Springfield Hospital

Quality Report

Springfield Hospital,
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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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

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

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

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

Summary of findings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Springfield Hospital is operated by Ramsay Health Care UK Operations Limited. The hospital has 64 overnight beds. Facilities include five operating theatres, a three-bed observational unit, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care and outpatients and diagnostic imaging services. We inspected surgery, medicine, children's and young people's services, and outpatient and diagnostic imaging services.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 04 October 2016 along with an unannounced visit to the hospital on 17 October 2016.

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

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

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

Services we rate

We rated this hospital as requires improvement overall.

We found areas of practice that require improvement in relation to outpatient services:

- Some patient's medical records generated by doctors holding practice privileges were taken off the hospital site without copies being made. Referrals were not always assessed by a clinical practitioner and at times patients arrived for an appointment without staff expecting them. Departmental risk registers were not in place and the hospital-wide risk register did not reflect known risk. Staff had not received training in duty of candour.

We found areas of practice that require improvement in relation to surgery:

- Concerns were noted with infection control. Despite practice changes results of audits showed that compliance with hand hygiene and infection control had not improved significantly. The hospital had identified the upward trend in the rate of surgical site infections over the 12 months prior to our inspection.Staff only had access to the NHS patient records because the relevant consultants had taken away their privately funded patients records off site.

We found areas of practice that require improvement in services for children and young people:

- There were no local audits undertaken to demonstrate outcomes for the effectiveness of outpatients or children and young people's services. Gillick competence was not being recorded in children's records to demonstrate whether this had been considered as required or not. Oversight or information relating to children's services had not been reported to the medical advisory committee. Risks identified during the inspections, specifically around monitoring of the service had not been identified as a risk by the service.

We found areas of practice that require improvement in medical care:

Summary of findings

- There was no formal triage tool in place which staff on the ward could refer to if an oncology patient called the out of hours helpline feeling unwell. This system did not promote timely intervention for conditions such as sepsis, which require immediate medical assistance. Oversight or information relating to oncology service had not been reported to the medical advisory committee. Risks identified during the inspections, related to oncology had not been identified as a risk by the service.

However, we found the following areas of good practice:

- Patient feedback about receiving care or treatment at the service was positive in all services.
- Equipment used for safe care and treatment, such as resuscitation equipment, was regularly checked.
- Staffing levels in theatre, outpatients and on the ward were observed to be sufficient to meet the activity in the service.
- There was good local leadership in outpatients, medical care and children's services.
- The service was responding to identified concerns and creating plans to address these.
- There was some good local innovation within services.
- Diagnostic imaging and physiotherapy appointments were coordinated to reduce the number of hospital outpatient appointments required where possible.
- The service made adjustments to meet the needs of patients with complex needs.
- Staff explained the child's procedure in an age appropriate way using photographs and teddy bears when necessary.
- No children's surgical procedures had been cancelled in the last 12 months.
- Cancellation rates for surgery were low.
- The service undertakes benchmarking though local audits on outcomes and PROMs, which are comparable across the Ramsay Health Care UK Operations Limited nationally.
- PROMs outcomes had seen an improvement in all areas except the Oxford knee score.
- The Endoscopy service had received accreditation form the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).
- Practicing privileges were routinely reviewed by the hospital. There was RMO coverage 24 hours per day.
- The hospital had a local business continuity plan in place.

Following this inspection, we told the provider that it should make improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Professor Ted Baker

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good 	Medical care services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section. The medical service comprised of an oncology day service and an endoscopy service. The oncology unit provided a range of chemotherapy treatments for patients. The service was also able to admit patients to the inpatient ward area if they were unwell. The hospital worked closely with another provider in the oncology centre who provided radiotherapy. The oncology unit at Springfield Hospital is the largest private chemotherapy provider in Essex.
Surgery	Requires improvement 	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Surgical services included a theatre department with five theatres, of which four had laminar airflow, five anaesthetic rooms and a six bedded recovery area. There was also an inpatient ward consisting of 55 single bedrooms, three double bedrooms and a three bedded close observation unit. Between July 2015 and June 2016 there were 11,445 inpatient and day case surgical procedures carried out at the hospital; of these 59% were NHS funded and 41% other funded.
Services for children and young people	Requires improvement 	Children and young people's services were a small proportion of hospital activity with 5% of activity related to patients under the age of 18 years of age. The hospital saw 41 inpatients, 226 day surgery cases and 2971 outpatient cases for patients under the age of 18 years of age. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

