Spire Clare Park Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Clare Park Hospital is purpose built and opened in 1984, it is currently run by Spire Healthcare Limited.

The hospital provides a range of services to patients of all ages who are NHS funded, self-pay or use private medical insurance. Services offered include general surgery, cosmetic surgery, orthopaedics, dermatology, physiotherapy, gynaecology, endoscopy and diagnostic imaging.

The on-site facilities include three operating theatres (two with laminar flow), two wards with 34 registered beds (used flexibly for inpatients and day care) and a three bedded enhanced recovery unit. All the beds are in single rooms with en-suite bathrooms. Extended recovery services are provided and there is no emergency department at the hospital.

The outpatient department has ten consulting rooms, two treatment rooms, an audiology booth and an exercise ECG room. The diagnostic imaging department offers X-ray, ultrasound, digital mammography, MRI and CT scans. Physiotherapy treatment is offered as an inpatient and outpatient service. There is an accredited sterile services department and a pharmacy on site.

We inspected the hospital as part of our planned inspection programme. This was a comprehensive inspection and we looked at the three core services provided by the hospital: surgery, outpatients and diagnostic imaging and services for children and young people. The endoscopy service was reported under the surgery core service report as the hospital provided only a very small medical service. The hospital also provides a weight loss service which we did not inspect as part of this inspection. This service will be inspected separately in the future.

The overall rating for this service was 'good'.

Are services at this hospital safe?

- Patients were sufficiently protected from avoidable harm and abuse across surgical services and in outpatient and diagnostic imaging., However, there were concerns about the safety of children and young people at the hospital. Individual patient rooms posed some risks to children; these were not accurately assessed or mitigated.
- Staff reported incidents and openness about safety was encouraged.Incidents were monitored and reviewed. We saw examples of changes in practice that occurred as a result of learning from incidents. However, the children and young people's service lead did not have oversight of the small number of incidents reported within their own service.
- Staffing numbers (nursing and medical) were sufficient to provide safe care and treatment in all areas. Staff completed mandatory training and they were on track to achieve their target of all staff to have completed all required training by the year end. In services for children and young people, staffing did not always meet recommended guidance. There was no process to ensure a registered children's nurse was identified to hold responsibility and accountability for the whole of the child's pathway, including their pathway through the outpatient's services.
- Most areas inspected were visibly clean and tidy though we found some areas of dust in the outpatient's department. Staff adhered to bare below the elbows guidance.Equipment was well maintained. However, there was insufficient regard or mitigation of the infection risk associated with children's' toys used in some areas of the hospital.
- Medicines were stored safely and staff mostly administered medicines within the hospital's policy.However, we found that anaesthetic cream was being administered to children without being prescribed.In surgical services, there had been inconsistencies in the management of controlled drugs which the hospital manager was taking action to address.

Summary of findings

- Clinical staff identified and responded to changes in patient's risks appropriately. When needed, arrangements were in place to ensure patients could be safely transported to a local NHS hospital.
- Staff received regular simulation training and we saw where individual learning needs in relation to safety scenarios were identified, and responded to, following this.

Are services at this hospital effective?

- Care and treatment followed best practice and evidence based guidance across services for adults.
- Patient outcomes were mostly monitored with joint replacements monitored through the National Joint Registry. Outcome data for gastrointestinal procedures was collected but not used to improve patient outcomes. The gastrointestinal endoscopy service was due to move into a newly developed unit and the reporting tool was in place to better use this data following the transition.
- There was no clinical audit plan for children and young people's services. A clinical scorecard was in use but did not benchmark clinical effectiveness across a wide range of measures.
- Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R audits were undertaken in line with regulatory requirements. Results indicated the service performed in line with national standards.
- Patient's pain was appropriately monitored and a variety of pain relief was offered when required.
- Patient's nutrition and hydration needs were met. The hospital offered a wide range of food choices and individual dietary requirements were accommodated.
- The Medical Advisory Committee were actively involved in reviewing patient outcomes and the renewal of practising privileges of individual consultants.
- Staff were competent and sufficiently skilled to deliver effective care and treatment though adult trained staff did not always receive appropriate additional training in the care of children and young people.
- The hospital provided training for staff in Mental Capacity Act, 2005, and Deprivation of Liberty Safeguards.Staff routinely considered patients' mental capacity to make decisions about their care and treatment.
- With the exception of one consultant, staff demonstrated understanding of consent procedures. .
- Multidisciplinary services were available to patients seven days a week, including physiotherapy, pharmacy and x-rays.
- Staff had access to clinical information and guidance to support patient care.However, parents/carers were not requested to bring their child's health record to appointments.

Are services at this hospital caring?

- Patients and their relatives were consistently positive about the care and treatment provided at this hospital. Friends and Family Test data and the hospital's own patient survey showed consistently high levels of patient satisfaction.
- We observed staff delivering kind and compassionate care that offered respect and dignity to patients.Staff worked hard to ensure that both patients and their relatives were comfortable and had their needs met throughout their appointment or procedure.
- Patients were mostly included in decisions about their care and treatment.
- Staff worked hard to ensure patients' emotional needs were met. However, children were not routinely invited to attend the hospital prior to any procedure to reduce potential anxiety associated with an unfamiliar setting.

Summary of findings

- The outpatient department offered a chaperone service to all patients so they could be emotionally supported throughout their appointment.

Are services at this hospital responsive?

- Services for adults were planned and delivered to meet the needs of local people.
- The importance of flexibility and choice was reflected across the services with appointments and procedures being organised at times to suit patients and their carers.
- Staff made adjustments to provide care for patients with additional individual needs such as people living with mental illness or a learning disability.
- The hospital had not met national referral to treatment targets for three months out of 12 between April 2015 and April 2016 for NHS surgical patient due to a staff vacancy. Following a successful apoointmen,action taken to improve this had ensured they met the target in August 2016.
- Complaints and concerns were taken seriously, responded to in a timely way and improvements were made to the quality of care as a result.

Are services at this hospital well led?

- The leadership team actively shaped the culture through effective engagement with staff, people who use services and their representatives, and other stakeholders. Patient forums, staff surveys and stakeholder feedback results were used to drive improvements.
- Staff valued recent changes within the leadership structure and found senior managers to be visible and accessible. There was an open and supportive learning culture.
- Staff were familiar with the organisation's vision and values and understood the future priorities within their own departments.
- Overall, there was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff told us they were aware of the risks, and action taken to mitigate these risks for their individual departments. However, there was a lack of clarity about the overall leadership of children and young people's services provided across the whole of the hospital. The children and young people's governance arrangements were newly implemented at the time of our inspection so had not, at that time, supported quality monitoring or improvements. It was not clear who had oversight of, or responsibility for, identification of risks associated with providing a children and young people's service at the hospital..
- The Medicines Advisory Committee (MAC) reviewed the practising privileges of consultants through quarterly meetings but attendance at the MAC did not reflect the range of specialities within the hospital.

Our key findings were as follows :

- Senior leadership at this hospital was strong. All staff were positive about their senior managers and recent changes in leadership. However, there was a lack of clarity regarding the local and senior leadership of the services for children and young people. Governance arrangements for this service were newly implemented and, as such, not fully embedded.
- Adult patients were sufficiently protected from avoidable harm and abuse. There were concerns about the safety of children and young people in some areas of the hospital. Individual rooms posed risks that we were not assured were sufficiently mitigated and we found some areas with toys we were not assured could, or had, been cleaned effectively to reduce the potential spread of infection.

Summary of findings

- Staffing was sufficient in numbers to provide safe care and treatment in all areas. Staff completed mandatory training and were on track to meet the hospital's year-end target of 95%. However, adult registered nurses did not always receive appropriate training in the care of children and young people and paediatric staffing did not always follow national guidance.
- The hospital environment was mostly clean and tidy and infection prevention procedures were mostly good. Staff adhered to bare below the elbows guidance across the hospital.
- Patient's nutrition and hydration needs were met. The hospital offered a wide range of food choices and individual dietary requirements were accommodated.
- Patients reported that staff managed their pain effectively and staff offered a range of pain relief when required.

There were areas of poor practice where the provider needs to make improvements -

Action the hospital MUST ensure;

- The 'five steps to safer surgery' checklist is always appropriately completed.
- The storage and management of medicines, including controlled drugs, meets the requirements of current legislation, hospital group policy and standard operating procedures.
- Risk of transmission of infections from children's toys is mitigated.
- Risk assessment processes identify all risks posed by the environment of the hospital to children and young people are identified and appropriate mitigating action is taken.
- The hospital's medicines management policy is adhered to and staff must not administer medicines that have not been prescribed.
- There is a clear and visible leadership structure which covers all areas of children and young people's care at the hospital in place to support staff in caring for children and young people.
- Staff must know who to contact outside the organisation in the event of a safeguarding concern and the hospital safeguarding lead is not available.
- Consider national guidance when planning staffing levels for children and young people's services in all departments of the hospital.
- All nursing staff that look after children and young people must complete competency assessments appropriate to the care and treatment they provide to children and young people.
- All clinical areas are visibly clean and free from dust and cleaning schedules displayed in public areas.

Action the hospital SHOULD ensure;

- Consultants should plan how they are going to use endoscopy outcome data to improve patient outcomes.
- Referral to treatment times are captured accurately and national targets are consistently met.
- Medical Advisory Committee meetings should be attended by representatives from a wide range of specialities across the service.
- Consider asking parents of young children to bring their personal child health books in for outpatient appointments and hospital admissions.
- There is a clinical audit plan in the children and young people's service that supports the clinical scorecard to measure a broad range of outcomes for children and young people.

Summary of findings

- Further consider how to ensure the environment is inviting and child-friendly to all age ranges in all areas of the hospital where children and young people receive care.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Overall, we rated surgical services as good for safe, effective, caring, responsive and well led care. Openness and transparency about safety was encouraged. Incidents were reported and investigated and learning was shared widely to prevent similar reoccurrences. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. Staff were appropriately qualified and had the skills to carry out their roles effectively. Peoples care and treatment was planned and took account of current evidence based practice, standards, best practice and legislation. Feedback from patients about their care and treatment was always positive. We observed patients were treated with kindness, compassion and dignity though out our visit. There was variability in the full completion of the 'five steps to safer surgery' checklist, and all aspects of the administration of controlled drug medication. The service was taking actions to improve the variability. Services were planned in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service and there were ongoing plans for further development. The hospital had not met national referral to treatment time indicator from January 2016 to July 2016 due to staff vacancy. Following a successful appointment, the hospital in August 2016 was back on track with the indicator. Complaints and concerns were taken seriously, responded to in a timely way and improvements were made to the quality of care as a result. The leadership actively shaped the culture through effective engagement with staff, people who use services and their representatives, and other stakeholders. There was a clear governance framework to monitor quality, performance and risk at

Summary of findings

department, hospital and corporate level. Staff told us they were aware of the risks, and action taken to mitigate these risks for their individual departments.

Services for children and young people

Requires improvement

Overall, we rated services for children and young people at this hospital as requiring improvement. We rated the children and young people's services as inadequate for well led and requires improvement for safe and effective care and good for caring and responsive care.

The environment of the hospital posed some risks to the safety of children. There was no oversight from the children and young people's lead of incidents occurring in the provision of children and young people services. Safe management and administration of medicine policies were not fully followed: nurses administered medicines that were not prescribed. There was not always a registered children's nurse identified, when children or young people attended the hospital for outpatient appointments, to hold responsibility and accountability for the whole of the child's pathway. Infection control practices did not fully protect patients from risk of transmission of infection from children's toys.

Children and young people's care did not always take account of national and best practice guidance. Adult nurses working with children and young people in the outpatient department, theatres and the recovery area did not complete competences about the care of children and young people.

There was no clinical audit plan for children and young people's services. A clinical scorecard was in use but did not benchmark clinical effectiveness across a wide range of measures.

There was a lack of clarity about the overall leadership of the whole children and young people's service at the hospital. The children's lead nurse had no oversight of the service delivered to children and young people in the outpatient department. The children and young people's governance arrangements were newly implemented at the time of our inspection so had not, at that time, supported quality monitoring or improvements. It was unclear who had oversight

Summary of findings

of, and was responsible for, the identification of risks associated with providing a children and young people's service at the hospital. There was a written strategy for the development of the children and young people's service but it did not include detailed action planning to achieve its aims and was not well understood by staff within the service.

Staff completed paediatric lifesaving training relevant to their role, which met national guidelines. Use of a nationally recognised paediatric early warning system (PEWS) supported staff to identify if a child's condition was deteriorating. All staff completed training about safeguarding children.
Children and young people had their pain managed effectively.
Staff at the hospital worked as a multidisciplinary team to support children in hospital. Children's and young people's surgery was carried out at the beginning of surgical lists. Processes were followed to ensure consultants had the appropriate skills and knowledge to carry out surgery on children and young people.
Children, young people and their parents spoke positively about the care and treatment they received. They thought staff were very kind and that they were informed about their care and treatment. Parents could stay with their children in hospital.
Staff spoke positively about the support they received from their local leadership and the hospital director.
Complaints were responded to and learning shared through the hospital's governance framework. However, the children's complaints register did not reflect all complaints relating to the care of children and young people across all departments of the hospital.

Outpatients and diagnostic imaging

Good

We rated this service as good overall. We found outpatients and diagnostic imaging was good for the key questions of safe, caring, responsive and well led. We did not rate effective, as we do not currently collate sufficient evidence to enable a rating.

Summary of findings

There were appropriate systems in place to keep patients safe. Staff fulfilled their responsibilities to raise concerns and report incidents and near misses. Patients were appropriately safeguarded from abuse and avoidable harm. Staff undertook appropriate mandatory training for their role and they protected patients from the risk of abuse and avoidable harm. The hospital was generally clean and tidy but we found areas of dust in a number of consulting rooms. Cleaning schedules were not displayed in all outpatient areas. Staff wore protective clothing and followed hand hygiene procedures to reduce the spread of infection.
Care and treatment was delivered in line with current evidence based guidance, and best practice and legislation. There was evidence of local and national audits, including clinical audits. Staff were qualified and had the appropriate skills to carry out their roles effectively. Managers supported staff to deliver effective care and treatment, through meaningful and timely appraisal.
We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who used the service and those close to them was positive about the way staff treated them.
There was good availability of appointments for patients across all specialities. Access to appointments was timely; staff held clinics on weekdays into the evening and on Saturdays to suit patients' preferences. Waiting times, delays, and cancellations were minimal and managed appropriately.
Translation services were available when required and staff made practical adjustments to accommodate patients' individual needs, for example, when caring for patients with dementia.
Complaints were taken seriously, investigated thoroughly and resulted in positive changes made to practice and procedures.
Effective governance and risk management systems were in place. Local and senior managers were visible and approachable to all staff. There

Summary of findings

was an open and supportive learning culture. Staff gave patients opportunities to provide feedback about their experiences and they used the feedback to improve the service.

Summary of findings

Contents

Good

Spire Clare Park Hospital

Services we looked at

Surgery; Services for children and young people; Outpatients and diagnostic imaging

Summary of this inspection

Background to Spire Clare Park Hospital

Spire Clare Park Hospital is purpose built and opened in 1984; it is currently run by Spire Healthcare Limited. The hospital is located just outside of Farnham, in its own grounds with parking.

The hospital has two wards with 34 registered beds, used flexibly for inpatients and day care, and a 3-bedded enhanced recovery unit. All the beds are in single rooms with en-suite bathrooms. Level 2 critical care is provided and there is no emergency department at the hospital.

The on-site facilities include three operating theatres (two with laminar airflow). The outpatient department has ten consulting rooms, two treatment rooms, an audiology booth and an exercise ECG room. The diagnostic imaging department offers X-ray, ultrasound, digital mammography, MRI and CT scans. The physiotherapy treatment is offered as an inpatient and outpatient service and the department and 5 treatment bays and a treadmill. There is an accredited sterile services department and a pharmacy on site.

The hospital provides a range of services to patients of all ages (over three years old) who are NHS funded, self-pay or use private medical insurance. Services offered include general surgery, cosmetic surgery, orthopaedics, dermatology, physiotherapy, gynaecology, endoscopy and diagnostic imaging.

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

There was no registered manager at the time of our inspection. The interim hospital manager at the time of our inspection has since submitted an application to be the registered manager.

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

Our inspection team

Our inspection team was led by:

Inspection Lead: Emma Bekefi, Care Quality Commission, Inspection Manager

The team included four CQC inspectors and a variety of specialists: a paediatric nurse, a surgeon, a surgery theatre manager, a radiographer and a governance lead.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the hospital and spoke to the local clinical commissioning group. We carried out an announced inspection visit between 30 and 31 August 2016.

We held focus groups for staff in the hospital. We also spoke with staff and managers individually. We talked with patients and staff from the ward, physiotherapy department, operating department, X-Ray and outpatient services. We observed care and treatment, talked with patients, and reviewed patients' records of care and treatment.

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	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

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

Good

Surgery

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

Information about the service

Spire Clare Park provides planned surgery to patients who pay for themselves, are insured or are NHS funded patients. From April 2015 to March 2016 there were 4957 patient visits to theatre. The surgical operations most frequently carried out were joint injections with or without image guidance (600), total hip replacements (157), spinal surgery (156), knee arthroscopy (143) and total knee replacements (127). Surgical specialities offered on this site included orthopaedic surgery, general surgery, breast surgery, oral surgery, bariatric surgery, bowel surgery, cosmetic surgery, vascular surgery, urology, gynaecology and plastics and reconstructive surgery.

The hospital had three operating theatres. Theatres one and two were fitted laminar flow, a system of circulating filtered air to reduce the risk of airborne infection. There was a dedicated recovery area within the main theatre complex. The in house theatre sterile supplies department achieved accreditation with the International Standards Organisation (ISO) in June 2015. The hospital had 34 beds within two wards, Redgrave and Chaucer, which were used flexibly for inpatients and day case patients. Redgrave ward also included a two bedded extended recovery area. There were no critical care facilities at the hospital. In an emergency the hospital transferred these patients to nearby NHS hospitals.

There was a small medicine service which was predominantly endoscopy, which was reported under surgery. From April 2015 to March 2016, there were 231 colonoscopies and 153 oesophago-gastro duodenoscopies.

From April 2015 to March 2016 there were 3977 day case attendances and 1262 inpatient attendances. The NHS funded approximately 25% of day cases and inpatient care.

The inspection included a review of all the areas where surgical patients receive care and treatment. We visited the pre-assessment clinic, the surgical ward, anaesthetic rooms, theatres and recovery area. We spoke with seven patients, and received three comments cards relating to patients who had undergone surgery. We reviewed 11 patient records. During the inspection we spoke with 25 members of staff, including managers, medical staff, registered nurses, health care assistants, operating department assistants, allied health professionals and administrative staff. Before, during and after our inspection we reviewed the hospital's performance and quality information.

Good

Surgery

Summary of findings

We rated surgery as good because:

Openness and transparency about safety was encouraged. Staff understood their responsibility to raise concerns and report incidents. When something went wrong, thorough investigation took place involving all relevant staff and people who use services. Lessons were learned and communicated widely to support improvement in other areas as well as services that were directly affected.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times. There were effective handovers and shift changes, to ensure staff could manage risks to people who used services.

Staff were appropriately qualified and had the skills to carry out their roles effectively and took account of best practice. The learning needs of staff were identified and training put in place to meet their learning needs. Staff were supported to maintain and further develop their professional skills and experience.

The surgical service had some variability in the full completion of the 'five steps to safer surgery'checklist, and all aspects of the administration of controlled drug medication. The service was taking actions to improve the variability .

Peoples care and treatment was planned and took account of current evidence based practice, standards, best practice and legislation.

Feedback from patients about their care and treatment was always positive. We observed patients were treated with kindness, compassion and dignity though out our visit.

Services were planned in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service and there were ongoing plans for further development. Due to staff vacancy, the hospital, in the period from January 2016 to July 2016 2016, had not met the national waiting times indicator for 90% of NHS admitted patients beginning treatment within 18 weeks of referral. The indicator had ranged from 83% to 88%. In August 2016, the hospital was back on track with the indicator following a successful appointment.

It was easy for people to complain or raise a concern and they were treated compassionately when they did. Complaints and concerns were taken seriously, responded to in a timely way and listened to. Improvements were made to the quality of care as a result of complaints and concerns.

The leadership actively shaped the culture through effective engagement with staff, people who use services and their representatives and other stakeholders.

There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff told us they were aware of the risks, and action taken to mitigate these risks for their individual departments.

Good

Surgery

Are surgery services safe?

Good

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

We rated safe as 'good' because;

- Staff reported incidents and received feedback. Lessons were learnt and shared following incidents
- Between April 2015 and August 2016 there been no confirmed hospital acquired surgical site infections.
- All clinical areas were visibly clean and appropriately equipped to provide safe care and treatment
- The hospital had a theatre sterile supplies department that had achieved accreditation with the International Standards Organisation (ISO) in June 2015.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Patient records were accurate, stored safely and provided detailed records of care and treatment.
- Staffing was at planned levels, following assessment of patient needs and guidance for safe care. Staff were trained and competent to undertake their roles.
- There were effective hand overs at shift changes.
- Staff routinely assessed and monitored risks to patients. They used the national early warning tool score to alert the if thepatient's condition deteriorated. The tool also gave specific actions to follow if the score changed.

