competent. The manager told us the training had been provided by the equipment manufacturer.
- Managers and staff, we spoke with told us that outpatient staff received chaperone training and had been assessed as competent to undertake this role. A chaperone audit had been added to the audit programme for later in the year.

Multidisciplinary working

- For our detailed findings please see the Surgery report.
- We saw there was good teamwork and positive relationships between staff of different disciplines and found evidence of multidisciplinary (MDT) working within patient records.

Good

Outpatients

- There were good examples of internal and external multidisciplinary team working. For example, staff worked closely with consultants and GPs on the development and review of clinical pathways and acceptability criteria.

Seven-day services

- For our detailed findings please see the Surgery report.
- Outpatient clinics were accessible at varying times of day and evening from 8am to 9pm and Saturday mornings.

Health promotion

- For our detailed findings please see the Surgery report.
- We saw lots of health promotion information in the outpatient departments. For example, the information included; healthy eating, stopping smoking, breast awareness, various mental health literature and hand hygiene for patients. There was also lots of other information for patients including information about costs and finance, cosmetic surgery, allergy notices, adult and children's safeguarding, and a guide to treatments and services available.
- Outpatient staff had received training in offering brief information and advice to patients about alcohol use and smoking.

Consent and Mental Capacity Act

- For our detailed findings please see the Surgery report.
- The hospital gained consent in a two-step process. Patients were given a full explanation of their proposed procedure and associated risks at a pre-operative assessment up to two weeks before surgery. On the day of surgery patients signed and dated the consent form to confirm they understood their procedure and risks and wanted to continue.
- Local audits had been introduced to monitor compliance with consent procedures and evidence of consent in patient notes. These showed 100% compliance with consent requirements.
- Staff demonstrated knowledge and understanding of the Mental Capacity Act and consent. They had received training that had included Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS).
- Staff showed a good understanding of informed consent and there were clear policies in place.
- We saw that verbal or implied consent was obtained from patients before care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and other physiological signs.

Are outpatients services caring?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Compassionate care

- Patients told us it was a really good experience using services and that all staff were always polite and helpful. Staff who answered calls about appointments and receptionists were also described as being very helpful. Staff everywhere were described as kind and caring, they were 'lovely' 'couldn't fault them'.
- We were told that outpatients carried out patient surveys which gave very positive feedback. Patient surveys included a waiting times survey. Friends and family test feedback from February 2018 to July 2018 was extremely positive with 95% to 100% of patients saying they would recommend the service. However, the response rate ranged from 10.4% to 24.3% in the same period.
- During our inspection we saw patients being treated respectfully by all staff. Staff were wearing name badges and were seen to introduce themselves to patients, politely and professionally.
- Reception staff were welcoming to patients as they entered the clinic and gave clear instructions and advice in a helpful, caring and compassionate manner.
- We saw patient's privacy was respected and the environment in the outpatient clinic area allowed for confidential conversations. However, the reception area was very open and lacked privacy for patients booking in.
- Notices offering chaperoning were displayed and staff told us this was provided whenever requested.

Good

Outpatients

- As a result of patient feedback, improvements had been made to appointment letters and the inclusion of additional information to ensure insurance and self-funding patients were fully informed of processes and charges.

Emotional support

- A member of the nursing team was made available to go with a consultant when breaking bad news to patients and was then also available to give support and answer questions from the patient and relatives until the patient left the clinic.
- A specialist nurse offered support to patients undergoing cosmetic surgery.
- Patients we spoke with told us they had been offered chaperones but had not needed one.
- We found that a call recording facility had been introduced so staff could listen back on difficult calls for debriefing and learning purposes regarding supporting and communicating effectively with distressed patients. Staff told us they could de-brief at team meetings.

Understanding and involvement of patients and those close to them

- We saw staff spending time explaining procedures to patients using both verbal and written information. Patients told us they were given time to ask questions and these were answered in a way they could understand.
- Patients and their representatives told us they were involved in decision making about their care and treatment and that they were clear about treatment options.
- Most of the patients we spoke with were satisfied with the information they received about their appointment, what to expect and requirements about tests and procedures.
- A patient using health insurance told us that information about appointments, tests and costs was included in the outpatient appointment information.