Outpatients and diagnostic imaging

Good 

Outpatient and diagnostic imaging services were separate departments and led by two different managers. Between July 2015 and June 2016 there were 63,967 total outpatient attendances, of which 43% were NHS funded and 57% other funded. The outpatient department was spread over the ground and first floor, and consisted of 21 consulting rooms, and four treatment rooms, which were used for minor procedures, phlebotomy and pre-admission. A range of outpatient specialities were available including trauma and orthopaedic (22%), general surgery (10%), urology (9%), and ears, nose and throat (8%). The diagnostic imaging department was located on the ground floor and provided x-ray, ultrasound scan (USS), computed tomography (CT) scan, Magnetic resonance imaging (MRI) and digital mammography services.

Summary of findings

Contents

Requires improvement

Springfield Hospital

Services we looked at:
Medical care; Surgery; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to Springfield Hospital

Springfield Hospital is operated by Ramsay Health Care UK Operations Limited. This private hospital is located in Chelmsford, Essex. The hospital opened in 1987 and was purchased by Ramsey Health Care in 2007 from another provider. The hospital primarily serves the community of Essex however referrals outside this region are accepted.

The hospital has had a registered manager in post since 08 December 2015.

Our inspection team

The team that inspected the service comprised of one CQC manager, four CQC inspectors, two specialist nurse advisors and a specialist advisor who was a surgical doctor.

Information about Springfield Hospital

The hospital is registered to provide the following regulated activities:

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

The hospital employs 192 doctors under practising privileges. There are two registered medical officers (RMOs), of which one is on duty 24 hours a day seven days a week.

During our inspection, we visited all of the areas of the hospital including the theatre, ward area, and the outpatient and diagnostic imaging department. We spoke to 17 members of staff, the registered manager, and the Matron. We spoke with 10 patients. We reviewed 14 patient records, patient feedback, and documentation relating to the running of the service. We also observed the care staff provided to patients.

There were no special reviews or ongoing investigations of the hospital by the CQC at any time during the 12 months before this inspection. The hospital had been inspected previously in 2014, which found that the hospital was meeting all standards of quality and safety it was inspected against.

Activity (July 2015 to June 2016)

- There were 11,445 inpatient and day case episodes of care recorded at the hospital between July 2015 to June 2016; of these 59% were NHS funded and 41% were other funded.
- 19% of all NHS funded patients and 23% of all other funded patients stayed overnight at the hospital during the same reporting period.
- There were 63,967 outpatient total attendances between July 2015 and June 2016; of these 43% were NHS funded and 57% were other funded.
- Of the total inpatient and outpatient episodes of care/attendances, 1% were children aged zero to two, 3% aged three to 15, and 1% aged 16 to 17 years.

There was an allocated accountable officer for controlled drugs (CDs) who had been the accountable officer since 08 December 2015.

Track record on safety (July 2015 – June 2016)

Summary of this inspection

- No never events
- 359 clinical incidents were reported, of which 57% occurred in surgery or inpatients, 40% in outpatient and diagnostic imaging services and 3% occurred in other services.
- Out of the clinical incidents reported, 15% were categorised as severe and 10 as serious injuries.
- No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- One incidence of hospital acquired Clostridium difficile (C. difficile)
- Two incidences of hospital acquired E-Coli
- 110 complaints

Services accredited by a national body:

- Endoscopy –JAG accredited 2015
- BUPA Accredited Breast Care Centre
- BUPA Accredited Bowel Care Centre

Services outsourced by the hospital:

- Emergency Blood Services
- Histopathology Services
- Medical Physics
- Pathology Services
- RMO services

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- We were concerned about the safety of the out of hours triage system that was in use for oncology patients. There was no formal triage tool in place which staff on the ward could refer to if a patient called the out of hours helpline feeling unwell.
- Concerns were noted with infection control. Despite practice changes results of audits showed that compliance with hand hygiene and infection control had not improved significantly.
- The hospital had identified the upward trend in the rate of surgical site infections over the 12 months prior to our inspection.
- Staff only had access to the NHS patient records because the relevant consultants had taken away their privately funded patients records off site. Records of all patients should be maintained by the service, whilst ensuring the consultant maintains their original copy as required.