However

- Compliance varied with completion ofthe World Health Organisation Safer surgery check list. The service was taking action to improve compliance.
- Compliance varied with the administration of controlled drug (CD) medication. Signatures were not always obtained when returning controlled medication to patients. Also in theatre 2, there was a single signature instead of two signatures on 10% of occasions when CD medication received.

Incidents

- The hospital had a good culture of incident reporting. Staff at all levels and disciplines knew what incidents they needed to report and how to report them. Staff told us they were confident with using the hospital's electronic incident reporting system. Staff confirmed they received feedback about any incidents they reported.
- The hospital reported incidents as clinical and non-clinical. There were 185 clinical incidents and 127 non-clinical incidents reported across the hospital from April 2015 to March 2016.Twelve of these non-clinical incidents occurred in the surgical speciality or inpatient setting. Clinical incidents includedunplanned transfers, malfunction of an item of clinical equipment, and clinical documentation incidents.
- The hospital reported four severe incidents within surgery from April 2015 to March 2016. Following a severe incident or a death, a root cause analysis (RCA) was undertaken, and lessons to be learnt were identified. For example, an incident when a surgical patient's skin was incorrectly prepared and sterilised which increased the risk for post-operative infection. Hospital actions following this investigation included ensuring that correct processes were followed with skin preparation solution, and a copy of the Association of Perioperative Practice (AFPP) Sstandards Manual was placed in each theatre. The theatre manager wanted to ensure staff had a reference guide immediately to hand.
- The hospitalhad a never event August 2015. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Wrong site surgery occurred with an operation on the incorrect web space between a patient's toes. The theatre manager following this incident designed a notice for staff with a traffic light showing red, amber and green. The red light had described the wrong site surgery, amber the investigation and the green light described the changes made. Changes included better checking of consent form against the operating list before commencement of anaesthetic and a revision of the patient booking form.

- The hospital reported two patient deaths from April 2015 to March 2016. One of these patients died following a colonoscopy. The consultant had advised the patient and their family of the benefits and that the procedure was high risk due to patient's existing diverticular and chronic renal disease. A root cause analysis was undertaken, and lessons were learnt from this incident. For example, the matron has discussed with the consultant the importance of them reviewing their patient in person, if staff alerted them with concerns about a deteriorating patient. The second patients' death occurred five days after they were discharged, and the following coroner's report confirmed the death was unrelated to the surgery.
- Staff in theatres and on the wards told us they were aware of the duty of candour legislation. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The matron, theatre and ward sister understood their responsibilities in terms of offering an apology to patients and meeting with and writing to patients if harm had been caused. We saw evidence that involvement and support by senior staff of patients and their relatives/ family did take place. If an incident occurred in theatres or on the wards, nursing staff knew to be open and honest with patients.

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

- The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient 'harm or harm free' care. The hospital is only required to submit data for the NHS patients, which the hospital are caring for on the day of the data input. The submission included data on patient falls, pressure ulcers, catheter and urinary tract infections, and these showed 100% harm free care for the past year (August 2015 to August 2016) for a total of 44 NHS patients.
- The hospital monitored patient safety for all patients, including NHS and those that were self-funded or funded by insurance policies via the electronic reporting system. The information gathered through this system was reported in the monthly clinical effectiveness meeting and monitored via the provider's clinical scorecard . The scorecard information benchmarked the hospital against other hospitals in the group and showed that the hospital achieved or exceeded targets for most of the 'safe' areas on the scorecard. For example , there were no incidents of patients with hospital acquired venous thromboembolism (VTE) and patients' falls incidents were below the target of two per 1000 bed days from April 2015 to March 2016. The hospital was rated at amber for completing the investigation ofincidents within 45 calendar days achieving 63% against a target of 75%.
- Staff assessed patients for venous thromboembolism (VTE) risk and took steps to minimise the patient's risk of developing a thrombosis (blood clot) taking account of NICE guidelines. The consultants gave patients chemical prophylaxis to prevent the formation of a DVT. However, the hospital clinical scorecard from January to December 2015 showed that for patients undergoing hip and knee replacements only 20% had VTE prophylaxis started within the recommended timescale (according to NICE). Nursing staff told us the orthopaedic surgeons were starting chemical prophylaxis the morning following surgery. We were told this was because the hospital had made a decision following review to follow the British Orthopaedic Association guidance on venous thromboembolism chemo-prophylaxis rather than NICE guidance as they said their local NHS trust also did.
- This decision was made due to consultants concerns that chemical prophylaxis given prior to surgery could cause wounds to ooze and increase the risk of infections.The hospital had 100% compliance for prescribed VTE chemical prophylaxis being given for the recommended number of days.

Cleanliness, infection control and hygiene

- The hospital had no incidences of clostridium difficile, meticillin-resistant staphylococcus aureus (MRSA), The hospital displayed information, in the reception area on a notice board, that included there had been no incidents of MRSA bacteraemia or clostridium difficile in 2015. Alsothe patient satisfaction survey for 2015, showed that patients using the hospital had rated cleanliness at 99%.

- The hospital risk assessed all patients to assess if they needed to be screened for MRSA prior to a procedure. The hospital group had a policy in place to support MRSA screening of patients.
- The hospital reported no surgical site infection (SSIs) acquired at the hospital from April 2015 to March 2016. However one patient who had a cosmetic surgical procedure in March 2016, had developed a surgical site infection. The investigation was not fully complete when we inspected in August 2016, as consultant microbiologist's a review of the investigation report awaited. Another patient who had undergone orthopaedic surgery was also found to have a surgical site infection at the time of our inspection in August 2016, the infection control leadwas investigating this incident.
- Ward and theatre areas were visibly clean at the time of inspection. General cleaning of the hospital was carried out by housekeeping staff. Daily cleaning and bi annual deep clean of theatres was outsourced to another provider. The infection control link nurse and the theatre manager and acting ward manager monitored the quality of cleaning, with the support of checklists.
- There was a safe 'flow' of equipment from clean to dirty areas to minimise the risk of cross contamination. The theatre manager had undertaken risk assessments to support the decontamination and management of endoscopes.
- The estates staff undertook quality weekly checks of the rinse water used to clean the endoscopes. The results had ranged from April to June 2016 as low to medium risk. Staff took action when needed following protocols, and rinse water results returned to a satisfactory or acceptable level. The theatre manager explained the endoscopy washer machines were old, and would be replaced with the new endoscopy unit due to be completed in November 2016.
- The theatre and ward cleaning records showed there was a programme of daily cleaning and these were mostly completed and up to date. The hospital used single use equipment where possible.
- There was a clear process for the management and prevention of infection. We observed staff adhered to the 'bare below the elbow' policy. Bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails or nail varnish. Staff were observed to wash their hands between patients and use personal protective equipment, such as disposable aprons and gloves to prevent cross infection.
- On the ward we observed that equipment items had 'I am clean' stickers, indicating they were clean and ready for use.
- The hospital had been auditing the use of hand gel by staff, rather than an observational handwashing hygiene audit. Spire policy had recently changed, and a new observational hand hygiene audit dated December 2016 to be implemented. Patient hand hygiene survey results were good with nine patients out of 10 indicating staff cleaned their hands appropriately. At an infection meeting led by the matron in June 2016, heads of department were asked to remind all staff to continue to follow the principles of the WHO 5 Moments for Hand Hygiene in everyday practice.
- The matron reported at the hospital infection control meeting in June 2016 that care audits of patient urinary catheters and patient peripheral cannula lines in their veins achieved 100% compliance.
- The hospitals patient led assessment of the care environment (PLACE) score for 2016 for cleanliness was 100%, against an England average of 98%.

Environment and equipment

- The hospital had three operating theatres for surgical procedures. Theatres one and two within the hospital were fitted with ultra clean ventilation systems also known as 'laminar flow'. The hospital organised operations and procedures, taking into account the limitations of theatre three which was not fitted with this system. Procedure that had a higher risk of infection, such as joint surgery, would always be performed within the 'ultra clean' or laminar flowtheatres.
- The hospital had a four bedded recovery area with facilities to care for patients in the immediate post-operative period before they returned to the ward.
- The wards and theatres had mobile resuscitation trolleys for use if a patient had a cardiac arrest. Records

showed that staff checked the trolleys daily in line with professional guidance to ensure equipment was available and in date. All trolleys had a tamper proof tag to prevent access by unauthorised personnel.

- Staff had access to the use of a lifting hoist if needed to transfer patients with restricted mobility. The hospital had the facility to wash the lifting slings on site, to ensure their cleanliness and availability.
- The hospital had achieved International Standards Organisation (ISO) accreditation in the theatre sterile supplies department in June 2015.We were told that staff working in the department had reported a problem of back pain due to a low equipment washing sink. The theatre manager had undertaken a risk assessment, and actions were, to ensure staff rotated regularly from working at the low sink and that they varied their tasks. The estates department were looking at the option of fitting a sink that could be raised up and lowered.
- Theatre staff planned surgical equipment for operations in advance. Surgeons completed an equipment requirement form when booking a patient for surgery, to ensure the correct equipment and staffing for a procedure was available. The hospital could meet additional requests for equipment by outsourcing to external companies. The theatre manager reported there had been an incident with an urology kit found broken and not made up properly. The surgeon had not been able to complete the procedure for the patient, which was then rescheduled at a nearby NHS trust two days later. The theatre manager had investigated and produced an action plan, which included changing one piece of equipment to single use.
- The theatre manager had a difficult intubation tray set up near theatres one and two. The tray contained equipment to be used when a patient's airway was difficult to manage. Theatre staff had completed a checklist to indicate checks of the equipment had been made.
- Equipment we checked had been serviced and safety tested, and action taken where needed to address faults. The theatre manager had also designed labels to put on equipment to make it easier for staff to identify who was responsible for servicing equipment.

Medicines

- Pharmacists supported the ward and theatre staff. A pharmacist reviewed all prescription charts and carried out medicine reconciliation (MedRec) for all inpatients to ensure continuity of their routinely prescribed medicines.
- Medicines were stored at safe temperatures. Staff monitored fridge and room temperatures where medicines were stored and took appropriate action when temperatures were outside the recommended range. We saw records that showed staff monitored the temperatures.
- On the ward and in theatre, medicines including controlled drugs, and intravenous fluids were stored securely in locked cupboards and rooms. Patients own medications were stored in small locked lockers in their rooms. Staff on the wards kept medicine trolleys locked and secured to the wall when not in use.
- Staff followed the hospital's medicine management procedures and policies. Patient were able to self-administer their medication, and there was a process in place to support self-administration. Staff told us that patients rarely did self-administer unless for inhalers and creams.
- Pharmacy and nursing staff monitored and managed stock levels of medicines and controlled drugs (CDs). When we checked the CD record books in Redgrave ward and theatre 2, these were correctly completed.Three monthly audits were undertaken of controlled drugs held by wards and departments. The hospital audit in June 2016 was 100% compliant for recovery in the theatre suite. The hospital audit in June 2016, showed 91% compliance on Redgrave Ward. This was due to staff not signing on three occasions when returning patients own CD's. The acting ward manager had taken action to improve compliance. In theatre 2 there was 90% compliance, the theatre manager had highlighted this to staff, and for new staff the management of CD was a part of their induction.
- There were piped medical gases in the theatre suite and ward. Portable oxygen cylinders were available for transfer of patients from theatre to the ward. A hospital audit carried out from May 2016 to June 2016 demonstrated that 100% of patients using oxygen had it prescribed correctly.

- The resident medical officer (RMO) and nurse in charge could access pharmacy out of hours.

Records

- Patient's records were held in the ward office securely. A board that detailed patients on the ward and patients coming in that day was located in the ward office. The door was kept shut for confidentiality and detail on the board could not be read from the ward corridor.
- An operating theatre register was maintained, which was found to contain all the information needed to ensure that an accurate record was kept.
- We reviewed 11 patient records and saw that they contained pre-operative risk assessments, records from the surgical procedure, recovery observations, nursing notes and discharge. The entries were legible and had been signed and dated by the members of staff.
- The hospital used printed booklets for recording patient care for different care pathways. These standard care pathways included prompts to record key information about patients, including their past medical history and medication, as well as details of their pre-operative risk assessments.
- All of the care records included risk assessments appropriate to the type of operation and length of stay in hospital. For example all care records contained risk assessments for venous thromboembolism (VTE) assessments. Patients who needed to stay overnight or for longer periods also had moving and handling, pressure ulcer risk and nutritional assessments.
- Theatre staff maintained an operating theatre register. The theatre manager also showed us records which were a log of all manufacturer registration numbers of prosthesis and implants used in theatres, for example, hip prosthesis and breast implants. The theatre manager advised us this information was also kept in the patients' medical records, in case of any complications in the future. We were told that , when the national register for breast implants became live, the hospital would register and complete as currently for the National Joint Register.

Safeguarding

- The matron was the adult and paediatric safeguarding lead for the hospital and trained to level 3 in safeguarding. The hospital director and physiotherapy manager were also trained to level 3 in safeguarding. Thismeant there were three senior staff at the hospital able to investigate safeguarding issues if required. Staff we spoke with were aware of who the safeguarding lead was at the hospital. The RMOs were also trained to level 3 in safeguarding.
- Safeguarding was part of mandatory training for all staffThe hospital provided training for staff to level 2, 87% had completed safeguarding adults training and 87% safeguarding children and young people at August 2016 against a year-end target at 31 December 2016 of 95%. The training lead told us that they expected to exceed the yearly compliance target by the end of 2016.Staff we spoke with knew what the term safeguarding meant and how to recognise signs of abuse. Staff could explain the reporting process, and how to seek support if they needed to.
- The chief nursing officer for Spire in May 2016 had introduced the requirement that all clinical staff must complete level 3 safeguarding children training in order to meet the guidance detailed in the Royal College of Nurses and Royal College of Paediatrics and Child Health Safeguarding Children and young People: Roles and Competencies for Health Care Staff, Intercollegiate document (2014). Discussions with staff demonstrated that some staff had completed level 3 training, with further staff booked to complete their training. The hospital told us at the end of December 2016 that 100% clinical qualified staff across the hospital had completed safeguarding level 3 training. The hospital target was 100% at 31 December 2016.
- The hospital from January 2015 to December 2015, reported one safeguarding issue internally. A contractor walked into what he thought was an empty room, but there was a patient in a state of undress. The hospital apologised, and following this, a new process was introduced, that contractors must be escorted by a member of staff.

Mandatory training

- The ward and theatre had an induction programme for all new staff. This covered the key statutory and mandatory training.

- The hospital assigned a role-specific mandatory training plan to each staff member. Staff completed most training electronically but this was complimented by practical training where appropriate, for example, fire safety.
- Individual training records were kept in the ward and theatre offices, and staff could access their information on line. Senior staff regularly monitored and organised completion of mandatory training.
- Staff had to complete mandatory training that included fire safety, health and safety, infection control and prevention, compassion in practice, safeguarding adults at risk and safeguarding children and young people (combined level 1 and 2) and moving and handling. Hospital compliance with mandatory training was making good progress at 75% in August 2016 against a year-end target of 95%.
- Hospital compliance with adult basic life support training was 85%, intermediate life support 100% and advanced life support 100%.
- Bank staff were supported by the hospital, to complete the hospitals mandatory training programme.
- Medical staff completed mandatory training within their employing NHS Trust andthis was checked through the practising privileges renewal process. Resident medical officer (RMO) mandatory training was provided by their employing agency, this included advanced life support training. Where a consultant did not work in the NHS, access was provided to Spire's training system to keep up to date.

Assessing and responding to patient risk

- Patients to be admitted completed a health questionnaire which nursing staff reviewed at pre-assessment to assess the suitability of patients for surgery at the hospital. Staff confirmed that if the pre-assessment raised concerns they would escalate the issue to the surgeon or anaesthetist by telephone or email for further assessment. Patients had to meet certain criteria before the hospital accepted them for surgery, these minimised risks to their health and well-being.
- The anaesthetist could request an enhanced recovery bed on the ward in advance of surgery if they identified a patient as high risk and requiring level 1 care post operatively for a short period of time such as 24 hours. (Level 1 care includes patients at risk of their condition deteriorating, whose needs can be met on an acute ward with additional advice and support from a critical care team.) If needed, the hospital sought advice from the local acute NHS critical care service. The hospital did not routinely admit patients who would require level 2 or 3 support postoperatively. However, they were able to provide short term level 2 care until patients could be transferred to the local acute NHS critical care service. Staff told us that once a month on a Saturday there was planned bariatric surgery, and for the first 24 hours post operativelypatients' needs were met in the enhanced recovery bay.
- Procedures were in place to monitor patients for any deterioration in their health. The hospital used the national early warning system (NEWS) after surgery to record patient observations, and a standard scoring system was in place across all patient pathways. Staff initiated the NEWS scoring in recovery and continued it on the ward. Staff consistently completed the patients NEWS in the 11 patient records we reviewed,and knew how to escalate concerns if a patient's observations deviated from expected ranges.
- There was an emergency transfer arrangement with a local acute NHS hospital for patients who deteriorated and needed critical care. The hospital policy and procedure for unplanned transfer of deteriorating patients was available on the intranet. Staff explained the procedure clearly and described how they had dealt safely with recent cases. The hospital had three unplanned transfers from April 2015 to March 2016. The hospital had an emergency blood transfusion procedure. All clinical staff received training to equip them with the skills and competencies to transfuse blood. Two units of blood suitable to use for all patients in an emergency were stored in the blood fridge.
- A consultant and cosmetic nurse assessed patients physically and psychologically preoperatively for cosmetic surgery.
- Theatre staff used the World Health Organisation safer surgery checklistwhich has evolved into the 'five steps to safer surgery' checklist. The change followed a patient safety alert from the National Patient Safety Agency in 2010. The checklist is a nationally recognised system of checks before, during and after surgery, designed to

prevent avoidable harm and mistakes during surgical procedures. The hospital carried out monthly audits of compliance with the 'five steps to safer surgery' checklist, which identified variable compliance. In May 2016 compliance was 80%, July 2016 60%, August 2016 100%, September 2016 100%, October 2016 90%, November 2016 70% and December 2016 100%. Gaps were for signing the step that 'sign out' and 'time out' had taken place. The theatre manager and deputy theatre manager had discussed with staff, including consultants,the importance of the 'five steps to safer surgery' checklist and reviewed the induction information for agency staff. The theatre manager also planned to discuss the audit results at the hospital clinical effectiveness meeting in December 2016.

- We observed thorough patient centred handovers and staff handed over changes in patient's conditions which ensured that actions were taken to minimise any potential risk to patients.
- The resident medical office (RMO) was on site at all times. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. The RMO was trained in advanced life support and held a bleep for any queries. The RMO attended if there was a cardiac arrest in the hospital as part of his responsibilities.
- Staff took part in scenario based unannounced resuscitation training. The trainer running the session provided feedback on learning points and actions to take following the training. An example was a RMO being required to repeat advanced life support training.

Nursing staffing

- The hospital advised us they followed Spire hospital group nursing guidelines of one registered nurse (RN) to five patients in the morning, one RN to six patients in the afternoon and night on the two wards. The hospital manager said when there was in-patients, there was always a minimum of two RNs on site. Staff we spoke with said staffing levels had been safe. A patient, who had been in previously, commented how much she appreciated seeing familiar staff.
- Ward staff told us staffing levels were adapted to meet the needs of the patients and the type of surgery they had received. For example, the hospital arranged extra suitably trained staff for enhanced recovery patients or other patients needing more close observation. We saw records of off duty, which proved this had happened.
- Student nurses worked on the wards in a supernumerary role. They were not counted in the shift numbers.
- The nurses conducted shift handovers of care when new staff arrived on duty. We observed a bedside handover over during the day. A taped handover took place in the morning from the night staff, and a verbal handover in the evening to the night staff.
- The hospital told us and staff confirmed there was always a senior nurse on call cover out of hours, with support of a duty manager at all times.
- We reviewed theatre rotas with the theatre manager, and found appropriate numbers and skill mix of staff in line with Royal College of Surgeons guidelines and the Association for Perioperative Practice (AfPP). There was no dual working by the scrub nurse.
- The hospital from April 2015 to March 2016 bank and agency usage in theatres ranged from 29% to 75%. The hospital had booked agency staff on long term bookings when possible. In August 2016, the theatre manager advised us that the theatre staffing vacancies were now all filled.