Are outpatients services responsive?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Service delivery to meet the needs of local people

- For our detailed findings please see the Surgery report.
- Service planning was responsive to the needs of local people and supported delivery of services offered by local NHS trusts. The service received referrals from three local trusts under service level agreements and had an emergency transfer agreement in place with one of them.
- The outpatient service provided consultations for Surgery, Cosmetic Surgery, Medical care and Oncology. Services were provided to children and adults of all ages (0 to 75+) and were offered to NHS and privately funded patients. The service had six consulting rooms, which included three specialist eye rooms, at the Hesslewood clinic.
- The main outpatient services offered on this site were ophthalmology, dermatology, neuro, psychology and dietetics.

Meeting people's individual needs

- For our detailed findings please see the Surgery report.
- There was a clear process to identify patients who needed an interpreter. Patients needing an interpreter were identified at booking and translation services were arranged in advance to ensure interpreters were present for outpatient appointments. There was information on display in the department about translation services and to advise that family members should not routinely be used as interpreters.
- The Hesslewood Clinic used the Spire Healthcare Limited consent policy which gives advice for staff on when an interpreter is required and clearly notes that; 'it is not appropriate to use children under the age of 16 years and preferably not under 18 years to interpret for family members who do not speak English.' Family members should not be used as interpreters in any clinical matter. We saw that information was displayed

advising of this. We discussed our concern with the senior team who acknowledged this and advised that they would raise the concern about the wording in the policy with the Spire corporate team.

- The clinic accommodated patients with a learning disability and mild dementia. The need for reasonable adjustments was decided at first outpatient appointment. There was a lead for safeguarding and dementia to give support to patients and staff when needed. Staff in outpatients had sourced a dementia friendly clock and a wooden pain board. Staff did not always know if someone with dementia or a person with a learning disability was going to attend the department. Sometimes this information was available from referral letters but not always. Staff tried to accommodate people's individual needs by making reasonable adjustments and involving family members or a carer where possible. When staff knew people may have additional needs they would arrange appointments around those needs.
- Written information leaflets including the complaints leaflet could be made available in several different languages if needed.
- When patients needed follow up appointments or investigations they were informed during their consultation and later received a copy of the consultation letter to the GP. Follow-up appointments were made at reception before leaving the clinic.
- Outpatient appointment letters sent to patients also included a patient registration form and a fees form which included information on charges and paying for treatment. The fees information had been added as a paper copy attached to the letter as result of patient feedback that had indicated a lack of information about charges, such as prescription charges.
- Managers told us that flexibility of appointment times was offered and most consultants could offer evening or weekend slots.

Access and Flow

- For our detailed findings please see the Surgery report.
- The Hesslewood Clinic accepted self-funded, insured and NHS referrals for children and adults from a large catchment area. Patients were mainly referred to the Spire consultants by their GPs. Patients could self-refer for cosmetic treatments and there was a system in place to contact the patient's GP to decide whether there were any contraindications for the treatment requested, prior to treatment commencement.
- Electronic referral systems were in place for both NHS and self-funded referrals with a fax system for GPs who did not yet use the electronic systems.
- NHS surgical referrals were screened and triaged by the outpatient manager as to suitability for treatment at the Spire Hull and East Riding Hospital. There were a number of exclusion criteria used to assess the suitability of patients. Other referrals went direct to the consultants who made the decision regarding whether it was appropriate to see and treat a patient at the Hesslewood clinic.
- Most of the patients attending the outpatients' and physiotherapy departments were NHS funded. From August 2017 to July 2018, 85% of patients seen, across both sites, were NHS funded and 15% were private patients. During this period, 8,736 NHS and 2,046 private patients attended for first appointments. There were 23,496 NHS and 3,862 private follow-ups. New to follow up ratios were 1 to 2.7 for NHS funded patients and 1 to 1.9 for privately funded patients.
- From August 2017 to July 2018, there were 38,140 outpatient and physiotherapy attendances across the two sites, 830 (around two per cent) of these were children; four appointments were for children aged 0 - two years, 607 were for three -15 years and 219 were for 16-17 years.
- Administration managers told us the service aimed for patients to be seen within two weeks of referral and there were systems in place to help the service meet this target. The admin team could liaise with consultants to offer extra appointments, or with GPs to arrange for a patient to be seen by a different consultant if that was acceptable.
- Appointment slots were ring fenced through the choose and book system for NHS patients and these appointments were opened up to self-funded patients if they were unused and there was a separate booking system for self-funded / insured patients.
- If appointments were made at short notice the admin team would ring patients with the appointment details. Staff told us they would rearrange appointments for