However:

- Mandatory training rates were mostly positive.
- Staffing levels were sufficient to meet the needs of patients.
- Practicing privileges were routinely reviewed by the hospital. There was RMO coverage 24 hours per day.
- The hospital had a local business continuity plan in place.

Are services effective?

Good

We rated effective as good because:

- Policies and procedures were based on national guidance and best practice.
- The surgery service undertook a range of local audits including on records, VTE, surgical site infections (SSI's), blood transfusion, the deteriorating patient and, medicines management.
- The service did not participate in national audits. The service would be informed by their head office if they qualified for any national audit participation.
- The service undertakes benchmarking though local audits on outcomes and PROMs, which are comparable across the Ramsay Health Care UK Operations Limited nationally.
- PROMs outcomes had seen an improvement in all areas except the Oxford knee score.

Summary of this inspection

- The Endoscopy service had received accreditation form the Joint Advisory Group on Gastrointestinal Endoscopy (JAG).

However:

- There were no local audits undertaken to demonstrate outcomes for the effectiveness of outpatients or children and young people's services.
- Gillick competence was not being recorded in children's records to demonstrate whether this had been considered as required or not.

Are services caring?

Good

We rated caring as good because:

- Feedback from patients and their families was positive. Survey results also showed positive outcomes for NHS and private patients.
- The service undertook a dedicated children's survey to get the views of children and their parents. Feedback from children and their parents was mostly positive.
- The hospital had access to specialist support services, nurses specialists and counselling services where required.

Are services responsive?

Good

We rated responsive as good because:

- Diagnostic imaging and physiotherapy appointments were coordinated to reduce the number of hospital outpatient appointments required where possible.
- The service made adjustments to meet the needs of patients with complex needs.
- Staff explained the child's procedure in an age appropriate way using photographs and teddy bears when necessary.
- No children's surgical procedures had been cancelled in the last 12 months.
- Cancellation rates for surgery were low.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The hospital undertook regular audits in relation to basic care and practice. However, as seen from the audits on hand hygiene action plans from the audits, whilst showing as completed, did not show a positive impact or improvement on the results in further audits.
- The entries on the risk register were not descriptive, did not reflect current service activity or risk.

Summary of this inspection

- Attendance at the MAC by all speciality leads was not consistent.
- Minutes of local meetings were not always recorded.
- Local governance arrangements for oncology services were weak.
- Oversight or information relating to oncology or children's services had not been reported to the medical advisory committee.
- There was a lack of evidence to show that the outpatient department was assessing and monitoring the effectiveness of the service.

However:

- There was good local leadership in outpatients, medical care and children's services.
- The service was responding to identified concerns and creating plans to address these.
- There was some good local innovation within services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Requires improvement	Good
Surgery	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Good	Good	Good	Requires improvement	Good
Overall	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Good

Medical care

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

Are medical care services safe?

Good

We rated safe as good:

Incidents

- We spoke with three members of staff within oncology and endoscopy services who were aware of their responsibilities to report incidents through the hospitals electronic reporting system. Each member of staff gave appropriate examples of the types of incident, which required reporting.
- Two of these members of staff were also able to give examples of incidents, which had been investigated and led to change. This meant that locally, there were mechanisms in place to ensure that learning and improvement following incidents took place.
- There had been no never events or serious incidents within the oncology or endoscopy services between July 2015 and the time of our inspection.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.
- The hospital's approach to duty of candour has been reported on under this section in the surgery report. 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.
- For our detailed findings relating to mortality and morbidity please see this section in the surgery report.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results).

- For our detailed findings relating to the use of the clinical dashboard please see this section in the surgery report.