Surgical staffing

- The hospital had 161 doctors, surgeons, anaesthetists and dentists who had practising privileges at the hospital.159 had their competency assured as they undertook similar work regularly in the NHS. Two of the consultants did not work in the NHS, and Spire's Goup Medical Director, as the Responsible Officer, was responsible for their annual appraisals and ensured the consultants undertook mandatory training and specialist training to ensure their compliance. The medical advisory committee (MAC) reviewed the practising privileges of all consultants every two years to check they continued to be suitably competent to work at the hospital.
- Consultants provided cover for their inpatients 24 hours a day, seven days a week. They arranged alternative cover by a named consultant if they were not available. We were shown a folder on the ward, which contained

this information, so it was readily at hand for staff. The Resident Medical Officer (RMO) and nursing staff told us consultants were always available out of hours for telephone advice and support. Staff told us consultants returned to the hospital to reassess their patients within 45 minutes if required.

- The hospital employed two RMOs who worked opposite each other in weekly blocks. They were resident on site and available 24 hours a day, seven days a week. Their role was to review patients when required, prescribe additional medicines and liaise with consultants responsible for individual patient's care.
- The RMO we spoke with told us consultants were on call for their patients 24 hours a day and were easily contactable. There was always an anaesthetist on call to review patients if needed. The RMO told us ward staff did not call them frequently at night, and they achieved enough rest time to work effectively.

Major incident awareness and training

- A generator was available for use in case of power failure with four hours back up. The hospital had business continuity plans in place, to support if the power did not come back on in four hours. The backup generator was tested weekly. The hospital director told us of a recent incident when water was cut off for several hours, and how effective the hospitals business continuity plans had been.
- A hospital wide fire alarm test took place on a weekly basis and staff knew this was planned. The hospital also held fire drills.

Are surgery services effective?

Good

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

We rated effective as 'good' because;

- Staff provided care and treatment that took account of nationally recognised evidence based guidance and standards.
- Patients reported staff managed their pain effectively and they had access to a variety of methods for pain relief.
- The hospital offered a choice of meals and drinks and the chef catered for patients requiring special diets.
- Outcomes of surgical procedures were monitored against national benchmarks which showed good outcomes.
- Staff working in the wards, theatres and in endoscopy had undertaken and completed competencies specific to their roles.
- Theatres and ward staff achieved 100% compliance with appraisals.
- There was evidence of good multidisciplinary working within the hospital and out of hours services were provided when needed.
- With the exception of one consultant, consent was gained appropriately for surgical and endoscopy procedures.

However

- Outcomes of gastrointestinal procedures were obtained, but not monitored by the hospital. The service was due to move to a newly developed unit, and the reporting tool was in place to better use this data following the transition.

Evidence-based care and treatment

- Staff provided care to people that took account of national guidance, such as the National Institute for Health and Care Excellence (NICE) guidelines and best practice. For example, staff used the national early warning system (NEWS) to assess and respond to any changes in a patient's condition. This was in line with NICE guidance CG50.
- We were shown a copy of the Association of Perioperative Practitioners standards published in 2016 in the three theatres and theatre manager's office. This enabled staff working in theatres to have nationally recommended standards and guidance to refer to, to support best practice. The theatre manager had discussed with staff at a team meeting the availability of these guidelines in theatres.

- There were different care pathways for staff to follow covering day and inpatient procedures for example, for spinal surgery and knee replacement. We saw that NICE guidance was followed,for example, when we observed an orthopaedic operation.
- The matron had noticed a decline in patient satisfaction with the orthopaedic pathway, despite an increase in efficient discharge process. The matron noted that the orthopaedic consultants were not informing NHS patients of the enhanced recovery programme, which reduced their length of stay from five nights to three. Staff now informed patients at pre assessment and during their patient journey of the enhanced recovery programme. Patient satisfaction with the way they were prepared for discharge had risen from 94% in February 2016 to 96% in April 2016.
- There was a local and corporate annual audit programme. This included audits such as patient's records, cosmetic reflective period of consent audit, World Health Organisation safer surgery checklist, , controlled drugs, infection prevention and control (IPC), VTE assessment and resuscitation. Staff discussed results at the clinical effectiveness group meeting, appropriate sub-committees and senior nurse group meetings at corporate level.
- The hospital was working towards achieving Joint Advisory guidance (JAG) in gastrointestinal endoscopy supported by the building a new endoscopy unit to meet best practice guidelines.

Pain relief

- Patients were given an information leaflet on 'pain relief after surgery' at their preoperative assessment. This ensured patient knew the type of medication available to them.
- The patients we spoke with on the ward reported that their pain was well managed and nurses responded quickly when they reported having pain.
- Patient's pain and the effectiveness of pain management were assessed regularly using a nationally recognised numerical scoring system .
- Records demonstrated patients were regularly assessed to ensure pain levels were controlled and they were monitored for unwanted side effects. The clinical governance lead carried out an audit of 20 medical records in April 2016, and there was 100% compliance with the monitoring of patients pain.
- Patients had access to pain relief appropriate to their operation. The hospital had patient controlled analgesia pumps that could be used that the staff were competent to use. Staff told us the PCA pumps were not frequently used.
- Staff could seek the advice of an acute pain team if required, through the anaesthetic on call daily service.
- During our inspection in August 2016, one patient we spoke with had been given a nerve block, which had provided them with effective pain relief.

Nutrition and hydration

- Staff advised patients about fasting times prior to surgery at pre-assessment and in their booking letter. The hospital aimed to ensure fasting times were as short as possible before surgery to prevent dehydration. For example a patient on an afternoon list, had eaten a light breakfast, then a glass of water at 11.30, and then sips of water until the time of surgery.
- The 'Malnutrition Universal Screening tool'(MUST) was used at the hospital. Patients scores were assessed and actions taken by staff as required.
- Staff monitored fluid intake and output for some major operations to ensure patients were adequately hydrated. We observed that staff correctly recorded this on fluid balance charts.
- The hospital offered light snacks and drinks for day case patients before discharge home.
- The hospital had a service level agreement with the local NHS trust so they could access the advice and support of a dietician when required. Staff were also able to obtain dietician support for bariatric patients undergoing surgery.
- In the Patient Led Assessment of the Care environment (PLACE) the hospital scored from February 2016 to June 2016 95% for ward food against the England average of 92%.

- Staff were able to access light snacks, such as soup, toast and sandwiches out of hours for patients who were post-operative.

Patient outcomes

- The hospital had three unplanned readmissions within 28 days of dischargefrom April 2015 to March 2016
- Three patients had had unplanned returns to theatre from April 2015 to March 2016. The theatre manager explained that these had been due to the formation of a haematoma (collection of blood) following plastic surgery.
- Staff asked all patients who were booked for joint replacement to consent to register on the National Joint Registry (NJR), which monitors infection, revision rates, prosthesis used and ninety day mortality. Hospital outcomes were in line with expected rates.
- NHS patients participated in the patient reported outcome measures (PROMS) data collection if they had undergone surgery for hip or knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patient's perspective. The PROMS results knee replacement were within the expected range and for hip replacement were significantly higher than the England average during the period April 2014 to March 2015, which showed most patients had an improved quality of life after knee and hip replacement.
- The hospital had installed an electronic data management system early in 2016 in the endoscopy suite to enable to consultants to input data to capture outcomes following endoscopy procedures. The data told the consultants information such as average amount of sedation and analgesia they have used with patients. The data also included the completeness of their patients with bowel preparation, and percent of procedures undertaken that were confirmed complete by an image. The endoscopy lead advised us that this data was not being shared. The endoscopy lead planned to set up an endoscopy user group where this data would be discussed.
- To further improve the national formal monitoring of outcomes for patients undergoing surgery that was self-funded or funded by insurance policies, the hospital group was working with the private hospitals information network (PHIN) on the future collation of clinical outcome data. In the meantime, information about patient outcomes was gathered by the hospital using a clinical scorecard, the National Joint Registry, patient discharge questionnaires, information provided by insurance companies and complaints data.

Competent staff

- All staff, including agency and bank staff, undertook a formal induction process. This was very detailed, with staff signing to say they had received the individual components of the induction training programme.
- Senior staff conducted annual appraisals for nursing staff and operating department assistants (ODPs) to enable staff to discuss their development and training needs in a formal way. Data provided by the hospital showed that 100% of employed staff had an annual appraisal completed by August 2016.
- The ward manager had a system of link roles given to nursing staff on the two wards to support best practice. The roles included staff induction, infection prevention, pressure ulcer prevention and dementia.
- The resident medical officer (RMO) completed training and appraisals through their employing locum agency. The hospital director had discussed with the medical advisory committee (MAC) chair the need for the RMO to have mentorship.
- Registered nursing staff completed competency assessments to ensure they had the skills and knowledge to carry out the roles they were employed to perform. This included aseptic non touch technique, level 1 care and medication. A medicine administration competency assessment was completed before a RN could undertake a medicine round at the hospital.
- Four practitioners in the operating theatre were acting in the role of surgical first assistant (SFA). These staff had successfully completed a nationally recognised competency training programme to undertake the role of SFA.
- The endoscopy lead showed us signed competencies that had been undertaken and completed by staff working in gastrointestinal endoscopy.
- Consultants and anaesthetists worked under a practising privileges agreement. The medical advisory

committee (MAC) were responsible for granting and reviewing of practising privileges biannually. New consultants provided evidence of qualifications, training, accreditation and scope of practice, and there was a similarly robust process at their two yearly review.

- Seven consultants undertook cosmetic surgery. Three were on the specialist general medical council (GMC) register (staff that hold practising privileges for cosmetic surgery), the other four consultants undertook cosmetic surgery within their particular specialty. For example, a breast consultant if he had needed to remove part of a breast due to cancer, would reduce the other breast to support patient's wellbeing. The hospital director also advised that the cosmetic surgeons had been advised that a governance meeting needed to be put in place for their speciality. The cosmetic surgeons agreed that a meeting wherecomplex cases could be discussed, best practice shared and any concerns discussed would be of benefit.

Multidisciplinary working (in relation to this core service only)

- Our observation of practice, review of records and discussions with staff, confirmed effective multidisciplinary team (MDT) working practices were in place. This included nurses, medical staff, pharmacists and physiotherapists. A ward sister led a daily MDT meeting at 09.15. This meeting was attended by the RMO, pharmacy, patient bookings, theatre staff and a member of the senior management team. At the meeting, inpatients management plans and their needs were discussed, plus the next two days theatre lists. The team communication ensured for example that patient's tablets to take home were ready, any changes to the theatre lists were communicated and any patient concerns followed up.
- Physiotherapy staff supported effective recovery and rehabilitation, including an appointment at pre-assessment for patients having orthopaedic surgery, and follow up at outpatient clinics. They visited the ward daily including weekends.
- The hospital had service level agreements in place to access the services of local NHS hospitals. These included microbiology services, dietetic support and the agreement for the local acute hospital to transfercritically ill patients for more intensive treatment.

Seven-day services

- Nursing staff were available on the ward seven days a week.
- Theatres one and two, which were fitted with ultra clean ventilation systems (laminar flow) were open Monday to Friday 8am to 8pm, and on a Saturday 8pm to 6pm. Theatre three was open Monday to Friday 8am to 7pm, and on a Saturday 8am to 1pm. On a Saturday there was a regular orthopaedic surgical list, and bariatric (weight loss) surgery once a month. An on call surgery team that consisted of a surgical consultant, anaesthetist, and three hospital theatre staff were available outside normal working hours. The hospital theatre on call staff included a practitioner to support the anaesthetist, a surgical first assistant and a circulating practitioner.
- Consultant surgeons provided cover for their inpatients 24 hours a day, seven days a week. They arranged alternative cover by a named consultant if they were not available. An on call consultant anaesthetist rota ensured there was anaesthetic support available 24 hours a day. Both consultant surgeons and anaesthetists were able to return to the hospital to reassess their patients within 45 minutes if required.
- The RMO and nursing staff said consultants were always available out of hours for telephone advice and support.
- A RMO was available on site 24 hours a day, seven days a week.
- Physiotherapists provided care to inpatients seven days a week.
- Pharmacy services were available between 9am and 3pm. Outside of these hours staff could telephone hospital pharmacy staff, or there was an agreement that support could be obtained from a nearby NHS trust

Access to information

- Ward staff ensured discharge summaries were provided to GPs which informed them of their patient's medical

condition and treatment they had received. A copy was given to the patient on discharge, one kept in the patients' records and one posted to the GP. This ensured the GPs knew of their patient's discharge

- Patient notes were held on site for three months following discharge. Patient notes could be recalled, if before 12 midday they would be received the same day. In an emergency patient records could be sent by courier or faxed securely to the hospital. This meant staff had access to patient's records in a timely manner.
- Staff accessed policies and procedures via the hospitals intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us they assessed patients' mental capacity to make decisions about their care and treatment at pre-assessment clinic. Staff were clear about the processes to follow if they thought a patient lacked capacity to make decisions about their care, which included a formal assessment of capacity by the patient's consultant. If the assessment concluded the patient did not have capacity to make the decision, the plans for treatment would be halted until the patient regained capacity or a formal best interest decision was completed.
- Patients consented for surgery prior to and on the day of surgery. We saw that consent forms had been completed correctly and detailed the risks and benefits of the procedure. Senior staff told us one consultant regularly invited a patient to sign the consent form confirming they wished the treatment to go ahead in the endoscopy treatment room, rather than during a patient's pre-operative consultation in outpatients or on admission. This practice was not in line with hospital group consent policy. The consent policy stated 'it should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown)'. We fed this practice back to the hospital director. The theatre manager had sent an e mail to all the consultants, to advise this practice was not acceptable. An audit was also planned to check compliance with the consent process, to check if changes in practice required.
- Staff told us they would seek the use of an interpreter where needed to sign consent forms and not rely on family members or friends.
- Cosmetic surgeons were required to adhere to GMC Good Medical Practice and The British Association of Aesthetic Plastic Surgeons (BAAPS) Code of Conduct, this included ensuring a two week 'cooling off period' after the pre-treatment consent process. The cosmetic sister had undertaken an audit, which demonstrated 100% compliance with the two week 'cooling off period".
- Staff undertook training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been fully considered and authorised by the local authority. Staff could explain to us what the MCA and DoLSmeant for their practice and their responsibilities.
- We observed nurses on the wards and in theatres sought verbal consent from patients before taking observations and delivering general nursing care.

Are surgery services caring?

Good

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

We rated caring as 'good' because;

- Feedback from patients about their care and treatment was consistently positive and we observed staff being supportive and compassionate to patients.
- The hospital's patient satisfaction survey and showed consistently high levels of patient satisfaction throughout 2015.
- The hospitals friends and family test score for NHS patients showed a high number would recommend the hospital to friends and family.

- Patients were given sufficient information to allow them to be involved with their care and had their wishes respected and understood.
- Staff provided patients with good emotional support.

Compassionate care

- We observed compassionate and caring interactions from all staff. Patients were positive about the care and treatment they received. They described staff as friendly, helpful, caring, considerate, kind and respectful. One patient commented, 'absolutely fantastic from diagnosis to after care (physiotherapy)'.
- We observed staff referred to patients in a caring way at handovers and ward meetings, and staff showed a keen interest in ensuring that patients had a pleasant and comfortable experience.
- We saw consultants talking with patients who were awake during surgery (for example varicose vein surgery with local anaesthetic) in a caring and reassuring manner.
- Staff treated patients with respect and dignity during our visit. We observed staff always introduced themselves to patients, and knocked on doors and waited for permission to enter patients' rooms. We saw staff in theatres being mindful of patients' dignity when they were in a vulnerable condition.
- The hospitals patient satisfaction survey for all patients for 2015 ranged from 98.3% to 99.6%. Patient experiences that were monitored included the admission process, overall nursing care and preparation for being discharged home.
- The hospitals friends and family test score for NHS patients who would recommend the hospital to friends and family ranged from 96% to 100% from October 2015 to March 2016. This was similar to the England average of other independent hospitals.

Understanding and involvement of patients and those close to them

- Staff gave information to patients about their surgical procedures at their pre admission appointments. Patients we spoke with felt they had been given sufficient information pre-operatively to prepare for the procedure and their post-operative requirements. One patient said how it helped her 'to feel in control', when for example she was asked about her dietary preferences.
- We spoke with seven patients and three patients gave their written feedback about the care they received at the hospital.Patients on the surgical wards said they understood their care and treatment and had adequate opportunities to discuss their surgery. One patient commented they weretold clearly and concisely about options available, to enable themto make informed decisions about their health issue.
- Patients and their relatives were encouraged to be involved in decisions made about their care and treatment. Onepatient said they had 'obtained good information regarding disease and treatment, been kept informed and felt confident in their treatment'.

Emotional support

- Ward staff showed sensitivity towards the emotional needs of patients and their relatives. At the daily multi-disciplinary team meeting we observed discussions about patients' anxieties and how to provide support. A patient told us how when she had felt unwell following surgery a nurse had sat with her and held her hand, and how reassured this had made her feel.
- The cosmetic sister provided additional skilled clinical and emotional support for patients and their families. For patients having cosmetic surgery, the cosmetic sister met with them at pre-assessment and followed patients up postoperatively.
- The hospital had a chaperone policy. The cosmetic sister described how she made patients aware of the availability of a chaperone, and how she provided this support.
- If consultants found a cancer during endoscopy procedures, they would contact the local NHS trust to ensure patients were followed up by the consultant led NHS cancer care specialist.

Good

Surgery

Are surgery services responsive?

Good

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

We rated responsive as 'good' because;

- Services were planned in a way that met the needs of the local population. The importance of flexibility and choice was reflected in the service and there were ongoing plans for development.
- Pre-assessment nurses reviewed patient's needs before admission for treatment ensuring individual needs could be met.
- Patients were admitted on a planned basis for planned surgery, this included private patients and NHS patients.
- The hospital dealt with complaints and concerns promptly, and there was evidence that the hospital used learning from complaints to improve the quality of care.
- The hospital had started building a new endoscopy suite.

However,

- The hospital had not achieved national waiting times indicator for patients beginning treatment in 18 weeks from January 2016 to July 2016.

Service planning and delivery to meet the needs of local people

- The hospital worked with local clinical commission group (CCG) to plan services for NHS patients. The CCG checked the hospital was providing NHS patients with services in line with agreed quality criteria at quarterly contract meetings.
- The hospital pre-planned all admissions to allow staff to assess patients' needs prior to surgery. They accepted patients for treatments with low risks of complication, and whose post-operative needs were met through mostly ward-based nursing care.
- The hospital had started to provide bariatric (weight loss) surgery early in 2016. The theatre manager told us the new service had started slowly, with one consultant undertaking surgery. The surgery was carefully planned, to ensure appropriately skilled ward staff were available to meet patients post operative needs. The ward sister said post operatively a patient having bariatric surgery would spend 24 hours in the enhanced recovery unit.
- The hospital was in the process of building a new endoscopy unit, to assist them in applying for Joint Advisory Guidance (JAG) in gastrointestinal endoscopy accreditation.

Access and flow

- There were 4957 visits to theatre from April 2015 to March 2016. Over 1183 theatre patients had orthopaedic surgical procedures. From April 2015 to March 2016, there were 384 gastrintentinal endoscopy procedures.
- Referral to treatment times (RTT) were measured for surgical NHS patients. The provider met the national indicator of 90% of all admitted NHS surgical patients beginning treatment within 18 weeks of referral from April 2015 to December 2015. However, from January 2016, to July 2016 the percentage of referred patients not beginning treatment within 18 weeks ranged from 83% to 88%. The operations manager explainedthey had not met the RTT indicator due to data recording issues as a result of staff vacancy. The operation's manager was confident they were on track to continue to meet the target.A new patient's booking lead had commenced post in June 2016 and the operations manager had been reviewing the RTT data regularly since July 2016. InAugust 2016, the hospital did meet the indicator of over 90% of referred NHS patient starting treatment within 18 weeks.
- There was no formal system for the monitoring of referral to treatment times for insured or self-funded patients However, there were feedback mechanisms such as the patient satisfaction questionnaire that would identify if patients were dissatisfied with their referral to treatment time.
- The hospital reported that one patient's surgical procedure was cancelled for a non-clinical reason betweenApril 2015 andMarch 2016. This patient was offered another appointment within 28 days of the cancelled appointment.

Good

Surgery

- The hospital had a commission for quality innovations (CQUIN) target in place. This included ensuring the hospital aimed for a 10am discharge time. When we inspected in August 2016 two patients for were discharged as planned at approximately 10am.
- The staff in the operating theatres provided an on call service to ensure that the department could be opened if there was a need for a patient to return to theatre urgently.

Meeting people's individual needs

- Staff knew how to support people with complex or additional needs and made adjustments wherever possible. For example, staff said that would offer more time to support individuals with learning disabilities or mental illness.The ward had a nominated nurse as a dementia lead. The hospital's patient led assessments of the care environment (PLACE) for February 2016 to June 2016 was 90% against an England average of 80%. However, staff noted there were rarely patients who had complex or additional needs.
- The hospital had a variety of menu options available for inpatients and the chef catered for the needs of patients with special diets.
- The hospital held nineto 10 cosmetic consultation evenings a year. The cosmetic sister explained there were mini consultation appointments lasting 15 minutes each, led by consultants. The cosmetic lead advised this was to support patients in deciding if a cosmetic surgery procedure was possible, and would meet their individual needs.
- All written information, including pre-appointment information and signs were in English. These were available on request in other formats, such as other languages, pictorial or braille, through a national contract. Staff described there were rarely patients whose first language was not English. The hospital were also able to access an interpreting service, to be able to communicate with patients effectively.
- Ward staff encouraged patients on discharge to ring the ward if they had any concerns. The hospital had designed a checklist for staff. The first question, are you qualified to talk to this patient? This enabled staff to recognise if a another colleague would need to take the call. A nurse telephoned any patient after discharge that had had major surgery such as a hip or knee replacement, and any patient who had rung for advice. This was to provide support with patients'individual post-operative needs.
- Family and friends were able to visit inpatients at any reasonable time to suit the individual needs of the patient and their visitors.
- Staff ensured call bells were accessible for patients on the ward to allow them to call for assistance if needed. Patients told us they found this reassuring.