patients if they were unable to attend. Managers told us they monitored the achievement of the two-week wait target; however, we did not see any data relating to the achievement of this target.

- Staff told us it was very rare to cancel a clinic and it would usually be due to a consultant being ill. When clinics were cancelled, admin staff told us they rang patients to reschedule to ensure they were aware of the cancellation, especially if this was within five working days.
- Monitoring of cancelled clinics, reasons why and timing of rescheduled appointments had been introduced and we saw that collated information was presented at the heads of department meeting. Monitoring of clinic start times and the length of time patients waited in department had also been introduced and was undertaken as a quarterly audit. From January 2018 to March 2018 there were 544 patients affected by clinic cancellations, across the Hesslewood Clinic and Spire Hull and East Riding Hospital, which was an improvement on the earlier three months when 746 patients were affected.
- Monitoring of clinic times had led to improved start and wait times by changing the start time of one clinic which had repeatedly started late and led to delays for patients. There were notices in the reception area to inform patients that if they had been waiting 15 minutes or more for their appointment, they should speak to reception and enquire about the delay. Staff told us if they knew a clinic had started late or was going to run late they would inform the reception staff so patients could be kept informed.
- Outpatient staff had a system in place to contact, by telephone, patients who did not attend (DNA) their appointment and offered an alternative appointment. Managers told us they were considering how best to collect and collate DNA data and how this could be best used. The outpatient department DNA rate, across the Hesslewood Clinic and Spire Hull and East Riding Hospital, from April 2018 to June 2018 was 4.7%, the administration team had altered their practice in relation to patients who DNA to collect information to better understand the reasons for this with the aim of reducing the rate.
- We saw evidence that audits were undertaken and action plans documented, regarding waiting times and appointments. An audit of four clinics at Hesslewood showed the waiting time of patients ranged from on-time to 40 minutes for one clinic and five to 15 minutes for the other three clinics. The action following this audit was to speak to the consultant whose clinic regularly started and ran late to determine if clinic times could be altered to better fit with the consultant's other commitments.
- Managers told us they had made some changes in the appointments office as they had noticed long call waits for patients, and phones not being answered. There was now a dedicated, manned desk for telephone calls only. Managers told us the change had resulted in tangible improvements in call answering however, the telephony system did not have an automated reporting system to obtain data from.

Learning from complaints and concerns

- For our detailed findings please see the Surgery report.
- Complaints could be raised through the clinics websites, through patient feedback forms, patient forums, social media, verbally to any member of staff as well as in writing and by email.'Please talk to us leaflets' explaining the complaints process were available in the outpatients' departments waiting areas. Multi-language complaints information posters were displayed in the reception areas.
- Complaints about outpatients were investigated by the Matron who involved and collated information from the other members of the team involved in the patient's treatment.
- We found that, complaints were discussed at safety huddles and team meetings to ensure widespread staff awareness of issues that gave rise to a complaint and so that learning could be shared. Complaints were also shared with all staff through the governance newsletter.
- We saw that complaints were taken seriously and the service had taken actions to improve patients' experience. For example; the service was exploring the possibility of direct onward referral if they received an inappropriate referral from a GP to save time for the patient going backwards and forwards; the service was also reviewing clinic waiting times and reasons for long waits or late starts and they had reviewed secretary cover to ensure timeliness and quality of clinic letters was maintained when consultants' named secretary was on leave.
- There was only one complaint relevant to the outpatient area at Hesslewood from January 2018 to August 2018, the complaint highlighted some administration issues.

Good

Outpatients

Are outpatients services well-led?

Good

We previously inspected outpatients jointly with diagnostic imaging therefore we cannot compare our new ratings directly with previous ratings.

Leadership

- For our detailed findings please see the Surgery report.
- The service was led by a head of department for the Hesslewood clinic which covered the outpatient clinics, the surgical bed area and the operating theatre. This had been a recent change and the manager was looking forward to having a clearly defined area of responsibility and being able to develop services within their remit.
- The clinic had a clear management structure in place with clear lines of responsibility and accountability. The Hesslewood manager reported to the clinical lead and then the Spire Hull and East Riding hospital matron.
- The matron was new in post and the former matron had taken up the role of clinical lead, staff were aware of these changes. The department managers and other staff told us that the matron and clinical lead were visible and approachable.
- Staff in all areas said they were well supported by their line manager and senior managers who were visible and accessible. Staff felt that managers communicated well with them and kept them informed about the running of the departments. Some staff told us they had not been very involved in the recent service changes but had been made aware of what was going on and the need for the recent redundancies. Staff indicated that they were satisfied with the information given and level of involvement.
- Staff we spoke with felt they were listened to and engaged in the organisation. They felt managers were interested in their work and encouraged them to express ideas for service development.
- A large proportion of staff had worked for Spire for many years and had benefitted from training and development to improve their performance. One manager we spoke with told us how they had been developed and trained over the years to be able to progress and take on a leadership role.
- We attended the daily safety huddle held at the Spire Hull and East Riding hospital site for all heads of departments led by the hospital director. The huddle was well structured and involved department leads from all areas. The huddle gave heads of department the opportunity to identify any pressures within their departments, escalate or de-escalate risk and share important information for the day that was relevant to other departments. Heads of department were seen to be fully engaged with the meeting and that this was a valuable communication strategy to promote patient safety and experience as well as a way of engaging staff in the running of the two sites as a whole. Unfortunately, due to the location, the Hesslewood manager could not attend this meeting every day and it was unclear how information was cascaded to the staff at Hesslewood.
- The Hesslewood manager told us it was their intention to have staff meetings one to two monthly and that they had their first site specific meeting in July 2018. Prior to July the staff from Hesslewood had been a part of meetings at the other site. Minutes of the meeting showed a comprehensive agenda which included updates about incidents, complaints, audits and actions, changes to practice, areas for improvement and successes/ progress. They also included information about service developments and improvements or upgrades. This ensured staff knew what was happening across the Spire group and that learning from complaints and incidents were shared with all teams.

Vision and strategy

- For our detailed findings please see the Surgery report.
- Staff we spoke with displayed engagement with the corporate Spire vision and five overarching strategic aims which were; to be famous for quality and clinical care; to be the first choice for private patients; to be the most recommended customer experience; to be the best place to practice and to be the best place to work.
- We found that the outpatient and administration teams had been involved in developing their own vision or aims for each of their areas and that these reflected corporate and local goals.
- For example; Spire Hesslewood Clinic aimed; to provide patients with an excellent service delivered by highly trained staff; provide a clean and safe environment and

make use of space; to improve and develop the use of theatre and clinic services; to encourage innovative thinking and staff flexibility; to listen, grow, be brave, think big, speak up and care.
- Appointments and reception staff also wanted to provide an excellent, efficient, caring service that would provide the best experience for patients, clients, consultants and GPs using the services.
- Staff were proud to work at the clinic, the service they delivered and wanted to provide patients with the best experience possible.
- Organisational expected behaviours and values were integral to staff performance, development and appraisal 'Enabling Excellence'.