Learning from complaints and concerns

- The hospital had received 27 complaints from April 2015 to March 2016. The rate of complaints is lower than 42 other independent hospitals the CQC hold data for.
- The hospital learnt lessons from complaints. One example, was a health care assistant (HCA) removed a patient's sutures incorrectly. A senior nurse and the HCA have now put together a resource folder for removal of different types of suture as a resource for clinical staff to refer to so sutures always removed correctly.
- Complaints themes and lessons learnt were shared with staff though meetings at the hospital, and communication folders named 'hot gossip' on the wards and in theatres.
- The hospital informed us that all patients were actively encouraged to complete a patient satisfaction survey that encouraged feedback. Patient feedback forms were part of the standard room set up for all admitted patients. The hospital also place 'please talk to us' leaflets in the patient bedrooms and throughout the hospital.

Are surgery services well-led?

Good

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

We rated well led as 'good' because;

- Staff were aware of the vision and strategy for surgery. The direction of the business and aims of the provider were well known.
- There was a clear governance framework to monitor quality, performance and risk at department, hospital and corporate level. Staff were aware of the risks, and action taken to mitigate these risks for their individual departments.
- Staff across the service told us they enjoyed working at the hospital. They described an open culture and felt supported, and listened to, by their management. They were complimentary about their managers and positive about the recent changes in management at the hospital.
- Staff and public engagement was good, with high levels of satisfaction.Engagement included patient and staff forums.

However,

- Consultant attendance at the quarterly medical advisory meeting ranged from five to eight when they were approximately 14 surgical specialities, which was a concern about consultant representation and their involvement in the running of the hospital. At all times meetings met the minimum attendance to be quorate and minutes were shared with non-attendees.

Leadership / culture of service related to this core service

- Theatres, the sterile supplies department and the ward had experienced several recent staff changes. The acting ward manager (a new ward manager was on induction as commenced in early August 2016) and theatre manager (in post since January 2015) explained the leavers had mostly been due to retirement. Some staff had worked at the hospital for a long time and said it was a good organisation and hospital to work for. All staff spoke positively about the teamwork they experience at the hospital. Staff said they felt respected, valued and listened to at the hospital and senior staff and management encouraged them to complete further training and qualifications.
- The hospital senior management also awarded 'inspiring people awards'. The monetary awards were available across all staff groups within the hospital, and ranged from three to nine awarded a month.
- A nursing sister explained a member of the senior management team attended the ward daily multidisciplinary team 'huddle' when plans for all patients were discussed. Staff we spoke with found this helpful with a member of the senior management being aware of any concerns. Following the 'huddle', the member of the senior management team would meet with any patients going home that day, for their feedback regarding their hospital experience. This member of the senior management team also made themselves available, leaving contact details for ward staff, if any concerns or issues arose during the day.

Vision and strategy for this this core service

- The hospital displayed its vision, values and mission statement for staff and public to see. The mission statement was "to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care". The vision was "to be recognised as a world class health care business". Their values were detailed as "Caring is our passion. Succeeding together, driving excellence, doing the right thing, delivering our promises and keeping it simple".
- All staff we spoke with were aware of the mission, vision, values of the hospital and wider organisation, and demonstrated commitment to them in their care practices and personal development plans.
- The theatre manager said the goal for surgery, was to achieve Joint Advisory Group (JAG) in gastrointestinal endoscopy supported by the new endoscopy unit due for completion in November 2016. The goal was also to consider increasing capacity for orthopaedic surgeons, through being able to use theatre 3 capacity, due to gastrointestinal endoscopies being undertaken in the new endoscopy unit. Staff we spoke with in theatres were aware and described being involved with the way the service was developing.

Governance, risk management and quality measurement for this core service

- The hospital had a clinical governance and local committee structure in place. This included monthly meetings, which included clinical effectiveness and audit board (CEAB) and the hospital management team (HMT). The hospital quarterly meetings included clinical

governance committee, infection prevention and the medical advisory committee (MAC). The hospital local committees included infection control, resuscitation and pain management.

- The MAC met quarterly and minutes showed these included key governance issues such as incidents, complaints and practising privileges. These governance issues were discussed and reviewed across the whole service. The hospital offered approximately 14 surgical specialities, however consultant attendance at the MAC meetings from May 2015 to May 2016 ranged from five to eight consultants. The hospital director in the October 2015, had recognised the need to increase the number of specialities represented and their involvement in the running of the hospital. This action by the hospital director had been successful inobtaining one further consultant regularly attending.
- The theatre manager and the ward lead held monthly team meetings. The meeting minutes showed that agenda items included patient feedback, audit, incident reporting and staffing.
- The hospital had one risk register that was separated into departmental risks. At the time of the inspection there were 13 risks identified for theatres,10 for the ward areas and three for the enhanced recovery unit. The risk register detailed who had overall responsibility for each risk and actions taken to mitigate the identified risk. Where action did not fully mitigate the identified risk, there was a plan of action, with the date due the action was due to be completed and detail of who was responsible for ensuring the action was completed.
- The clinical departments also had a risk assessment register. In theatres 52 risk assessments had been completed, in sterile supplies department 55 risk assessments, and on the wards 16 general risk assessments and eight bariatric risk assessments. The assessments included the hazard, likely harm and measures in place to manage the risk. The risk assessments had been reviewed, and had a next review date.

Public and staff engagement

- Staff encouraged patients to complete a patient satisfaction survey before discharge. The hospital used this with the 'friends and family test' feedback to evaluate their service provided to the patient. Clinical performance notice boards displayed information about actions the hospital had taken in response to patient comments. This included plans to make improvements to parking at the hospital and refurbishment of patient bedrooms.
- The hospital also held an annual patient forum. The hospital invited patients discharged from September 2014 to January 2015. The governance lead chaired the patient forum in May 2015, when patients made very positive comments about their experiences at the hospital including 'the follow up calls offering advice over the telephone instead of waiting for appointments'. The governance lead noted the areas of concern from all of the patients who attended which included parking availability, lighting in the car parks and the requirements for redecoration. The hospital was making progress at the time of our inspection in August 2016 to address these concerns.
- The hospital consultant survey score of 87% meant Clare Park was in fifth place in overall satisfaction out of 38 Spire Hospitals for 2015. The hospital score was 10% up on 2014 and 8% up on the organisation average. The consultants we spoke with were positive about working at the hospital.
- The GP survey satisfaction rate was 93% in 2015. This satisfaction rate was above the organisation average. The GP response rate in 2015 had been 95%, an increase of 8% in comparison to 2014. 91% of the GP respondents felt the hospital helped their practices achieve their objectives in 2015, a rise of 8% in comparison to 2014.
- The hospital staff satisfaction survey average score of 85% meant it was third highest out of 38 in the hospital group. An example of successful engagement of staff was a local photograph initiative , which were framed and hung on the walls of the hospital. The hospital had awarded staff a prize for their pictures. Staff we spoke with had been very pleased to be involved in this project.
- The hospital had also started to hold monthly staff forums in August 2016. The new inspiring people awards certificates will indicate what the person had done and who had nominated them, as this had previously been omitted.

Innovation, improvement and sustainability

Good

Surgery

- The hospital was in the process of building a new endoscopy unit, which was due for completion in November 2016. This was to support them in achieving Joint Advisory (JAG) accreditation in gastrointestinal endoscopy.
- The service was aware of the publication of the National Safety Standards for Invasive Procedures (NatSSIPs) in September 2015 by NHS England. The theatre manager was waiting to see how these standards to be embedded into the hospital group local safety standards to support staff, to produce local safety standards for invasive procedures.
- The hospital had signed up to the national Patient Safety Campaign in June 2016. The acting matron was the lead to take actions forward.
- Maintenance work in the corridors of the theatre suite was planned for the Christmas period 2016, one particular concern was to protect the walls in the corridors from damage by beds and trolleys.

Requires improvement

Services for children and young people

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

Information about the service

The children's and young people's service provided by Spire Clare Park hospital includes inpatient and day case surgical procedures, outpatient consultations for elective surgical procedures, general paediatrician outpatient consultations, diagnostic tests and physiotherapy. Surgical proedures and physiotherapy services is only provided to children over the age of three. Between April 2015 and March 2016 there were14 children admitted as in patients and 75 admitted as day cases. Of those children admitted, 26 underwent surgical procedures. In the same period a total of 541 children attended the out patients department. In total for the period April 2015 to March 2016, children's work across the whole hospital accounted for 3% of the hospital's work.

Surgery for children was planned as day case surgery or overnight stay as inpatients. Due to the small patient numbers, there were no wards or waiting areas specifically for children. Children were nursed in individual rooms, with private facilities, on the adult wards. Parents were able to stay with their children and were supervised at all times.

Consultant surgeons were responsible for the medical care of the child during their stay. A resident medical officer (RMO) was available at the hospital 24 hours a day, who was appropriately qualified to look after children and young people.

The children's lead nurse, who worked across three of the Spire hospitals, coordinated the children's inpatient services. The hospital policy was that all children aged 15 and under looked after by a children's registered nurse. There were no children's registered nurses working in the outpatients department, theatres or the recovery area.

As part of our inspection, we visited the children and young people's service. We spoke with two parents and three children who were at the hospital for outpatient appointments. After the inspection, we spoke with one parent of a child who had been admitted for surgery at the hospital in the previous three months. We also spoke to staff including the lead children's registered nurse, pharmacists, adult nursing staff, theatre and recovery staff, the RMO, administration staff and senior management. Before the inspection, we reviewed performance information from, and about the service.

Requires improvement

Services for children and young people

Summary of findings

We rated the children and young people's services as inadequate for well led, requires improvement for safe and effective and good for caring and responsive care.

The environment of the hospital posed some risks to the safety of children. There was no oversight from the children and young people's leadership of the small number of incidents reported in the children and young people services. Safe management and administration of medicine policies were not fully followed: nurses administered medicines that were not prescribed. There was not always a registered children's nurse identified , when children or young people attended the hospital for outpatient appointments, to hold responsibility and accountability for the whole of the child's pathway. Infection control practices in some areas did not fully protect patients from risk of transmission of infection from children's toys.

Children and young people's care did not always take account of national and best practice guidance. Adult nurses working with children and young people in the outpatient department, theatres and the recovery area did not complete competences about the care of children and young people.

There was no clinical audit plan for children and young people's services. A clinical scorecard was in use but did not benchmark clinical effectiveness across a wide range of measures.

There was a lack of clarity about the overall leadership of the whole children and young people's service at the hospital. The children's lead nurse had no oversight of the service delivered to children and young people in the outpatient department. The children and young people's governance arrangements were newly implemented at the time of our inspection so had not, at that time, supported quality monitoring or improvements. It was unclear who had oversight for or responsibility for the identification of risks associated with providing a children and young people's service at the hospital. Whilst there was a written strategy for this service, it was not supported by a detailed action plan and was not well understood by staff, including the identified children and young people's lead.

Staff completed paediatric lifesaving training relevant to their role, which met national guidelines. Use of a nationally recognised paediatric early warning system (PEWS) supported staff to identify if a child's condition was deteriorating. All staff completed training about safeguarding children.

Children and young people had their pain managed effectively.

Staff at the hospital worked as a multidisciplinary team to support children in hospital. Children's and young people's surgery was carried out at the beginning of surgical lists. Processes were followed to ensure consultants had the appropriate skills and knowledge to carry out surgery on children and young people.

Children, young people and their parents spoke positively about the care and treatment they received. They thought staff were very kind and that they were informed about their care and treatment. Parents could stay with their children in hospital.

Staff spoke positively about the support they received from their local leadership and the hospital director.

Requires improvement

Services for children and young people

Are services for children and young people safe?

Requires improvement

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

We rated safe as requires improvement because,

- The children and young people's service leads did not have full oversight of the small number incidents reported within their service.
- Risk of transmission of infections from children's toys was not fully mitigated. Some toys were made of material that could not be effectively cleaned. In one department of the hospital, there was no documentary evidence to provide assurance that children's toys were cleaned.
- The environment posed some risks to the safety of children. The entrance to the ward was not secure and individual rooms where children were cared for posed potential risks to the safety of children which had not been fully assessed or mitigated.
- Staff did not fully follow the hospital's management of medicines policy and the Nursing and Midwifery guidelines for administration of medicine. Staff administered anaesthetic cream to children that was not prescribed.
- Whilst all staff were confident in identifying safeguarding concerns and said they would contact a senior member of staff, not all staff knew who to contact externally in the event of a safeguarding concern if the safeguarding lead for the hospital was not available.
- There was not always a registered children's nurse identified when children or young people attended the hospital for outpatient appointments to hold responsibility and accountability for the whole of the child's pathway.

However,

- Equipment designed for paediatric use was available and the paediatric resuscitation system was understood by clinical staff.
- Records were fully completed, were legible and stored securely.
- The hospital had recently required all clinical staff to complete safeguarding children level 3 training. There was a programme being followed to ensure all staff completed this training in a timely manner.
- The hospital used a nationally recognised paediatric early warning system (PEWS) to identify children whose conditions were deteriorating; there was a process to follow to transfer a deteriorating child to critical care facilities.
- Staff completed paediatric lifesaving training relevant to their role that met relevant national guidelines.
- Processes were followed to ensure a registered children's nurse was on site when children and young people were admitted to the hospital as inpatients.

Incidents

- Conversations with all staff who cared for children and young people evidenced they had a good understanding about incident reporting. They knew how to report incidents and the types of incident that needed to be reported.
- Staff in theatres described an incident they had reported using the electronic reporting tool. The incident was attributed to communication problems where an older child recovered from surgery quickly and was returned to the ward, with staff not following the hospital's procedure of calling the children's nurse and parent to attend the child in the recovery area. We saw email evidence that discussions were held between recovery staff and the children's lead nurse following the incident. Learning from the incident resulted in the practice of the children's nurse on duty visiting theatres on the day of surgery to discuss the list and agree if some older children or teenagers had chosen not to have their parent in the recovery area.
- However, information received from the hospital prior to the inspectionand discussion with ward staff and the children's lead nurse indicated their understanding there had been no reported incidents relating to children's and young people's services in the reporting period April 2015 to March 2016. With staff and the children and young people's lead nurse not informing

us about this incident, this meant we were not assured that incidents involving children and young people that occurred away from the inpatient ward area were considered as a children and young people's incident.

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents.' Conversations with the children's lead nurse evidenced an understanding of the Duty of Candour legislation.There had been no incidents that necessitated the Duty of Candour processes to be followed. The electronic incident reporting system included a prompt for staff to consider whether Duty of Candour processes needed to be followed.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly tidy and clean.
- Staff we spoke to were aware of the hospital policy on infection control. We observed nurses in outpatients and on the wards using hand gel frequently and washing their hands before and after attending to patients.
- Infection control risk assessments were conducted on all children and young people as part of their pre admission process. This included any recent illnesses, exposure to viruses or childhood illnesses, and whether childhood immunisations were up to date. Any infection risks were highlighted at the earliest time in the patient's care pathway to ensure that correct infection prevention and control precautions were instigated.
- We saw there were sufficient hand washing facilities and protective personal equipment, such as gloves and aprons, available. Hand sanitisers were provided in the consulting rooms and treatment areas at the point of care.
- In areas where children were treated and cared for there was a small supply of young children's toys. Most toys were of materials that enabled thorough cleaning. However, in the general outpatients department we saw one of the reading books had touch and feel pages that were made of a fabric that would not enable effective cleaning. We brought this to the attention of the staff who immediately removed the book. In the ears, nose and throat (ENT) outpatients area we saw some of the entertainment provision were books that would be difficult to effectivelyclean. Staff had not carried out assessments to identify the level of risk this posed to patients.
- Staff told us they cleaned toys after each child had used them and completedfull cleaning of toys once a week. We saw records evidenced staff completed this cleaning in the general outpatients department. However, in the ENT outpatients department, there was no documentary record that staff cleaned toys. This meant the hospital had no assurance the cleaning was carried out. The health care assistant (HCA) working in in that department at the time of our inspection promptly added cleaning checks onto the essential equipment check list document.
- We observed staff adhered to the 'bare below the elbow' guidance, which enabled thorough hand washing, and reduced the risk of spread of infection between staff and patients.

Environment and equipment

- There was no dedicated facility for children and young people. Children were cared for in rooms located on the adult ward. Review of patient records showed the room the child was going to be cared in was assessed for any risk the environment might pose.
- During the inspection, we viewed the rooms where children were usually nursed. We found the room risk assessment did not detail all identified risks. We found the call buzzer unit above bed with cord dangling in U shape immediately adjacent to level of pillows posed a ligature(strangulation) risk, a plastic bag in the bin posed a suffocation risk and the toilet cleaning brush stored in a container that held the remains of cleaning fluid located on the floor in the ensuite bathroom posed a risk that children might ingest cleaning fluid. We discussed these issues with the children's lead nurses. They told us these risks were discussed with the child's parents so they were aware and took appropriate action to protect their child. However, when we reviewedpatient records, none of these detailed that staff discussed these environmental risks with the child's parents or guardian.
- The rooms were in close proximity to exits from the ward into an outpatient's area, the enhanced recovery area and one of the surgical theatres. The doors to these

areas were not locked and the door to the operating theatre suite was left slightly open. The environmental risk assessment completed on admission did not include risks associated with the general ward environment, only the room environment.However, both the hospital director and the children's lead nurse said the unlocked doors had been identified as a risk and key coded door locks had been ordered to secure these doors and only allow authorised staff access to these areas. We saw documents that evidenced these were on order.

- The entrance to the ward where children were nursed was not secure.To mitigate risk of children leaving the ward unobserved and unauthorised persons accessing the children's areas, children's nurses were not included in the ward staffing numbers and only cared for the children on the ward.The children's nurses stayed with the child throughout their admission, which reduced the risk of them leaving the ward unaccompanied.
- There was dedicated children's resuscitation equipment located on the main ward and in the outpatients department. The hospital used a nationally recognised paediatric emergency system that provides a fast, accurate method for equipment selection and medicine dosages in emergencies. Two members of staff checked all contents of the equipment once a month. Daily checks by staff gave assurance the tamper proof seals were intact. There were clear guidelines about what action to take if the seals were not intact. We viewed records evidencing the monthly and daily checks were completed.
- There was separate paediatric emergency equipment in the theatre suite. Records showed staff checked this equipment weekly, and before and after a child had undergone treatment in the theatre suite. We saw all equipment was in date and there was age appropriate equipment, for example different sized airways.

Medicines

- The medicines policy attached to the Procedure for the care of children and young people in Spire Healthcare stated, "Any medication administered to a child must be appropriately calculated to the child's weight by a practitioner with up to date competencies in place. Any medication administered must be documented within the patient medical records and /or medication chart. Allergies must be clearly documented on the prescription chart."
- Review of patient records showed staff recorded children and young people's weights and allergies in their records and on the prescription chart.
- All medicines prescribed on the prescription chart were dated and signed by the prescriber. Prescriptions detailed the dose and time the medicine needed to be administered. Nurses signed to demonstrate they had administered the medicine to the child.
- However, we found staff administered medicines that were not prescribed. Review of children and young people's records showed the anaesthetic cream applied to the back of children's hands prior to insertion of venous catheters was not prescribed. Patient pathway records showed the anaesthetic cream had been applied, evidencing nurses administered medicine that was not prescribed. We raised this issue with the hospital who promptly responded by emailing a reminder to all staff about the requirement to have medicine prescribed before it was administered to patients.

Records

- The hospital kept patient records in paper format and stored them securely in the ward office while patients were on the ward.
- The patient records we reviewed showed that staff completed the relevant assessments and child's details on every page. The entries were legible, and signed and dated by the member of staff who completed the entry.
- Staff confirmed patient records were always available.
- The picture archiving and communications system (PACS) is a nationally recognised system used to report and store patient images. This system was available and used across the hospital.

Safeguarding

- We reviewed the hospital's safeguarding policy for children and young people. The policy followed relevant national legislation and guidance, for example the Children's Act and the Safeguarding Children and Young People intercollegiate document (March 2014). It also

included relevant and current information about female genital mutilation (FGM) and child abduction that followed current guidance and legislation, for example from the World Health Organisation.FGM was also included as part of the level 2 safeguarding training.