Culture

- For our detailed findings please see the Surgery report.
- Staff and managers told us the outpatient departments had an open culture. Staff of all grades spoke positively about the culture within the clinic and they were clearly passionate about delivering a high-quality service and providing patients with the best experience possible. Staff who had joined the company more recently told us they were made to feel welcome by the whole team and had been supported.
- Staff told us they would be confident to raise a concern with their managers and that this would be investigated appropriately. They told us they would have no hesitation in raising concerns, if they had any, and that in the first instance they would go to their immediate line manager. We saw posters displayed in outpatient areas informing staff of the freedom to speak up guardian.
- Staff told us the management team were welcoming of staff ideas for improvement, supportive of staff development and encouraged staff to report and learn from incidents. Staff felt they were encouraged to seek feedback from patients and take immediate action when issues or concerns arose.
- A positive culture was evident within the outpatients' low turnover and length of staff service.
- The appraisal system "Enabling Excellence" was underpinned by Spire's behaviours and helped ensure that patient experience and customer service were top priorities for all staff.

Governance

- For our detailed findings please see the Surgery report.
- There was an established governance committee structure to support sharing of information and drive improvement.
- Staff we spoke with were aware of governance arrangements and feedback from governance and management meetings was given at team meetings. All staff had access to the minutes of meetings on the intranet.
- We found that heads of outpatient deportments attended the leadership team meetings where incidents, complaints, performance against audits and potential items for the risk register were reported and discussed.
- Incidents, complaints and new policies were reported to and discussed at the clinical governance committee and at the medical advisory committee.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints at team meetings where audits and quality improvement were also discussed.
- Registration status had been verified for 100% of staff in outpatients.

Managing risks, issues and performance

- For our detailed findings please see the Surgery report.
- Recording of risks and mitigations and regular review of risks had improved since our last inspection. The outpatient manager told us that the risk champion had met with heads of departments and was to attend team meetings to explain the risk registers and how these should be reviewed and updated. There was an expectation that actions to mitigate risks were clear and entered on the electronic system. The risk lead was responsible for monitoring compliance with this approach and sending reminder alerts to the heads of departments when necessary.
- The service had a risk register in place for business and clinical risks and managers escalated new risks when necessary. The outpatient manager did not have a separate risk register for their department but felt that the hospital risk register covered the department's risks.
- Staff knew how to escalate risks within their department and there was opportunity at the daily safety huddle for heads of department or a representative to raise immediate risks to the wider management team and the hospital director. Heads of department could also raise any new risks through the governance meeting structure as appropriate. A rapid response meeting with the

heads of department, chaired by the governance lead was held weekly, to discuss recent incidents and ongoing investigations, any immediate actions that needed to be taken and to ensure all staff were aware of any implications for their departments
- Performance was monitored and managed through a programme of audits which all had an expected level of compliance. We saw that audits were reported and shared on a clinical performance scorecard. Not all of the benchmarked audits were relevant to the outpatient areas but there were other audits in these areas.
- We found that the audits of waiting times and appointment bookings had found some issues and some actions with deadlines had been documented. However, these tended to be single actions which lacked detail and did not include any subsequent actions needed by staff in other departments such as x-ray or appointments, to make the improvements aimed for.

Managing information

- For our detailed findings please see the Surgery report.
- All staff had access to the intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Minutes from meetings and important documents such as the risk register could be accessed by staff on the intranet.
- Staff could access patient information such as x-rays and medical records appropriately through electronic and paper records.
- The typing of outpatient letters was outsourced to an independent company.
- Compliance with information governance training for staff in outpatients, and associated admin and reception teams was at or better than the September 2018 target of 75%.
- We found that patient records were stored safely and securely away from patients and that there was a secure transport system in place for transferring records from one site to another.

Engagement

- For our detailed findings please see the Surgery report.
- Staff were seen to be passionate about their roles and invested in the success of the clinic. Staff we spoke with were engaged in the future of their services and the desire to be excellent providers of care. Some of the staff we spoke with were proud to have received recognition from their colleagues and managers for long service and or good work and achievement.
- All staff we spoke with felt valued by their line managers and the senior management team. Staff gave examples of engagement activities and rewards the senior team offered these included; an annual staff party, a free birthday lunch, long service awards and inspiring people awards.
- Staff said the hospital director was 'always around and knows every body's name', that managers had an open-door policy and were very approachable.
- Other staff told us that work life balance was respected and that the investment in their training made them feel valued.
- The hospital director held a daily safety huddle for managers from all areas, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Managers cascaded the key messages from the huddle to their own teams. If the Hesslewood manager was unable to attend they received the information from managers at the Spire Hull and East Riding hospital.
- Patient engagement occurred in several ways, for example, patient feedback was encouraged and surveys were undertaken of patient experience and waiting times. Compliments were also collected and shared with staff and or used in appraisal and revalidation. All feedback was shared to promote improvement from a patient perspective and improvements were displayed on 'You said we did' boards in the outpatient waiting areas. Patient experience surveys showed a high level of satisfaction.
- Managers told us that patient feedback had been used to inform developments such as increasing outpatient clinic capacity and developing evening services.
- The Hesslewood Clinic and Spire Hull and East Riding Hospital was to take part in the pilot of a new outpatient specific feedback survey later in the year, which will be completed online.
- Staff told us they were kept up to date with what was happening across the Hesslewood Clinic and Spire Hull and East Riding Hospital through team meetings. All staff received an email of the meeting minutes and also received updates through a 'hot topics' communication.

Good

Outpatients

- Staff could access hospital wide information, such as the minutes from clinical governance committee, local policies and risk assessments electronically on a shared computer drive.

Learning, continuous improvement and innovation

- For our detailed findings please see the Surgery report.
- Staff told us they were encouraged to propose innovative ideas for service developments and or to improve patient experience.

Outstanding practice and areas for improvement

Outstanding practice

The children and young people's (CYP) service provided a 24-hour telephone line that children and their parents could contact post discharge if they had any concerns about the recovery of their child. Families could also send a text message to the same number.

The service provided a consultant led service for gender reassignment and staff used national guidance to support this pathway such as Interim Gender Dysphoria Protocol and Service Guideline 2013/2014 (NHS England) and Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People (the World Professional Association for Transgender Health).

The CYP lead demonstrated compassionate leadership and a clear understanding of the emotional needs of young people undergoing gender transition. For example, using appropriate pronouns and language to describe procedures, the importance of confidentiality, and the role of the registered children's nurse and child and adolescent mental health service (CAMHS) in supporting young people to maintain supportive friendship networks through the process.

The CYP lead described supporting a child with a needle phobia by inviting them to visit the pathology lab, wear a child-sized white coat and meet the scientists to understand what happens to their blood samples, to reduce anxiety about the process.

The service followed the Royal College of Anaesthetists guidance about preoperative fasting to ensure children and young people fasted for the safest minimal time possible. The service audited whether CYP theatre starve times were within guidelines and scored 100% compliance from January to June 2018.

All CYP staff (100%) had completed paediatric competencies. In addition to this some diagnostics and pharmacy staff had undertaken the competencies despite this not being a requirement of their role. In total we found 56% of all staff who did not require the competencies had undertaken them. This included 92% of outpatients staff, 81% of physiotherapy staff, 45% of theatres staff and 19% of ward staff.

Longer appointment times were allocated for children in the diagnostics department and to reduce fear, staff would x-ray the child's teddy bear and show them the x-ray picture, before x-raying the child.

We saw that children's procedures were booked at the beginning of theatre lists, which usually meant it was timely and children and young people could recover and return home the same day. We reviewed the paediatric admission register which confirmed this and spoke with staff who were flexible about coming in early to accommodate early lists.

Areas for improvement

Action the provider SHOULD take to improve

The outpatients service should continue to monitor cancellation of clinics and act to reduce the number of cancelled and rearranged outpatient appointments.

The outpatients service should continue to improve how patient outcome and audit data are implemented, interpreted and used to improve, sustain good practice and support innovation. To include the review of the level of detail needed in improvement action plans.

The clinic should consider removing reference files containing paper copies of policies and protocols to ensure staff are not referring to out of date guidance.

The service should ensure that they improve the level of feedback from patients, including children, young people and their families.

The service should take steps to improve the waiting area environment for children and young people at Hesslewood clinic.

The senior team should consider whether the CYP service is sufficiently represented at senior and strategic level to influence and support a growing service.