- The hospital had recently introduced the requirement that all registered clinical staff had to complete level 3 safeguarding children training in order to meet the guidance detailed in the Royal College of Nurses and Royal College of Paediatrics and Child Health Safeguarding Children and Young People: Roles and Competencies for Health Care Staff, Intercollegiate document (2014). Discussions with staff and review of records showed that a large number of staff had completed level 3 training, with further staff booked to complete their training.
- Records provided by the hospital showed that all registered children nurses who worked at the hospital had completed level 3 safeguarding children training.
- Records provided by the hospital showed that at 4 September 2016, 86% of all staff working at the hospital had completed the level 1and 2 safeguarding children e-learning module.Records also showed that 50% of 115 staff requiredto complete level 3 safeguarding children e-learning had done so.A programme of training was being followed by staff to ensure staff completed this training in a timely manner.
- Medical staff that treated children and had not completed level 3 safeguarding children training, had their practising privileges suspended until they demonstrated they had completed the training. We viewed records that evidenced this occurred.
- Nursing staff, that we spoke with, demonstrated an understanding about safeguarding children. They all said any safeguarding concerns would be escalated to the hospital safeguarding lead, who would notify the relevant local authority safeguarding team.
- The hospital had given all staff a pocket clinical reference guide. This included adult and children's safeguarding procedures and the contact details for the relevant local authority children's and adults safeguarding teams. Despite being provided with this guidance, not all staff spoken with were clear about how to contact relevant local authority children's safeguarding teams. However, all staff said, to ensure they protected children and young people were from abuse, they would escalate any safeguarding concerns to a senior member of staff who they believed would be the most appropriate person to contact the relevant authorities if the safeguarding lead was not available.

Mandatory training

- Spire Healthcare set a target that the staff group at the hospital must be 95% compliant with all elements of mandatory training. The training coordinator at Spire Clare Park explained that monitoring of compliance with mandatory training ran from January to December each year. Spire Healthcare set a target that the staff group at the hospital must be 95% compliant with all elements of mandatory training. The training coordinator at Spire Clare Park explained that monitoring of compliance with mandatory training ran from January to December each year Hospital compliance with mandatory training was making good progress at 75% in August 2016 against a year-end target of 95%.
- Mandatory training included Equality and Diversity, Fire Safety, Food Safety, Health and Safety Awareness, Infection Control, Managing Violence and Aggression, Manual Handling, Mental Capacity Act, Safe Transfusion Level 1, Safe Transfusion Level 2, Safeguarding Adults at Risk Combined Level 1 & 2, Safeguarding Children and Young People Combined Level 1 & 2, safeguarding Children and Young People Level 3 and Information Governance.

Assessing and responding to patient risk

- Nurses completed risk assessments for each child's admission including risks due to the patient's condition and treatment and risk associated with the environment.
- Review of patient records showed all children and young people attending for surgery had a preadmission risk assessment completed by a registered children's nurse. The assessment included risks associated with the child's health and wellbeing. Children aged between 16 and 18 were assessed for their appropriateness to be looked after by adult nurses rather than a registered children's nurse.
- Children's health and wellbeing was monitored using the nationally recognised paediatric early warning system (PEWS). This identified if a child was at risk of

deteriorating and identified when a child's condition needed to be escalated to a medical practitioner. There were different scoring charts for children of differing ages, to ensure early detection of changes in their condition. Review of the PEWS charts showed they were completed thoroughly with frequency of observations carried out according to the patient's condition and guidance detailed on the PEWS charts.We saw observations were scored correctly, with no escalation to medical practitioners required.

- In the event of a child deteriorating and requiring critical care facilities, children were transferred to NHS paediatric critical care facilities using the local paediatric critical care retrieval service.
- We saw records of communications that evidenced the hospital was in the process of negotiating a service level agreement with a local acute NHS trust for children whose condition deteriorated to the degree they needed expert care from an acute hospital, but did not require critical care facilities or there was a staffing crisis in the children and young people's services.
- All staff we had conversations with told us there had been no incidents in the last year that necessitated the transfer of a child to other facilities.
- Adult nurses told us children's emergency scenarios were carried out at regular intervals. One nurse told us she had attended two in the last year.
- The procedure for the care of children and young people in Spire Healthcare policy document included detail about paediatric resuscitation. The policy included information and reference to relevant legislation (Resuscitation Guidelines 2010, Resuscitation Council (UK) October 2010) and the training requirements for the different staff groups employed at the hospital.
- Records and discussion with members of staff evidenced that training requirements for the staff groups were met. This meant all clinical staff completed Paediatric Basic Life Support (PBLS) training annually. Records provided by the hospital showed that at the time of the inspection 92% of staff had completed PBLS training.
- All registered children's nurses, recovery and anaesthetic staff and adult registered nurses who had delegated children's responsibilities completed Paediatric Intermediate Life Support (PILS) training annually. The European Paediatric Life Support (EPLS) or the Advanced Paediatric Life Support (APLS) training was required to be completed by the paediatric lead nurse, the hospital resuscitation lead, the RMO and sufficient numbers of recovery staff so there was always a member of the recovery staff with EPLS or APLS available when a child was having surgery.Records were viewed evidenced there was always a member of recovery staff with EPLS or APLS when children were undergoing surgery.
- The anaesthetist stayed on site during children's recovery period and we were told that they were supportive of nursing staff

Nursing staffing

- There was a children's lead nurse who oversaw the inpatient and day case services. They worked full time for Spire Healthcare, but only around one day a month at Spire Clare Park hospital. They coordinated the admission of patients to the hospital. However, they had no input into the management of children and young people attending the hospital for outpatient appointments. There was also a bank registered children's registered nurse and three agency registered children's nurses who worked at the hospital.
- The hospital did not always meet the Royal College of Nursing Defining Staffing Levels for Children and Young People's Services Guidance (2013). The guidance details, "In order to ensure that children and young people are cared for by nurses with the right knowledge, skills and expertise, a registered children's nurse will be employed to care for those children admitted to adult wards and services."
- The Spire Healthcare policy for caring and treating children gave conflicting guidance and lacked clarity about staffing requirements. In one part of this policy (staffing) it suggests that when there is not a children's nurse immediately caring for the child there must be a children's nurse on-site and in another part (consent) it suggeststhe children's nurse need only to be available for advice but does not specify they need to be on site. This could lead to confusion amongst staff about their responsibilities in organising and providing care for children.

- When we spoke with staff, the lead registered children's nurse and the booking team, They told us, to ensure they met national guidelines,processes were followed to ensure there was always a registered children's nurse working when a child was admitted to the hospital. Discussions with staff and viewing booking forms showed that confirmation of a child's admission date to the hospital for surgery was only made after assurance was obtained that a registered children's nurse was available for any child under the age of 16. Records showed only one child was admitted at a time, so there was no requirement to have more than one registered children's nurse on duty at any one time.
- However, when we reviewed the children's staffing numbers against the dates children were admitted for surgery for June, July and August 2016, we found that one child under the age of 16 had been looked after by a registered adult nurse. We asked the hospital about this. They told us the patient was risk assessed by the lead children's nurse and the parents and child were happy for registered adult nurse to care for them. The hospital told us a registered children's nurse and a paediatrician were available by telephone for advice. They told us this was in line with Spire Healthcare Policies. However, this did not meet the the Royal College of Nursing Defining Staffing Levels for Children and Young People's Services Guidance (2013) as a registered children's nurse was not employed to care for the patient on this occasion.
- Staffing practices at the hospital meant there was only a registered children's nurse in the hospital when children or young people were admitted to the ward. There was no process to ensure a registered children's nurse was identified and available with responsibility and accountability for the whole of the child's pathway, including their pathway through the outpatient's services.
- The Royal College of Nursing guidancedetails that "at all times there should be a minimum of one registered children's nurse in the recovery area" and when children were being recovered from general, epidural or spinal anaesthesia there should be two registered children's nurses on duty. There was no registered children's nurse employed on the recovery area. However, the hospital had a policy of only one child being admitted at a time, which meant there was never more than one child in hospital at a time. This meant the registered children's nurse on duty was always available to support the recovery staff to recover children.This was confirmed in conversations with staff in recovery.

Medical staffing

- A named consultant looked after all children during the day, whose practising privileges included paediatric experience in the procedures they were carrying out at the hospital. The Spire Healthcare policy was that consultants had to be able to access the hospital within 45 minutes. This did not meet the recommendations set out by the Association of Independent Healthcare Organisations (AIHO). However, staff on the wards, told us the hospital's individual requirement was that consultants had to be available to attend to the child within 30 minutes of being called Staff told us consultants and anaesthetists always made themselves available to provide advice over the telephone or attend the hospital when needed.
- There were 28 consultants with paediatric practicing privileges. This included eight anaesthetists with the skills to carry out paediatric anaesthetics.
- Consultants were required to complete annual paediatric basic life support training and safeguarding children level 3 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 records that evidenced this occurred.
- All consultant surgeons 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 hospital management team to determine whether the person had the required skills and experience to carry out paediatric treatments at the hospital. Medical staff who could not demonstrate they had the relevant skills were not granted practicing privileges. We saw records that this occurred.
- A suitably qualified RMO was available 24 hours a day. The RMO was required to provide evidence of four to six months paediatric experience and evidence of annual updates of EPLS.

Major incident awareness and training

Requires improvement

Services for children and young people

- The hospital had a business continuity plan.
- The hospital risk register identified risks associated with loss of water, gas and electrical supply and failure of IT systems.
- The maintenance manager told us in the event of a power failure, the hospital had an emergency generator that would supply electricity to the hospital. The hospital wide risks register detailed this was only for essential services.

Are services for children and young people effective?

Requires improvement

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

We rated effective as requires improvement because,

- The hospital did not follow the guidelines set out in the Royal College of Nursing: Defining staffing levels for children and young people's service (2013), to ensure all staff who cared for children and young people had the necessary skills and competencies.
- In outpatients, theatres and recovery areas adult registered nurses working with children and young people did not complete any competency assessments.
- Compliance with some policies was measured through a clinical scorecard which showed inconsistent compliance in some areas. There was no clinical audit plan for children and young people's services.The clinical scorecard but did not benchmark clinical effectiveness across a wide range of measures.
- The hospital did not follow best practice guidance in that parents of young children were not routinely asked to bring the Personal Child Health Record (PCHR) books in for outpatient appointments or hospital admissions.

However,

- Children's and young people's pain was monitored and pain relieving medicine administered as required.
- Children and young people had their surgery carried out at the beginning of lists to ensure minimal pre surgery fasting times and maximise recovery time whilst the consultant was present at the hospital.
- The hospital policies relating to the care of children and young people took account of evidence based clinical guidelines.
- The service had access to X-rays and pharmacy 24 hours, seven days a week.
- There were arrangements in place for children and parents to consent to surgery and treatment.

Evidence-based care and treatment

- Children's care and treatment mostly took account of national guidance .We saw that policies and procedures referenced national guidance. For example the resuscitation policy referenced Resuscitation Guidelines 2010, Resuscitation Council (UK) October 2010.The procedure for the care of Children and Young People in Spire Healthcare policy included references to the UN Convention on the Rights of the Child 1989,Royal College of Nursing :Caring for children and young people(2014), Royal College of Nursing: Defining staffing levels for children and young people's service (2013), Royal College of Nursing: Healthcare Service standards in caring for neonates, children and young people (2013) andRCN London and Royal College of Paediatrics and Child Health. Safeguarding children and young people: roles and competencies for health care staff. Intercollegiate Document (2014).
- However, the hospital did not follow the guidelines set out in the Royal College of Nursing: Defining staffing levels for children and young people's service (2013), to ensure all staff that cared for children and young people had the necessary skills and competencies.
- The hospital used a paediatric clinical scorecard to monitor compliance with some policies. This included monitoring of compliance with completing PEWS charts, pain scores, temperature scores and completion of patient records. The target for compliance was 95%. Records for 2016 showed between January and March 2016 compliance was not achieved with scores between 81-88%. For the period, April to July all areas scored above 95% with the exception of completion of patient records where the compliance score was 90%.

- The hospital did not have an identified clinical audit plan in place specifically for paediatric care at the time of our inspection.The clinical scorecoard could be used to track some clinical outcomes such as unplanned return to theatres or surgical site infections but did not benchmark clinical effectiveness across a wide range of measures.
- Staff we spoke with told us parents of young children were not routinely asked to bring the Personal Child Health Record (PCHR) books in for outpatient appointments or hospital admissions. The PCHR (or 'red book') is a national standard health and development record given to parents or carers at a child's birth. The PCHR is the main record of a child's health and development. The parent or carer retains the PCHR, and health professionals should update the record each time the child is seen in a healthcare setting.This meant the hospital was not following these best practice guidelines.

Pain relief

- We saw the care pathway for a child day case or overnight stay included an assessment of the child's pain on admission.
- Children's policies and discussion with staff indicated management of pain after the procedure was discussed with the child and parent at the time of admission.
- Review of children's records showed pain following a surgical procedure was measured using a nationally recognised age appropriate tool.We saw patient's higher pain scores corresponded to when pain relieving medicines were administered. The records showed effectiveness of pain relieving medicines was assessed, and that pain scores were lower after administration of this medicine.
- A parent of a child who had undergone surgery at the hospital confirmed their child had received pain relieving medicines when needed and their pain had been well controlled.
- If required, staff could access specialist pain relief could for children from the anaesthetic team.

Nutrition and hydration

- Children had access to a choice of refreshments when required and there were child appropriate menus available.
- Children, young people and their parents were advised about pre-surgery fasting (that is omitting food and fluids except water before an operation) times by the children's nurse during the pre-admission assessment process. The hospital sent written information about pre-surgery fasting times. The "Procedure for the care of Children and Young People in Spire Healthcare"gave guidance about when children should stop having fluids and food before an anaesthetic.
- The care of children in Spire Clare Park hospital local policy detailed it was highly recommended that children were operated on first on the operating lists to ensure minimal fasting times and maximum recovery time whilst the consultant was on site.Discussion with the admission coordinator, children's lead nurse, theatre staff and ward staff evidenced children were placed first on operating lists.

Patient outcomes

- There were no recorded unplanned returns to theatre for children and young people during the reporting period April 2015 to March 2016.
- Children and young peoples' outcomes were not measured separately at this hospital.

Competent staff

- The hospital did not follow the Royal College of Nursing Defining Staffing Levels for Children and Young People's Services Guidance (2013), which described itself as relating to both children and young people's health care services whether provided by NHS or the independent sector. This details that if children are cared for by adult registered nurses, these nurses should have completed relevant competencies for the age range of children admitted and the conditions they treat. Only adult registered nurses who worked on the ward completed paediatric competencies. Adult registered nurses who worked in the outpatients department, theatres or recovery area did not complete relevant competencies about care and treatment of children and young people
- We viewed a sample of competency assessment documents for adult registered nurses working on the wards. They showed adult nurses knowledge about care

of children was assessed. However, there was lack of evidence of robust assessment of staff skills in caring for children. Evidence was from discussion rather than observation of care.

- The hospital provided information about the training of all registered children's nurses (permanent, bank and agency staff) who cared for inpatient children and young people. This showed the hospital was assured all these staff had a current children's nurse registration with the Nursing and Midwifery Council and had completed relevant training to equip them with the skills to care for children and young people at Spire Clare Park hospital.
- All consultant staff were required to provide evidence of their accreditation, validation and appraisal before practising privileges were granted. All of the consultants with practising privileges were also employed by local NHS trusts to perform surgical procedures on children and young people. The medical advisory committee (MAC) and hospital director were responsible for granting and reviewing of practising privileges biannually to ensure the consultants were competent in their roles.
- The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals
- The RMO on duty when children were admitted was trained in advanced paediatric life support.
- There was a corporate policy for staff appraisal, in which staff had three appraisals per year. Both the children's lead nurse and the bank nurse we spoke with had recently been appointed and so had not yet completed any appraisals. However, they were both aware of the appraisal process and the line manager who would appraise them.
- The children's lead nurse told us she had her appraisals carried out by her line manager at another Spire hospital.The hospital told us it was standard practice within Spire Healthcare Limited to take into account a staff member's full employment performance during the appraisal process, even when working across more than one department or hospitals.We were told appraisals were completed at year end and the matron from the children's lead nurse employing hospital had requested evidence and feedback from Spire Clare Park to complete the whole practice appraisal for the children's lead nurse.
- Feedback from parents showed they considered staff were knowledgeable. One parent said, "Staff are confident, so we are reassured" and continued to say staff (nurses and doctors) appeared to have professional knowledge.

Multidisciplinary working (in relation to this core service)

- The children's nurses took full responsibility for communicating the needs of all inpatient children under their care with the general nursing staff, medical staff and other healthcare professionals as appropriate.
- Staff told us there was effective working between all staff groups. When children were admitted, the children's nurse would meet with ward and recovery staff to discuss the needs of the specific child. All staff we spoke with told us staff in the hospital worked as a team to support children in hospital.
- Service level agreements were in place for children under the age of three to have phlebotomy service in the local acute NHS trust.
- A service level agreement was being arranged with the local acute NHS hospital to transfer children to their children's wards in the event of a child's condition deteriorating.
- In the event of a child deteriorating and requiring critical care facilities, children were transferred to NHS paediatric critical care facilities using the local paediatric critical care retrieval service.
- The anaesthetist stayed on site during children's recovery period and we were told that they were supportive of nursing staff.

Seven-day services

- Records showed that inpatient children were seen by their consultant daily.
- The RMO was on site and available at night and at weekends.

Requires improvement

Services for children and young people

- The diagnostic imaging department was available for routine x-rays and ultrasound scans between 8am and 9.30pm weekdays. During the weekend and overnight, radiographers provided an on call service though they told us they were very rarely called out of hours.
- The hospital pharmacy service was available between 9am and 3pm Monday to Friday. An agreement was in place between the hospital and the local acute NHS trust for an emergency out of hour's service.

Access to information

- Staff were able to access any necessary information about caring for children and young people on the hospital's intranet and as paper copies.
- The hospital, in line with Spire Healthcare, was transferring all patient records to a single patient record. This meant medical, nursing, physiotherapy and other health professional's records were held together. This ensured all staff had access to information to ensure continuity of care.
- Diagnostic imaging results were available electronically, accessible by the clinician during clinic appointments.
- Discharge information was provided for the patient's GP and district nurses when appropriate and a copy was given to the patient.
- Parents confirmed notes and paperwork were all available and ready for their child's outpatient consultation when they arrived at the hospital.
- Staff knew how to access policies, both on the hospitals intranet and as paper copies on files kept in the ward. This meant they had easy access to current guidance about the care and treatment of children and young people.

Consent

- Guidance about obtaining informed consent of parent or carer and a child were included in Spire's Procedure for the care of children and young people issued in March 2016, Spire's policy for Consent to investigation or treatment issued in January 2016 and Spire Clare Park's own guidelines for the care of Children in Spire Clare Park hospital dated July 2015.
- There was clear guidance in the documents that children under the age of 16 could consent to their medical treatment if they understood what was being proposed and could weigh up the advantages and disadvantages of the proposed treatment, (Gillick competency). However, Spire's Procedure for the care of children and young people in Spire Healthcare described this as being Gillick/Fraser competent. There was no differentiation in the policy between Gillick competency and Fraser guidelines. Fraser guidelines only apply to contraceptive advice and treatment in young people under the age of 16 and was not relevant to the service provided at Spire Care Park. However, the hospital told us, this may be relevant to other hospitals in the Spire Group and was therefore included in the corporate children and young people's policy. The consultant paediatrician who worked in the outpatients department demonstrated, in conversation, a good understanding of Gillick competency.
- Parents we spoke with confirmed consent was obtained from them prior to procedures being carried out on their child. They confirmed that although their child did not sign the consent form, the procedure was discussed with them in a manner they understood and informal verbal consent sought from their child before the procedure was carried out.
- We reviewed five sets of notes. For four of these we saw appropriate consent forms according to the age of the child were completed correctly. However, for one 17 year old a consent form for children under the age of 16 had been used rather than an adult consent form.

Are services for children and young people caring?

Good

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

We rated caring as 'good' because,

- Feedback from one child we spoke with and feedback from several children's surveys showed they thought staff were very kind and they were fully informed about their care and treatment.

Requires improvement

Services for children and young people

- Feedback from parents we spoke with and feedback from surveys showed they found staff kind and respectful to themselves and their children and they felt fully informed about their child's care and treatment.
- The emotional needs of children and their parents were considered. Parents could accompany their child to the anaesthetic room and be with them in the recovery area. After discharge, parents could contact the hospital for advice and support.

Compassionate care

- Due to the low numbers of children being treated at the hospital, we were only able to speak to one patient with their parents, observe interactions, and speak to the parent of two young children attending outpatient appointments during our inspection. Following the inspection, we had a telephone conversation with the parent of a child who had undergone surgery at the hospital. We also reviewed surveys, specific to the children's inpatient service, completed by children and their parents. All children and their parents praised the service provided at Spire Clare Park hospital.
- A child told us the nurses were "very kind, I like them…and the doctor was kind too." They also told us "I did not want to come in today but I liked everyone and I should not have worried". Parents told us, "staff are very helpful;…it has just been a positive experience." All parents and children we spoke with confirmed all staff introduced themselves by name
- Comments from children in the surveys included "the staff were lovely and kind, the bed was comfy." In answer to the survey question what was good about the hospital a child responded, "My bed, the nurses, watching DVDs." Comments from parents in the surveys included, "the care has been second to none," "they were so kind and patient," and "everyone very friendly and makes you feel relaxed".
- Conversations with adult registered nurses on the wards showed they were mindful of supporting and caring for the whole family. This included supporting parents and siblings of the child who was having surgery.
- Discussion with staff indicated they were mindful of maintaining the privacy and dignity of children. Examples included in the outpatient department, always weighing children in the privacy ofn the consulting room.
- Children were always chaperoned when seen by staff, this was usually a parent or someone known and trusted by the child.

  The Clinical scorecard measured the degree of patient satisfaction. Recorded patient satisfaction was detailed as 100% for the period January to August 2016.

Understanding and involvement of patients and those close to them

- Staff told us they always explained what was happening to children in a manner they could understand. This was confirmed in the conversations we had with children and parents. A child in outpatients told us they understood what the doctor was explaining to them. Parents told us, "Everything was clearly explained and we could ask as many questions as we wanted." The parent of a child who had surgery at the hospital said that their child was included in all discussions about care and treatment.
- However, practices for completing growth charts and monitoring child's growth did not always fully involve the child or their parent. For example, in the outpatient department, we observed a paediatrician completing plotting of the charts after the consultation. This meant there was no opportunity for discussion at the time of consultation about the child's growth or development.

Emotional support

- All staff were aware of the need to provide emotional support to both children and their parents.
- The preadmission assessment process was used to help relieve children, young people and their parents of anxieties about coming into hospital. Children, young people and their parents were told what to expect during their admission to hospital. However, the usual practice was for the preadmission assessment to be carried out in a telephone conversation. This did not routinely give children, young people and their parents the opportunity to visit the hospital, view the premises and meet staff who would be looking after them during their admission to help relieve anxieties.

Requires improvement

Services for children and young people

- Theatre recovery staff met children on the ward before surgery to explain what to expect when in the recovery area and so the child knew who would be looking after them in the recovery area.
- Parents accompanied their child to the anaesthetic room staying with them until they were asleep and were taken into the recovery area when their child woke up. This practice was confirmed as occurring in conversations with staff and parents. Parents said it helped to relieve their child's and their own anxieties.
- Following discharge parents were given the telephone number of the hospital they could contact at any time of day or night for advice and support.
- Children returned to the hospital, where they knew the staff, for any post discharge care, such as removal of sutures. Staff felt this practice helped relieve anxieties for children about having their sutures removed.

Are services for children and young people responsive?

Good

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

We rated responsive as good because,

- Children and young people attended the hospital for planned surgical procedures and an inpatient service was only offered to children age three and above, in line with national guidance.
- The hospital took action to mitigate risks to children being cared and treated in areas where adults were accommodated.
- Parents could stay with their child in hospital.
- There were a small number of toys to entertain younger children. Older children were encouraged to bring in their own electrical devices, books or games for entertainment purposes.
- A "Coming into hospital" booklet helped younger children understand what to expect when they were in hospital.
- Interpreting facilities were available if needed.
- Action was taken in response to complaints.

However,

- There were no information leaflets in outpatients suitable for children or young people.
- Whilst we were told children and young people were usually seen within two weeks of being referred, time to treatment following referral was not formally monitored for children and young people.

Service planning and delivery to meet the needs of local people

- Children and young people attended the hospital for planned surgical procedures, outpatient appointments, xray services and physiotherapy. Inpatient surgical services and outpatient physiotherapy services were only offered to children age three and above, in line with national guidance.There were no dedicated children's areas of the hospital. This meant children were seen and treated in areas that adults were seen and treated in. However, staff took action to mitigate any impactthis might have on children and young people. On the ward, children and young people were nursed in side rooms that were located in the quieter area of the ward.In the recovery area, screening was used to separate children from adults being recovered in the same area and the hospital tried to arrange outpatient lists so children's appointments were grouped together.If parents wanted to stay with their child, a bed was made up for them in the child's room.
- The lead paediatrician told us 85% of referrals to the children's outpatient service were from GPs.

Access and flow

- Children and young people attended Spire Clare Park hospital as privately funded or insured patients and procedures were planned in advance
- Children's procedures were booked at the beginning of theatre lists, which usually meant children and young people could recover and return home the same day.
- In paediatric outpatients, the one parent we spoke with told us they had a 10 day wait from being referred to being seen. They said they only had a few seconds wait in the waiting area before being called into the appointment. Another parent with their children at a

surgical follow up clinic told us they had been waiting for 20 minutes on this occasion, but that was because they had arrived early, usually they went straight into their appointments.

- There was no monitoring of waits from time of referral to time of first appointment or commencement of treatment for children's services. The consultant paediatrician told us they saw children within two weeks of referral or sooner if the child's condition was urgent or the parents were worried. However, as waiting times following referral were not formally monitored the hospital could not be assured that children and their families/carers were not waiting unduly long to be seen, even if they had been referred urgently.
- The hospital had not received any concerns or complaints about referral to treatment times for children and young people.

Meeting people's individual needs

- In all clinical areas there were no child appropriate decorations or artwork. The lead children's nurse said she was hoping to get permission to purchase pictures suitable for different aged children that could be put in the room when a child was admitted and removed when the child was discharged.
- Each department (ward, outpatient areas and X-ray) had a small number of toys for children to entertain themselves with and for staff to use as distraction therapy when children received treatment. Most toys were for young /preschool age children.
- The hospital actively encouraged older children to bring electronic devices, such as phones and tablets for entertainment purposes, as well as books and games . The hospital had Wi-Fi access that children and their parents could access. They were made aware of this facility during the preadmission assessment process.
- Children and parents we spoke with did not express any concerns about the availability of play equipment.
- There were no leaflets or information in the outpatients departments available in formats suitable for children to understand.Staff told us individual consultants had their own supply of leaflets and information to give to parents and children.
- A coming into hospital booklet helped younger children understand what to expect when they were in hospital.
- Staff said generally they did not admit children who had complex needs, but sometimes they did admit children who had a learning disability, including those on the autistic spectrum. Children's individual needs were discussed during the preadmission assessment process and if required the child's needs were discussed with any specialist health providers involved in the care of the child. The information was used by staff to provide care and treatment in a way that would not distress the child or parent. Staff confirmed there was no specific training provided about caring for children with a learning disability.
- Staff and parents told us food provision met children's choices. The children's lead nurse told us she was in the process of reviewing the children's menu to add more choices for children.
- There were appropriate scales for weighing children of differing ages.
- Staff told us, if needed, interpreting facilities were available to support children and parents whose first language was not English. The children's lead nurse said admission dates for surgery would not be confirmed until she was assured appropriate interpreting facilities would be available on the day of admission and surgery. However, there had been no recent need for interpreting facilities, so we were unable to test whether this practice occurred.

Learning from complaints and concerns

- The children's lead nurse said there had been no complaints about children's services at Spire Clare Park since she was appointed as the children's lead role and hospital records confirmed this.
- We viewed the children's complaints register, which showed there had been no formal complaints about the children's service relating to the care and treatment provided since commencement of the register in 2013.
- The complaints register for outpatients departments listed two complaints about children and young people's service in 2016. One of these related to outpatient test results and the other related to the

cancelling of a child's surgery due to an administrative error. The complaints register demonstrated that action and learning had taken place in response to the complaints.

Are services for children and young people well-led?

Requires improvement

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

We rated well-led as 'requires improvement' because,

- There was a lack of clarity about the overall leadership of all the children and young people's services at the hospital. The identified lead children's nurse had no oversight of the service delivered to children and young people in the outpatients department. Not all staff working with children knew who the children's lead nurse was.
- Whilst there was a written strategy for this service, it was not supported by a detailed action plan and was not well understood by staff, including the identified children and young people's lead.
- Governance processes specifically for the children and young people's service were newly implemented at the time of our inspection so had not, at that time, supported quality monitoring or improvements.
- It was not clear who had oversight of, or responsibility for, identification of risks associated with providing a children and young people's service at the hospital. Staff looking after children were not aware of the all risks for children detailed on the hospital risk register. Risk management processes did not fully identify all risks posed to children and young people.

However,

- Processes were in place to enable children and young people treated as inpatients and their parents provide feedback about the service they received.
- There was a lead consultant anaesthetist to co-ordinate and oversee the anaesthetic services for children and young people who was a member of the hospital Medical Advisory Committee (MAC).

Leadership / culture of service

- There was a lack of clarity about the overall leadership of the children and young people's service The lead children's nurse worked across three Spire hospital locations and was ward manager at one of the other locations. This meant she managed the children and young people's services at Spire Clare Park remotely. She only spent on average one day a month at Spire Clare Park hospital. She told us she was mainly responsible for the children and young people's inpatient services and oversaw the services for children and young people in the outpatients department. The hospital told us the matron, who was not a registered children's nurse, had overall leadership responsibility for children and young people's services in the hospital, with the children and young people's lead nurse reporting to her.
- It was unclear whether the children and young people's lead nurse had a full overview of the children and young people' services provided at Spire Clare Park hospital.This was demonstrated by them not being aware of complaints made to the outpatient department about services provided to children in the 12 months prior to the inspection and lack of knowledge of all entries about children and young people's services on the hospital wide risk register. Whilst it was acknowledged, the children and young people's lead was not in post at the time the complaints had been made, their induction to the service should have provided them with an overview of concerns raised that impacted on the wellbeing of the children and young people who used the service. This would support them to ensure any changes made to the provision of children and young people's service, which included the administrative support, continued to be embedded.
- Since the inspection, we have been told that the matron takes overall responsibility for the children and young people's service.However, staff we spoke with during inspection were not aware of this and the matron, during interview, did not report this as a key responsibility within their role.

- There was a lead consultant anaesthetist, with paediatric admitting rights, who oversaw the anaesthetic service for children and young people and ensured that a child was anaesthetised there is always an anaesthetist with the relevant qualifications. The lead anaesthetist was a member of the hospital Medical Advisory Committee (MAC).
- A paediatrician consultant had recently been granted practising privileges at the hospital and was part of the MAC to provide medical leadership for the children's and young people service.
- Staff on the wards knew who the children's lead nurse was for the hospital. However, some staff working in the outpatients department with children and young people were not clear who the children's lead nurse was. Some staff quoted one of the adult nurses working in outpatients as being the children's lead.
- However, staff spoke positively about their local leadership and described a culture of working as a team. Recovery staff described the children's service as "a team approach from the moment the child arrives in our care."The paediatrician told us working at Spire Clare Park was "amazing" and that nothing was too much trouble for staff.

Vision and strategy for this this core service

- The hospital director and children's lead described a strategy they had in place for the development of children and young people's services at the hospital over the next two years.based on their hope to expand the children and young people's service.
- Following our inspection we were provided with the written strategy for the children and young people's service which set out the planned development of the service at the hospital over the next two years. The strategy was not dated specifically, only stating 2016.The overall plan was detailed as "continue to extend the range of services offered for children and young people and to grow the numbers of patients seen. This requires the provision of specific facilities that are suitable for caring for children, an increase in appropriate staffing and a clear commitment to meet the relevant standards." There was no clear detail about the actions that needed to be taken to develop and expand the service, although the new hospital manager confirmed this would be addressed once she had assessed the service as part of her new role and once the new lead for the service was established in post. The children and young person's lead was not familiar with some of the actions written within the strategy.Some staff we spoke with could describe the overall aims for the service but were not familiar with the written strategy.

Governance, risk management and quality measurement for this core service

- The development of the management and running of the children and young people's service at the hospital was in the process of being embedded into the running of the hospital.Since the appointment of the children and young people's lead in May 2016, a dedicated children and young people's quarterly multidisciplinary governance meeting had been set up but only one meeting had taken place at the time of our inspection.This meeting included medical representation.The hospital director told us outputs from these governance meetings were shared at clinical effectiveness meetings.
- As the lead for the service worked remotely and did not attend the meetings, the hospital director told us the matron represented the service at these meetings.However, it was not clear how information was communicated between staff caring for children, the children's lead nurse and the matron given that the children's lead worked approximately one day per month at this hospital and staff caring for children were unsure who the lead was.
- The children's lead nurse told us children and young people's service meetings were held at the hospital that included them self, the hospital director, matron, and representatives from theatres, outpatients, radiology, recovery and the bookings team. We reviewed a record of one of these meetings, which showed the pathways for children in the hospital were being reviewed and equipment required for the effective support and care of children was identified and sourced. However, there was no record to evidence incidents or concerns raised locally, corporately or nationally in children and young people's services were considered, or risks to the children and young people's service at the hospital were reviewed.
- References to children and young people's services were included in the senior management meetings. These

showed consultant paediatrician recruitment and the requirement for all clinical staff to complete safeguarding children level 3 training was regularly reviewed.

- Records from the MAC meetings showed applications for paediatric practicing privileges were reviewed and a newly appointed consultant would represent the children's service at MAC meetings in the future.
- The MAC had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant, who carried out children and young people's surgery, was required to complete annual reviews with the MAC chair, where data on their clinical performance was reviewed. We saw records to evidence this occurred.
- The hospital told us they reviewed the score cards (outcomes) for the children and young people's service at clinical effectiveness meetings, and that any concerns with consultant outcomes would be raised and noted in the MAC meeting minutes.We reviewed minutes of meetings and found no evidence of these discussions but were told by senior leaders this was because no such concerns had been identified within this service.
- There was insufficient recognition of risks within the service.The hospital used a risk register to identify and monitor high level risks and another register of risk assessments completed by individual departments that identified lower level risks and the action taken to mitigate the risks. However, review of the hospital wide and departmental level risk registers and register of risk assessments showed risks we identified during the inspection process were not included within either. This included risks relating to the security of the environment and to the service not meeting the national guidance for safely staffing a children and young people's service. The children and young people's lead nurse was only aware of one risk being on the hospital wide risk register in relation to their service when there were, in fact, two.They were not aware of the risk on the register that related to care of the deteriorating children in the outpatient department.
- There was a lack of oversight of incidents that affected children's and young people services across the whole hospital. Despite learning and changes in practises occurring as a result of an incidentin the theatre recovery area where hospital procedures had not been followed, the incident was only identified as an incident affecting the recovery area and not as an incident affecting the children's and young people's services.

Public and staff engagement

- Staff told us the recently appointed senior team were always accessible and open to new ideas and ways of working. Staff forum meetings had recently been restarted. Staff spoke positively about them being and opportunity for their views and opinions to be heard.
- The hospital had a system of "inspiring people awards." This was to assist leaders in demonstrating their value and respect for staff.
- There were various processes for the service leaders to engage with staff. This included one to one meetings, team meetings and multidisciplinary staff forums. However, agency and bank staff involved in the care of children and young people told us there was no forum for the permanent, bank and agency registered children's nurses to meet, express their views and opinions and discuss the quality and safety of the service. As they were the staff group most involved in delivering direct care to children and young people, it is difficult to see how the service leads could take a robust view of the quality and safety issues within the service without their involvement' .
- Part of the admission process for children and young people was to provide surveys for them to complete at discharge about their experience. There were two different surveys; one for an older child, which was similar to adult surveys, and one for a younger child that required less written responses. However, there were no surveys that supported preschool children to feedback their views about the service. There was no collation of the feedback received, which meant trends in children's and parents views about their experience could not be identified. However, the children's lead nurse said a feedback spreadsheet was being started which would enable trends in children and parents views and experiences to be identified and monitored. Following the inspection we were provided with the feedback spreadsheet. This showed that children and their parents who submitted feedback were wholly satisfied with the service provided.

Requires improvement

Services for children and young people

- In the outpatient departments patients were encouraged to leave feedback about their experience by the use of a patient satisfaction questionnaire and for NHS patients by the Friends and Family Test. Patient feedback cards were available in the waiting areas and posters were clearly displayed to inform patients. However, none of these related to the children and young people's service. There was no process for children seen in outpatients to provide feedback specifically about the children and young people's service.This meant the feedback from children, young people and their carers given about outpatients could not be extracted from overall feedback about outpatients generally so could not be reviewed with other feedback across the hospital to form an overarching view of children and young people's experience of care at this hospital.

Innovation, improvement and sustainability

- The recently developed strategy for children and young people's service set out a development of the children and young people's service at the hospital over the next two years. At the time of the inspection, there was no detailed development plan for the expansion of the service.

Good

Outpatients and diagnostic imaging

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

Information about the service

Spire Clare Park opened in 1984; the hospital treats patients from Surrey, Hampshire, Berkshire and West Sussex. The hospital has expanded significantly over time The outpatient clinics include cardiology, orthopaedics, gynaecology, urology, gastroenterology, ENT, paediatrics, mole screening, psychiatry, dietetics, rheumatology, haematology, respiratory, vascular, neurology, fertility, urodynamics and bariatrics. Patients are able to attend between the hours of 8am and 9.30pm. There are 10 consulting rooms, two treatment rooms, an audiology booth and an exercise electrocardiogram (ECG) room.

There was a physiotherapy department which provided a service for patients following orthopaedic and gynaecology procedures. The service was available between 8am and 7pm. The physiotherapy team worked in five treatment bays and had access to a treadmill. The team also provided other classes at a local gym and swimming pool, which did not form part of our inspection.

The diagnostic imaging facilities included a newly installed magnetic resonance imaging (MRI) scanner, digital mammography, ultrasound, and plain x-ray. Computerised tomography (CT) scanning was available on site one day per week provided by an external company.

There were 24,226 outpatient attendances during the reporting period (April 2015 to March 2016) and of those 18% were NHS funded. During the same period the outpatient department (OPD) provided 2,195 new patient appointments and 22,031 follow up appointments.

The majority of patients seen (88%) were between the ages of 18 and 74 years and 10% were aged 75 and over.

During our inspection, we visited the outpatients department, the diagnostic imaging services and the physiotherapy team. We spoke with seven patients, and 16 staff including, nurses, healthcare assistants, consultants, radiographers, physiotherapists, administrators and managers.

Throughout our inspection, we reviewed hospital policies and procedures, staff training records, audits and performance data. We looked at the environment and the equipment in use, and we observed interactions between staff and patients.

Good

Outpatients and diagnostic imaging

Summary of findings

We rated this service as good overall. We found outpatients and diagnostic imaging was good for the key questions of safe, caring, responsive and well led. We did not rate effective, as we do not currently collate sufficient evidence to enable a rating.

There were appropriate systems in place to keep patients safe. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. There were clearly defined and embedded systems, processes and standard operating procedures to keep patients and staff safe and safeguarded from abuse. Staff undertook appropriate mandatory training for their role and they protected patients from the risk of abuse and avoidable harm. Staff followed hospital infection prevention and control practices and they monitored them regularly, to reduce the risk of spread of infections. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines. The hospital was generally clean and tidy with a pleasant atmosphere but during our inspection, we found areas of dust in a number of consulting rooms, and cleaning schedules were not displayed

Staff planned and delivered patients' care and treatment in line with current evidence based guidance, and best practice and legislation. There was evidence of local and national audits, including clinical audits. Staff were qualified and had the appropriate skills to carry out their roles effectively. Managers supported staff to deliver effective care and treatment, through meaningful and timely appraisal.

Patients were positive about the care they received from staff, access to appointments and the efficiency of the service as a whole. We observed that staff were caring, kind, compassionate, and treated patients with dignity and respect. Feedback from people who use the service and those close to them was positive about the way staff treated them. Staff demonstrated they were passionate about caring for patients and clearly put the patient's needs first, including their emotional needs.

There was good availability of appointments for patients across all specialities. Staff planned and delivered services in a way that met the needs of patients. Access to appointments was timely; staff held clinics on weekdays into the evening and on Saturdays to suit patients' preferences. Waiting times, delays, and cancellations were minimal and managed appropriately.

Interpretation services were available when required and staff made practical adjustments to accommodate patients' individual needs, for example, when caring for patients with dementia.

There was openness and transparency in how staff dealt with complaints, which they investigated and changes made if necessary.

There was a clear statement of vision and values, which was driven by quality and safety. Staff were well informed about issues relating to their department. Effective governance and risk management systems were in place.

Local and senior managers were visible and approachable to all staff. There was an open and supportive learning culture. Staff gave patients opportunities to provide feedback about their experiences and they used the feedback to improve the service.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good

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

We rated safe as good because:

- Staff protected patients from the risk of abuse and avoidable harm in the outpatients, physiotherapy, and diagnostic imaging departments.
- Staff had a good understanding of how to report incidents and learning from incidents was shared at departmental level.
- Staff adhered to the national 'bare below the elbow' guidelines.
- Staff undertook appropriate mandatory training for their role and managers supported them to keep this up-to-date.
- Appropriate equipment was available for patient procedures and tests. Equipment was well maintained and tested annually or in accordance with manufacturers' guidelines.
- Staffing levels and the skill mix of staff was appropriate for both the outpatient department and diagnostic imaging service.
- Medicines were stored securely and well managed.
- Patient records were available prior to a patient appointment.
- Staff received training in basic life support to ensure they could respond appropriately in an emergency.

However,

- Cleaning standards were not consistent throughout the department and cleaning schedules were not displayed in all areas.

Incidents

- In the reporting period April 2015 to March 2016, there were 21 clinical incidents and six non-clinical incidents reported by outpatient or diagnostic department staff. There were no serious incidents reported over the same period; all of the 27 were graded as low or no harm incidents.
- There were no never events reported during the same period in the outpatient and diagnostic department.
- Staff were confident they knew how to report an incident on the electronic incident management system, and could give examples of what to report. The receptionist and two healthcare assistants (HCAs) that we spoke with told us that they were well informed of actions taken following an incident, not only in their area of practise but across the hospital and the Spire group. Managers shared learning at team meetings, via email, and a newsletter.
- The radiographers in the MRI scanning room told us that when they reported incidents, they received some feedback from the electronic system, and gave an example. When they reported a wet slippery floor they received an e mail when the problem was resolved.
- There were no radiation incidents reported under the ionising radiation medical exposure regulations (IR(ME)R) within the reporting period (April 2015 to March 2016); staff we spoke with were clear about the reporting process and described how they would report onto the electronic reporting system and inform the Radiation Protection Supervisor (RPS) at the earliest opportunity.
- All heads of Departments attended clinical governance meetings and shared the information gained with their teams; minutes were produced and staff expected to sign when they read them. This meant that staff understood what incidents occurred, what the organisation had learned and what changes needed to happen to prevent reoccurrence
- The electronic reporting system identified trends; we were given the example of pathology request forms returned by laboratory due to lack of detail on forms.
- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable

safety incidents. Staff were aware of the principles of duty of candour and could give examples of when a patient would need to be approached, although no staff recalled any incidents where DoC was triggered.

- We saw a copy of the DoC policy on the wall of the MRI scanner; the policy was comprehensive and included a letter template for issue to patients following an incident which triggered a DoC notification.

Cleanliness, infection control and hygiene

- Spire Healthcare had an infection control manual in place that included details of all infection prevention activities required of all hospitals in the group; this included education programmes, audit programmes, hand hygiene procedures and many others. Spire Clare Park held a quarterly Infection prevention meeting, which included all heads of departments and infection prevention leads.
- Hand sanitizer points were widely available throughout the outpatient department including the waiting areas to encourage good hand hygiene practice. We observed staff adhered to the national 'bare below the elbow' guidance in clinical areas, which enabled thorough hand washing, and reduced the risk of spread of infection between staff and patients.
- The hospital management agreed a programme of replacing carpets with vinyl washable flooring to infection control requirements for outpatient consulting rooms due for completion in the autumn 2016.
- We saw cleaning records in all of the radiology rooms, itemised and dated.
- The MRI scanner area was visibly clean throughout and there were cleaning records displayed, which showed that staff cleaned the area daily.
- The toilets in the MRI scanning waiting area had elbow control taps, which minimised infection risks.
- We saw the three cardiology rooms and all were visibly clean.
- We observed staff cleaned equipment and tidied rooms between patients.
- Personal protective equipment (PPE), such as gloves and aprons, were readily available for staff in all clinical areas, to ensure their safety when performing procedures. We saw staff used them appropriately.
- The outpatient department had no incidents of MRSA or MSSA in the reporting period (April 2015 to March 2016).
- Since our inspection visit, Spire Clare Park Hospital has introduced additional training and a programme of hand washing audits.
- A number of outpatient consulting rooms had cleanliness issues. In rooms one and three, and room seven in the joint reaction clinic, we saw dust at the rear of stacking trolleys. In room three the privacy curtain was visibly soiled, and the curtain in room seven did not display a date label for changing. Patient couches had some dust on frames, and some phones were dusty. Doors were obviously dirty with greasy hand marks around handle side edges. One examination light in room seven was visibly dirty around the hand positioning area.
- There were dirty plug tops, and the carpet edges close to the walls were not hoovered.
- We saw desk fans with dirt on the blades and the safety grills, the majority of ceiling vents were visibly dusty with dirty surrounds.
- There were no cleaning rotas visible for patients or visitors to view in the general outpatient areas.
- In the "Joint Reaction Clinic," waiting area there was dirty paintwork around the beverage point, and the rear and top of the beverage machine was covered in a film of dust. The notice stand at the entrance had patches of rust on the base so could not be cleaned properly, and the carpet was stained in toilet entrance.
- The monthly housekeeping audit report for April 2016 showed that there were a number of rooms in the OPD that did not meet the cleanliness standards with consulting rooms (69%), treatment rooms (75%), and patient reception areas (67%) and the crash trolley audit in June found that the OPD trolley was very dirty. After our inspection we reviewed monthly audit reports for July, August and September 2016 which showed some improvement in some areas.

- We saw evidence in senior team meeting minutes that cleaning issues were ongoing and actions were developed in an attempt to address the problems.

Environment and equipment

- The outpatient areas were well signposted and corridors were free from clutter.
- We saw that doctors had the appropriate equipment available to them. A healthcare assistant(HCA) stated that they covered the same clinics each week where possible so they understood what equipment specific doctors required and were able to prepare for clinics accordingly. We witnessed a doctor request a shoulder model in order to demonstrate an injury to a patient; the HCA immediately provided it from a locked cupboard.
- Staff checked the resuscitation trolley daily and we observed it was tamperproof and clean.
- During the inspection, we saw equipment labelled as serviced, and electrical appliances were tested and dated August 2016.
- The engineering services manager explained that he contracts an external company on an annual basis to test equipment throughout the hospital. He said the company completed the testing the week before our inspection visit and he was awaiting receipt of a report. The testing company informed him of some small faulty items which he removed from service immediately as they were no longer safety compliant. We saw purple stickers indicating the test date on all the equipment in the consulting and treatment rooms.
- Staff we spoke with were clear on the procedure to follow if they identified faulty or broken equipment. Staff sent paper requests to the engineering maintenance team who prioritised the tasks and kept a record of jobs on a spreadsheet.
- The engineering maintenance team tested the fire alarms each week on Wednesdays.
- There was clear radiation hazard signage outside the x-ray rooms for staff and patients.
- The Radiology department had a full maintenance contract with the equipment manufacturer, who also provided support on the end of the phone if required.
- All new radiology equipment was risk assessed and applications training carried out before use.
- A medical physics expert (MPE) from an external organisation undertook quality assurance equipment checks every six months in mammography and on the magnetic resonance imaging (MRI), equipment; we saw the records for January and July 2016 and there were no concerns.
- The staff also completed daily and weekly equipment checks and we saw the signed and dated records.
- A radiation protection advisor (RPA) completed an annual audit against ionising radiation (medical exposure) regulations IR(ME)R 200 and the ionising radiation regulations (IRR) 1999 in January 2016; the outcome report showed that the radiology department was fully compliant with no improvements required.

Medicines

- We saw that staff stored and checked medicines appropriately and drug fridge temperatures were maintained and recorded. The radiographers checked and recorded the fridge temperature that stored the contrast media daily.
- Staff in the Joint Reaction Clinic area reported that they kept prescriptions in a locked cupboard and we saw this to be the case. When a doctor required a prescription, they were provided with a pad and the numbers were logged maintaining an audit trail. Staff then provided the pharmacy staff with the numbers used. However, we observed a private prescription pad was left unsecured in an unattended cardiology consulting room. We raised this with the hospital management team, who took immediate action to store the prescription pad securely in line with the hospital's medicine management procedures.
- Senior staff checked all prescription pad numbers daily.
- The pharmacy manager told us she oversaw the ordering and re-stocking of "crash bricks" (pre-packed medicines to be used in a medical emergency).They were all due for re-stocking at the same time unless used in an emergency, which was very rare. We saw that re-stocking was due in November 2016.
- The pharmacy was open Monday to Friday 9am to 3pm covered by a pharmacist and pharmacy technician who

was the department manager. Outside those hours, the staff directed patients to their local pharmacy with any prescriptions, in accordance with the medicines management policy.

- The radiology department contrast media supply and anaphylaxis box were kept in a locked temperature controlled cupboard. Staff recorded a daily temperature check and a check to ensure that the contents were within date.

Records

- Patients seen in the OPD had clinical records provided by the consultant. Consultants also had access to the picture archiving and communication system (PACS) in all consulting rooms, which enabled them to see patient x-rays and scans.
- All pathology results were available online throughout the hospital.
- Medical secretaries put together set of notes for all patients who attended the hospital; this record did not leave the hospital.
- We saw that all the healthcare staff that completed a consultation or treatment updated the clinical records.
- In the event that a patient arrived for an appointment, and no clinical notes were available, the medical secretaries were able to fax a copy of the clinical entry from the last consultation, or if appropriate the GP discharge letter and a copy of pathology reports sent from the laboratory.
- Consultants and staff employed by the hospital were not allowed to take medical notes off site unless they were taking them to or from the offsite repository. In this situation, they were in a sealed case and transported in a controlled way.
- Spire Healthcare was registered with the information commissioner's office (ICO) which covers all staff transporting notes between hospital and the Medical records facilities. The Consultant handbook recommended that consultants taking their own notes off site also register with the ICO.
- The organisation was currently moving to a single patient record, so the receptionists asked all patients to check a form, which stated the personal details the hospital held.
- The hospital used a data encryption service. Each licensed user had an outlook plugin installed this allowed them to send and receive encrypted email.
- Staff told us that if an information breach occurred they would log it onto the electronic reporting system and an investigation would take place, with any learning points shared.
- We did not see any medical records left unattended during our inspection.

Safeguarding

- Safeguarding training for vulnerable adults and children levels 1 and 2 were mandatory for all staff. Compliance with safeguarding training was 100% within the outpatients department in diagnostic imaging, and in the physiotherapy department at the time of our visit.
- The outpatient manager, the physiotherapy manager, and the radiology manager were all trained to level 3 in safeguarding. Staff received training about female genital mutilation (FGM) as part of the level 3 training.
- Training for clinical staff in FGM was included in induction for new staff, and was included in the annual e-learning programme for all clinical staff
- Safeguarding policy and procedure was displayed in the large MRI control room, and the local safeguarding team's point of contact was displayed in each department.
- The matron was the hospital lead for safeguarding children and adults and told us that she completed any referrals to the appropriate local authority and she was recently invited to their quarterly safeguarding committee meetings.None of the staff we spoke with could recall having made a safeguarding referral but said they would discuss any concerns about patients or their visitors being at risks of avoidable harm or abuse with the matron or most senior person on duty.

Mandatory training

- All staff in the outpatient, radiology and physiotherapy departments completedthe following mandatory training: child protection online training, vulnerable adults online training, managing violence and aggression, equality and diversity, mental capacity act, compassion in practice, fire safety training, infection control online training, health and safety training online,

safeguarding adults level 1and level 2,safeguarding children level 1 and level 2, and information governance training. Overall compliance was over 97% across the board.

- Two members of the outpatient department team undertook controlled drugs training and this was 100% compliant with the hospital's target.
- A smaller group of staff (22) completed medical gas safety training; they achieved 82% compliance with this training, as four of the group had not undertaken the training at the time of our inspection.
- Mandatory training targets were added to all heads of department yearly objectives for 2016.
- Staff told us that they received an email when training was due and they were able to use an individual portal for updating their mandatory training on line.
- Most training was delivered on line, except for clinical updates, which were given face to face. Staff told us that they were given time to complete their training, or time in lieu if they completed the training at home.
- The physiotherapy manager undertook a needs assessment for manual handling training throughout the hospital and took the lead for all the required training.
- Regular bank staff were also expected to complete mandatory training and had access to the online system to ensure they were up to date when they were required to work.
- The radiation protection adviser (RPA) provided annual radiation protection training for all imaging staff in line with current regulations.

Assessing and responding to patient risk

- Staff in each department were clear about how to respond to patients who became unwell and how to obtain additional help from colleagues in caring for a deteriorating patient.
- Staff explained that, in the event of a patient's condition deteriorating, they called the resident medical officer (RMO) who assessed the patient's condition and made a decision for ongoing care. This could be admission to the hospital ward or transfer to a critical care service. The hospital had transfer agreements in place with three local NHS trusts.
- The hospital recently committed to a programme of upgrading clinical staff training in immediate life support.
- It was a requirement of the hospital's practising privileges (PP) policy that consultants remained available or arranged appropriate alternative named cover at all times when they have inpatients in the hospital. Practising privileges is authority granted to a physician by a hospital governing board to allow them to provide patient care within that hospital. Outpatient staff reported no difficulties in contacting the consultants for patients who attended the department for a follow up appointment.
- Signage for the radiology department was clear with radiation warning lights and yellow warning symbols evident.
- Female patients aged between 12 and 55 years signed a book in the radiology department confirming that they were not pregnant at the time of the x-ray examination.
- There was one appointed and trained Radiation Protection Supervisor (RPS) within the diagnostic imaging department. The RPS role was to ensure that equipment safety, quality checks and ionising radiation procedures were carried out in accordance with national guidance and local procedures. We saw evidence that staff completed these checks and procedures correctly.
- A radiation protection adviser (RPA) completed an Ionising Radiation (Medical Exposure) Regulations IR(ME)R 2000 review of practice at Spire Clare Park in March 2016. The overall summary stated, "A good standard of radiation protection is in place with appropriate procedures and documentation available. The local quality assurance programme is excellent with a good system for ensuring the action loop is closed."

Nursing staffing

Good

Outpatients and diagnostic imaging

- Diagnostic imaging and physiotherapy departments reported they had sufficient numbers of staff to meet the workflow and patients' needs in a safe manner. At the time of our inspection, they did not need to use agency staff to support the service.
- There were no set guidelines on safe staffing levels for the outpatient department (OPD). At the time of the inspection, there were vacancies for two registered nurses. The matron told us that the department managed any shortfall thanks to the good will of a flexible team, and some use of agency nurses.
- The turnover and sickness levels for all the outpatient teams was low and there were no unfilled shifts during our inspection period (April 2015 to March 2016)
- The hospital at the time of the inspection employed 161 medical staff working under rules or practising privileges.
- Radiographers reported there were no difficulties with availability or contacting consultants in the imaging department.
- The hospital contracted two resident medical officers (RMOs) through an established agency, which provided all required mandatory training documents.
- Nursing and radiography staff called on the RMO when required and said they were very responsive.
- There was sufficient consultant staff to cover outpatient clinics, including Saturday clinics. Consultants agreed clinic dates and times directly with the hospital outpatient and administration teams. Within the outpatient department, consultants covered all specialities for all clinics. There were no concerns raised about the availability of consultants to cover their clinics.

Major incident awareness and training

- The engineering services manager they told us that he provided fire safety training for all staff at induction and a table top evacuation-training session took place twice a year.
- There was a generator on site in case of a power failure; the engineering services manager tested this on a weekly basis.
- The hospital director told us how effective the business continuity plans were when the water was cut off for several hours recently.
- Staff told us that the resus officer leads scenario training in the department annually.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

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

- Staff took account of national and local guidance when providing care and treatment. For example, guidance related to diagnostic imaging to ensure safe exposure.
- Staff were encouraged to participate in training and development to enable them to deliver good quality care. Managers supported them in their role through a performance review process and they all had regular appraisals.
- There were audits of clinical practice undertaken regularly.
- Patients' pain needs were met appropriately during a procedure or investigation
- Ionising Radiation (Medical Exposure) Regulations 2000 IR(ME)R audits were undertaken in line with regulatory requirements. Results indicated the service performance was in line with national standards.

Evidence-based care and treatment

- The hospital took account of evidence based care pathways as commissioned and developed by Spire head office. These care pathways took account of clinical guidelines from established and recognised bodies. The care pathways were located on the hospital intranet and were printed on the day of service to ensure they were the most up to date issue.Examples included Urodynamics, and the mole removal screening and removal service.
- Staff in in all outpatient areas reported they followed national or local guidelines and standards to ensure patients received effective and safe care.

Good

Outpatients and diagnostic imaging

- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Managers supported staff to maintain and further develop their professional skills and experience.
- IR(ME)R audits were undertaken in line with regulatory responsibility, copies of these audits, outcomes, actions and results were seen during our inspection. Examples of which included; radiology records audit, radiology request form audit, image intensifier audit.
- Radiation exposure/diagnostic reference levels (DRLs) were available in each room, and audited every six months by the RPA. (Diagnostic reference levels are intended for use as a simple test for identifying situations where the level of patient dose is unusually high. If it is found that procedures are consistently causing the relevant diagnostic reference level to be exceeded, there should be a local review of procedures and the equipment in order to determine whether the protection has been adequately optimized. If not, measures aimed at reduction of doses should be taken.)
- Staff followed Royal College of Radiology (RCR) guidelines for administration of contrast media and we saw that guidelines were available in folders in the viewing room.

Pain relief

- Staff discussed options for pain relief with patients before they performed any procedure. Many procedures were undertaken with the use of local anaesthetic, which enabled patients to go home the same day such as mole removal.
- Staff gave patients written advice on any pain relief medicines they may need to use at home, during their recovery from their outpatient procedure.
- Patients' records demonstrated pain relief was discussed when local anaesthesia was used for minor procedures.
- The hospital feedback data for March 2016 showed that 95% of patients said their pain was controlled a great deal, and 5% said that it was controlled a fair amount.
- The physiotherapy department offered an acupuncture service to patients who required pain relief.

Patient outcomes

- The hospital offered NHS patients the opportunity to take part in the Patient Reported Outcome Measures (PROMS) data collection if they had received treatment for hip and knee replacement and inguinal hernia repair. PROMS measures the quality of care and health gain received from the patients perspective.
- The Medical Advisory Committee (MAC) monitored outcome data for individual consultants as part of the biennial review of consultant's practising privileges. This included readmission rates, venous thromboembolism (VTE) risk assessments and hospital acquired infection.
- All radiology reports were audited for compliance with the reporting times. Ultrasound scans were reported on the same day and general x-rays were reported within 24 hours and usually the same day. This ensured that a system was in place to prevent unverified reports causing delays to patient care.
- The physiotherapists supported the enhanced recovery programme, which enabled patients to go home quicker following hip and knee surgery. The patients had the opportunity to take bespoke exercise classes as outpatients to ensure a full recovery.
- The physiotherapy manager provided a personalised brace fitting service.
- The hospital used a clinical scorecard to monitor outcomes for all patients with a comprehensive list of clinical indicators; for example percentage of eligible females who have a documented pregnancy test (aged 15 to 55) prior to x-ray examination. For each of the previous four quarterly reports the department has achieved 100%.
- The MAC and the Clinical Governance Committee reviewed performance. Many of the scorecard measures are based on national external benchmarks such as those published by Public Health England. Areas that achieve a red rating or amber had actions and action plans developed for the specific indicator.
- The hospital was a member of the Private Health Information Network (PHIN). PHIN provide information for the public on 11 key performance measures, so a patient can make an informed choice where to have their care and treatment for providers offering privately funded healthcare. No data was yet available.

Competent staff

Good

Outpatients and diagnostic imaging

- The hospital completed relevant checks against the Disclosure and Barring Service (DBS). The registered manager and Medical Advisory Committee (MAC) chair liaised appropriately with the General Medical Council (GMC) and local NHS trusts to check for any concerns and restrictions on practice for individual consultants.
- Patients told us that they felt staff were appropriately trained and competent to provide the care they needed. Staff confirmed they were well supported to maintain and further develop their professional skills and experience.
- All practitioners and assistants complete an assessment of competence to undertake the role of a chaperone.
- The two HCAs we spoke to were able to articulate how they would take blood, dispose of the equipment and send the specimens to the local NHS Trust.
- At the time of our inspection, 100% of all outpatient staff had received an appraisal. This included the registered nurses, healthcare assistants, radiographers and the physiotherapists.
- Practising privileges is authority granted to medical practitioners by a hospital governing board to allow them to provide patient care within that hospital. There were appropriate systems in place to ensure that all consultants' practising privileges were kept up-to-date. Evidence of this was seen during the inspection.
- The MRI radiographers completed a competency programme, which enabled them to cannulate patients with contrast media prior to their scan.
- One specialist radiographer who works in cardiac MRI had practising privileges to support the cardiologist. The MRI scan can detect and evaluate the effects of coronary artery disease such as limited blood flow to the heart muscle and scarring within the heart muscle after heart attack; plan a patient's treatment for cardiovascular disorders, and monitor a patient's progression over time.

Multidisciplinary working (related to this core service)

- There was a service level agreement between the hospital and a mobile computerised tomography (CT) scanner provider (which was part of another organisation and not subject to this inspection process). The mobile CT scanning service visited the hospital once a week.
- The radiology service received support from a medical physics expert (MPE) from a local NHS trust for advice when required.
- Departments worked closely to ensure patients did not have to make unnecessary visits. For example, radiographers offered patients x-rays on the same day as their clinic appointment, if needed and results were available electronically for consultants to view in the clinic.
- Staff told us that medical staff were supportive and advice could be sought when needed.
- From the care we observed, there was effective team working, with strong working relationships between all staff groups.
- Effective communication was observed between a medical secretary and receptionist and between the receptionist, medical secretary and three patients. We also observed the interaction between consultants and healthcare assistants (HCAs) which demonstrated a good working relationship between them.
- The communication was appropriate and appeared to demonstrate a good working relationship between all staff observed.
- Physiotherapists worked closely with consultants to develop bespoke treatment plans for patients.

Seven-day services

- The majority of outpatient clinics were held Monday to Friday 8am and 9.30pm. Clinics were also held on Saturdays between 8am and 4pm. Patients we spoke with reported good access to appointments and at times which suited their needs.
- In the diagnostic imaging department, x-rays and ultrasounds were available between 8am and 8pm weekdays. During the weekend and overnight, radiographers provided an on call service.
- Staff in the physiotherapy department told us they cover appointments between the hours of 7am and 8pm "to provide a commuter friendly service."

Good

Outpatients and diagnostic imaging

Access to information

- Radiology administration staff knew that patients should have all previous images available. They checked with the patients as to whether they had received x-rays or scans before, when making the appointment; and requested any previous images from source in preparation. Staff documented such requests and made images available according to the daily clinic lists. Diagnostic imaging results were available electronically, accessible by the clinician during clinic appointments, this enabled prompt discussion with the patient on the findings and treatment plan.
- Pathology results were available electronically for consultants to view in the clinics.
- Patient notes were always available to ensure continuity of care. Hospital notes were kept on site and hospital secretaries made the consultants' own notes available.
- Staff followed the Royal College of Radiologists (RCR) guidelines for administration of contrast media, and these were available in folders in the viewing rooms.
- Radiographers had access to policies and standard operating procedures for radiological examinations. Local rules (local instructions relating to radiation protection measures for the service) were on display in every x-ray room.
- A summary of any procedures undertaken was given to the patient on discharge, as well as one kept in the patients' records and one posted to the GP. This ensured the GPs knew what care and treatment their patient had received at Spire Clare Park hospital.
- We saw that all Spire and specific hospital policies were available to staff on the hospital intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients gave verbal consent for general x-ray procedures, outpatient procedures and physiotherapy treatments carried out.
- Patients signed written consent forms for all minor surgical procedures.
- An external company provided staff with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) as part of mandatory training. DoLS are to protect the rights of people, by ensuring that any restrictions to their freedom and liberty have been fully considered and authorised by the local authority.
- At the time of our inspection, 100% of staff had completed the relevant training as part of their mandatory training programme. Staff we spoke with could explain to us what the MCA and DoLS meant for their practice and their responsibilities.
- Useful information for staff was displayed on staff poster boards in the dining room, which contained information on DoLs.

Are outpatients and diagnostic imaging services caring?

Good

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

We rated caring as good because:

- All feedback received from patients was positive, including the Friends and Family Test and the patient satisfaction survey. Staff treated patients with dignity and respect and confidentiality was maintained at all times.
- The department offered a chaperone service to all patients.
- Staff informed patients about their care and treatment, and spent time with patients to discuss concerns and answer questions.
- Staff gave patients appropriate support and information to cope emotionally with their care, treatment or condition.

Compassionate care

- Throughout the inspection, we saw staff treated patients with dignity and respect and patient confidentiality was maintained at all times. The main outpatient reception desk was located sufficiently away from waiting areas so patients could speak to reception staff confidentially, without their conversation overheard.

Good

Outpatients and diagnostic imaging

- When patients arrived at the reception desk we saw that the receptionist had a good manner when asking patients to check the form which contained their personal details, and provided a clear explanation as to why it was required. She also explained the confidentiality and data-sharing element of the form, asking each patient to sign their consent to data sharing.
- Consultants saw patients in private consultation rooms and staff kept doors closed during consultations.
- We saw staff speaking in a calm, friendly and relaxed way to patients and the patients told us staff were helpful and supportive.
- All the patients we spoke with were positive about the care and treatment they had received. We received comments such as; "I've had lots of hospital treatment and stays and nothing has been better than Clare Park, where nothing is too much trouble, everything is as pleasant as possible."
- We reviewed seven comments cards from patients who had used the outpatient service. They all included overwhelming praise, particularly for the physiotherapy service. For example "I am very satisfied with my treatment at physio and would recommend the treatment at Clare Park to anyone" and "No areas of weakness, very happy with the care received here (several visits and three ops later)" There were no negative comments from any patients within outpatients and diagnostic imaging.
- The outpatient department provided a chaperone service during intimate personal care or when patients requested it.
- The hospital staff took part in the NHS Friends and Family Test and for the reporting period April 2015 to March 2016, they reported a response rate of 34% and achieved a score of 100% for NHS funded patients.
- The hospital collected monthly patient satisfaction data from all patients; in March 2016 98% of all patients would recommend Clare Park and 100% of all patients said that care and attention from nurses was either excellent (94%) or very good (6%).

Understanding and involvement of patients and those close to them

- For the reporting period Aril 2015 to March 2016, patient feedback data showed that 94% of patients said that they were involved in decisions about their treatment, which was 3% higher than the Spire group as a whole.
- Appointments were not rushed and staff spent time with patients to discuss concerns and answer questions.
- Patients understood how to book their next appointment and who to contact if they had any concerns following treatment.
- We witnessed interactions between staff and patients in the radiology and physiotherapy departments, which demonstrated information was conveyed at an appropriate pace, staff checked understanding and patients asked if they had any follow up questions.

Emotional support

- Staff gave patients and their carers' appropriate support and information to cope emotionally with their care, treatment or condition and we were told that all the clinical teams received training for breaking bad news.
- Staff told us they always offered to chaperone patients undergoing examinations and we saw records that showed patients were supported in this way.
- For the reporting period April 2015 to March 2016, patient feedback data showed that 92% of patients said that they were able to find someone in the hospital to talk about any worries or fears they had. This was 4% higher than the Spire group as a whole. We saw the minutes for a patient forum which took place in May 2016 where patients were offered the opportunity to support each other and share their experiences of care at Spire Clare Park.

Are outpatients and diagnostic imaging services responsive?

Good

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

We rated responsive as good because:

Good

Outpatients and diagnostic imaging

- Staff planned and delivered services in way that met the needs of the local population. Patients told us that there was good access to appointments with time slots that suited their needs.
- Waiting times, delays, and cancellations were minimal and managed appropriately. Facilities and premises were appropriate for the services carried out.
- Diagnostic test results were available to consultants and patients in a timely way.
- Patients requiring physiotherapy had access to a variety of treatments including, for example, acupuncture.
- Staff made adjustments to accommodate patients' individual needs, for example, patients with dementia.
- Senior managers dealt with complaints with openness and transparency.

Service planning and delivery to meet the needs of local people

- Managers planned services around the needs and demands of patients. Outpatient department clinics were arranged in line with the demand for each speciality. Clinics were held Monday to Friday until 9.30pm in the evening and on Saturdays, to accommodate patients with commitments during the working week.
- The diagnostic imaging services were available in the evenings in order that patients could have imaging completed at the same time as their outpatient appointment.
- The physiotherapists arranged appointments for patients before they went to work and after work if needed.
- The outpatients' waiting area was a comfortable environment with adequate seating and refreshments available. All consulting rooms and communal spaces were wheelchair accessible. The reception was clearly visible to patients when they entered the department.
- There was parking available for patients attending the hospital, with clear signage directing people to the hospital main reception. Car parking was free but availability was variable depending on appointment times. There was a plan to extend the car park in the coming months after our inspection in response to the increasing demand.
- The hospital worked with the local clinical commission group (CCG) to plan services for NHS patients and there was a commission for quality innovations (CQUIN) target in place for effective discharge from hospital. The physiotherapy team supported this and ensured that all patients had a programme of exercises in place following knee surgery.
- The physiotherapy service provided acupuncture alongside routine treatments providing pain control to enhance patient recovery.
- The local population included a high proportion of runners, cyclists and golfers; the physiotherapy team developed specialist skills to provide specific treatments for the conditions that this group of patients presented.

Access and flow

- During our inspection, we saw data that showed that patients in OPD were seen within five minutes of their appointment times unless there was an unavoidable delay for the consultant to be at the hospital e.g. delayed in theatres due to an emergency. Patients that we spoke with confirmed this. When this happened, the theatre manager informed the outpatient manager, who informed the patients and offered extra refreshments while they waited or an alternative appointment if preferred.
- Administrators offered patients a choice of appointments, including same day appointments if needed. Patients told us that they were given appointments within two weeks if that was their choice.
- The matron told us that the "did not attend (DNA)" rate was very low, but secretaries contacted any patient who did not attend for their appointment and offered an alternative.
- Staff told us that they run three one-stop breast clinics per week, which included input from consultant radiologists, radiographers and a consultant surgeon. Patients attending these clinics received all the required tests in one visit and received results within 48 hours, which reduced their anxiety levels.

Good

Outpatients and diagnostic imaging

- Radiographers told us that where possible they provided continuity for patients who required plain x-ray investigations as well as a scan by undertaking both investigations.

Meeting people's individual needs

- For patients whose first language was not English staff had access to a commercial interpretation service.
- In diagnostic imaging, a range of leaflets was available and provided to patients about diagnostic imaging procedures.
- Patient Led Assessments of the Care Environment (PLACE) for the first six months of 2016 showed the hospital scored over 90% for dementia which was higher than the England average of 81%(2015) and 88% for disability.
- The hospital participated in the "Patient Passport" system, which supports patients with any kind of verbal or physical disability. It was used to support the patient throughout the clinical pathway with documented details of their condition and where they require additional support and therefore avoids repetition.
- The hospital trained staff in each service area as a dementia champion. The champions provide extra support for patients with dementia and their carers, to ensure staff plan their clinical appointment appropriately.
- Staff recognised the need to support people with complex or additional needs and made adjustments wherever possible. However, staff said it was very rare for them to provide care or treatment to a patient with complex or additional needs, for example, dementia or a learning disability.
- The radiographers described a recent patient with dementia who attended for x-ray with her son-in-law. The same radiographers also performed the MRI scan the following day providing familiarity for the patient.

Learning from complaints and concerns

- The hospital had a robust complaints process in place that patients could access via the website, email, verbally or in writing. The hospital director responded to complaints received by the hospital, with administrative support from their personal assistant.
- Complaints trends and themes reports were produced weekly, monthly and quarterly and discussed monthly at the heads of departments, senior management team meetings and the quality assurance committee meeting. The MAC discussed the trends and themes on a quarterly basis. The aim was to identify quality improvement opportunities.
- The clinical governance committee and The Heads of Departments attended the clinical governance meetings and were responsible for cascading information to staff for discussion at team meetings. Trends were also posted on the clinical governance information board in the staff restaurant
- Compliment correspondence was shared via internal email with all staff. Named staff, were highlighted with names displayed in staff only area.
- If there were any issues that could be resolved quickly, whilst the patient was on the hospital site, the duty manager would discuss the issue with the patient to provide an immediate resolution where possible.
- The outpatient and diagnostics department had received 12 complaints during the reporting period (April2015 to March 2016), all of which were resolved within 20 days. No trends were developed from the complaints received.
- The "Please Talk to Us" leaflet outlines how to raise a complaint and was available throughout the hospital along with the "Please Talk to Us" poster, which had multiple languages outlining the process.
- A common complaint was about the lack of parking at the hospital site. This was being addressed by the hospital with an extension to the car park already at planning stage.

Are outpatients and diagnostic imaging services well-led?

Good

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

We rated well-led as good because:

Good

Outpatients and diagnostic imaging

- Effective governance and risk management systems were in place. Staff were well informed about issues relating to their department.
- Managers were committed to provide high quality care and improve services and facilities for patients.
- Staff in all areas stated they were well supported by their immediate line managers. All staff spoke highly of their senior management team, stating that they provided a visible and strong leadership within the hospital
- There was an open and supportive learning culture.
- Patients and other stakeholders were given opportunities to provide feedback about their experiences and the hospital used the information to improve the service.
- Quality of care was regularly discussed in board meetings, and in other relevant meetings below the board level and cascaded to the outpatient departments via their managers.
- There was a culture of collective responsibility between teams and services. Information and analysis was used proactively to identify opportunities to drive improvement in care.

Leadership / culture of service

- A senior registered nurse who reported to the hospital matron managed the outpatient department. The radiology manager and the physiotherapy manager also reported to the matron.
- Staff we spoke with told us that access to their managers was very good as they always made themselves available to staff at the earliest opportunity.
- Staff also told us that, as they had an appraisal three times a year, they had a formal process to discuss developments and opportunities.
- Staff told us they were impressed with the changes made since the new hospital director was in post. One member of staff described the positive change in atmosphere since the new hospital director had taken up her post.
- The staff in outpatients were very positive about their previous manager (who had not long changed role) and told us that they were very pleased that she was now the acting matron because they knew that she was supportive and approachable. The new acting manager had taken up her post the previous week and was not available at the time of our inspection due to planned holiday leave.
- Staff in each of the outpatient, imaging and physiotherapy departments told us they viewed their managers with high regard as supportive leaders.
- During our conversations with staff, it was clear they were passionate about caring for patients and put the patient's needs first.

Vision and strategy for this this core service

- Spire Clare Park Hospital had a simple and straightforward vision document in place that was displayed for staff and public to see. This vision was "to be recognised as a world class health care business."
- The hospital values were stated as: caring is our passion; succeeding together, driving excellence; doing the right thing; delivering our promises and keeping it simple
- There was also a mission statement which was "to bring together the best people who are dedicated to developing excellent clinical environments and delivering the highest quality patient care"
- The staff we spoke with understood these values and they were aware of the longer-term vision to develop the site, and we saw minutes of team meetings, which demonstrated that discussions took place.
- Managers in outpatients and diagnostic imaging knew about the executive team plans for developing their respective services. The plans included refurbishment of consulting rooms in outpatients; the imaging and diagnostic department had recently opened a new MRI suite and staff told us of plans to convert a store room into a CT scanning suite.

Governance, risk management and quality measurement for this core service

- The medical advisory committee (MAC) met quarterly and minutes showed these included key governance issues such as incidents, complaints and practising privileges. The (MAC) also had a role in reviewing consultant contracts, maintaining safe practising standards among consultants and clinicians and granting practising privileges. Each consultant was required to complete biennial reviews with the MAC

chair, where they discussed data on their clinical performance. The hospital also ensured that consultants had appropriate professional insurance in place and received regular appraisals

- Senior management told us that they focussed on the importance of incident reporting and communicating a no blame culture; the drive towards transparency and openness was also manifest in an increase in reporting of incidents.
- The hospital had a robust clinical audit programme and approach to policy management. The hospital completed national and local audits that include elements of the care pathways in use and input into PROMS and NJR for example. All audits featured in the clinical audit plan and were discussed at the clinical audit and effectiveness committee. Specific relevant department audits, such as diagnostic imaging audits, were discussed at the radiation protection committee.
- The committee was purposefully made up of front line staff as well as managers in an attempt to further integrate staff understanding of audit and raise awareness.
- The dedicated risk management committee that was set up in 2015 and met quarterly to review the hospital wide risk register, drove risk management activity. The committee membership includes senior managers who cascaded information at team meetings with front line staff.
- Risks were tracked and managed in the hospital using a Risk Assessment Register and every department had their own risk assessment register managed by the head of department.
- We saw evidence of items on the risk register relating to the outpatient and imaging department. For example; the management of a patient who's health deteriorates while they attend the department; insufficient surgical notes provided to physiotherapy team to deliver appropriate care; lone workers in imaging when radiographers are providing out of hours service. All of the risks were mitigated with risk assessed actions.

Public and staff engagement

- Patients were encouraged to leave feedback about their experience by the use of a patient satisfaction survey and for NHS patients by the Friends and Family Test. The satisfaction survey for the reporting period (April 2015 to March 2016) showed that patient satisfaction with the overall quality of the service was more than 98% positive.
- Hospital staff told us that a patient forum was established to involve patients in hospital strategic decision making and, in the long term, improve patient satisfaction. We saw evidence of minutes for one of these meetings in May 2016.
- Staff told us that they received feedback on patient survey information at their monthly meetings. Clinical performance notice boards displayed information about actions the hospital had taken in response to patient comments. This included plans to make improvements in parking at the hospital.
- Staff forums had re-started as part of the hospital director's work in developing open meetings which enabled staff to "have their say"
- The hospital had a staff achievement recognition scheme, Inspiring People, where awards were made to staff for going the extra mile in their role, or with patients and colleagues. Nomination forms were available throughout the areas we visited. One member of staff told us that she had worked in healthcare for many years but had never received any recognition until she joined Spire Clare Park.
- A GP survey undertaken in 2015 showed that 93% who responded rated Spire Clare Park as excellent or very good for overall satisfaction. However, the response rate was very low at 16%.
- A consultant survey undertaken by the Spire Group showed that Clare Park achieved 5th place out of 38 hospitals with 87% of consultants rating the hospital as excellent or very good compared with the Spire Group average of 79%. Comments included; "Staff go out of their way to make a difference" and "compared to others the hospital staff were easy to do business with."

Innovation, improvement and sustainability

- The imaging department recently opened a new MRI scanner onsite and the staff told us that the hospital planned to open a new CT scanning suite in the near future which would provide a full service for patients requiring imaging.

Good

Outpatients and diagnostic imaging

- The hospital had signed up to the National Patient Safety Campaign in June 2016. The outpatients' manager (acting matron at the time of our inspection) was the lead to take actions forward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The 'World Health Organisation surgical safety checklist' is always appropriately completed.
- The storage and management of medicines including controlled drugs meet the requirements of current legislation, hospital group policy and standard operating procedures.
- Risk of transmission of infections from children's toys is mitigated.
- Risk assessment processes identify all risks posed by the environment of the hospital to children and young people are identified and appropriate mitigating action is taken.
- The hospital's medicines management policy is adhered to and staff must not administer medicines that have not been prescribed.
- There is a clear and visible leadership structure which covers all areas of children and young people's care at the hospital in place to support staff in caring for children and young people.
- The children's service must have oversight of all incidents and complaints relating to the children and young people's services.
- Staff must know who to contact outside the organisation in the event of a safeguarding concern and the hospital safeguarding lead is not available.
- Consider national guidance when planning staffing levels for children and young people's services in all departments of the hospital.
- All nursing staff that look after children and young people must complete competency assessments appropriate to the care and treatment they provide to children and young people.
- All clinical areas are visibly clean and free from dust and cleaning schedules are displayed in public areas.

Action the provider SHOULD take to improve

- Consultants should plan how they are going to use endoscopy outcome data to improve patient outcomes.
- Referral to treatment times are captured accurately and national targets are consistently met.
- Medical Advisory Committee meetings should be attended by representatives from a wide range of specialities across the service.
- Consider asking parents of young children to bring their personal child health books in for outpatient appointments and hospital admissions.
- There is a clinical audit plan in the children and young people's service that supports the clinical scorecard to measure a broad range of outcomes for children and young people.
- Further consider how to ensure the environment is inviting and child-friendly to all age ranges in all areas of the hospital where children and young people receive care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12(1) Care and treatment must be provided in a safe way for service users. 12(2)(a) assessing the risks to the health and safety of services users of receiving the care or treatment. 12(2)(b) doing all that is reasonably practicable to mitigate any such risks. 12(2)(c) ensuring that persons providing care or treatment to service users have the qualification, competence, skills and experience to do so safely. 12(2)(g) the proper and safe management of medicines. 12(2)(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. • There was not always a registered children's nurse identified and accessible to the hospital when children and young people's outpatient clinics were taking place to take responsibility for the whole of the child's care pathway. • Registered adult nurses working with children and young people in the outpatient department did not complete relevant competencies about the care and treatment of children and young people. • Nurses administered anaesthetic cream to patients without it being prescribed by a medical practitioner. • The hospital had not identified or sufficiently mitigated some risks the environment posed to children and young people. • Risk of transmission of infections from children's toys was not fully mitigated.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17(1) Systems or processes must be established and operated effectively to endure compliance with the requirements in this part. 17(2) Systems or processes must enable the registered person, in particular, to (a) assess, monitor and improve the quality and safety of the services in the carrying on of the regulated activity (Including the quality of the experience of service users receiving those services). (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk, which arise from the carrying on of the regulated activity. (e) seek and act on feedback from relevant persons and other persons on the services provided in the carrying out of the regulated activity, for the purpose of continually evaluating and improving services. (f) evaluate and improve their practice in respect of the information referred to in subparagraphs (a) – (e) • There was a lack of clarity about the overall leadership of the children and young people's services at the hospital. The lead children and young people's nurse worked part time at the hospital and only led the inpatient children and young people's service. The lead children's nurse had no oversight of the service delivered to children and young people in the outpatients department. • There was no representation from children and young people's services in the hospital's governance processes. • Governance processes were not embedded and did not support quality monitoring in the children and young people's services. • It was unclear who had oversight of, or responsibility for, identification of all risks associated with providing a children and young people's service at the hospital.