Cleanliness, infection control and hygiene

- For our detailed findings relating to cleanliness, infection control and hygiene please see this section in the surgery report.
- Locally however, we saw that both the oncology unit and endoscopy suite were visibly clean. There were green "I am clean stickers" on equipment and furniture which demonstrated cleaning had taken place in the days preceding our inspection.
- Staff were observed to comply with hand washing, bare below the elbow and personal protective equipment requirements.
- We noted aseptic techniques being utilised when preparing and laying out trolleys prior to drug administration.
- We visited the decontamination suites for the endoscopy service and noted appropriate systems in place to ensure effective decontamination of equipment such as scopes.

Good

Medical care

Environment and equipment

- The majority of the equipment that we saw such as patient monitoring machines, infusion pumps and scales had been safety tested and serviced within recommended timescales. We did however see one suction machine, which did not have any servicing information recorded on it.
- We reviewed the resuscitation trolley on the oncology unit and found that daily and weekly checks had been marked as complete on all days the unit was open during August and September.
- However, we noted that the machines used to decontaminate equipment in the endoscopy suite were past their scheduled servicing date. This was a known risk for the service as they were replacing and redeveloping their endoscopy suite. Assessments on risk were in place and equipment was safe to use.
- Track and traceability was in place for all endoscopes used on patients. This meant that there was processes in place to monitor the risks and spread of infections by monitoring of equipment use.
- The environments in both the endoscopy suite and oncology unit were well maintained and free from clutter.
- The oncology unit was within a new building that had opened in 2016. It was therefore in good décor and had been designed to suit the needs of the patients being cared for there.

Medicines

- Medicines on the oncology unit were stored securely. We saw that medicines were kept in a locked room behind locked cupboards which only authorised staff had access to.
- There were separate storage arrangements for both intravenous antibiotics and cytoxic medicines. These again were kept in a locked cupboard which only authorised staff had access to.
- The oncology unit had access to a safe seal chemotherapy disposal system. This meant unused drugs could be placed into a machine and were automatically sealed and colour coded to ensure that the correct disposal method for the medication was used.
- Room and fridge temperatures were monitored and recorded daily. We reviewed checks for August and September and saw these remained within acceptable levels.
- We observed the administration of chemotherapy medicines and saw that dose were double checked by two members of staff. This was in line with best practice requirements.
- Controlled drugs were not kept on the oncology unit. Should controlled drugs be needed then these were accessed on the ward.
- For our detailed findings on overall hospital medicines management arrangements, access to medications with the theatre environment for endoscopy services and controlled drug arrangements please see this section in the surgery report.

Records

- Records were easily accessible within lockable cupboards kept in the nursing office. We reviewed four sets of patient records on the oncology unit during the inspection.
- Nursing records, including risk assessments were completed in full as needed and plans of care were documented.
- Care pathway documentation was in place and completed appropriately.
- Pre assessment and risk assessments were all completed prior to each round of chemotherapy.
- Consultant notes were present and legible within the patient record.
- There was appropriate information and recording in relation to the prescribing and administration of medications. Prescribers were identifiable through legible signatures and records were up to date and well completed with allergies documented where applicable.

Safeguarding

- For our detailed findings on safeguarding please see this section in the surgery report.

- Four members of staff we spoke with across oncology and endoscopy services during this inspection were aware of their responsibilities in relation to safeguarding and appropriately described how they would escalate safeguarding concerns.

Mandatory training

- Staff received mandatory training in the following subjects: fire safety, health and safety, infection control, manual handling, resuscitation, information security, data protection, safeguarding children and vulnerable adults, medical gases, and deprivation of liberty and Mental Capacity Act.
- Staff in oncology were 100% compliant with mandatory training and were included as part of ward staff within the training compliance rates. The three members of staff we spoke with on the oncology unit confirmed that they had received mandatory training.
- Endoscopy staff training data was included within the theatre staff group training data, which confirmed that 72% of staff had completed their mandatory training.

Assessing and responding to patient risk

- In order to assess a patient's risk factor and provide appropriate interventions during treatment we saw that the administration pathway included pre-treatment checks and risk assessments including the taking of recent medical history, venous thromboembolism (VTE) assessments and observations such as temperature, pain or discomfort and side effects during treatment.
- Telephone assessments took place for all patients prior to pre-treatment blood tests being carried out. These blood tests were carried out on all patients. If patients presented for their blood test they would also be called in for a face-to-face assessment prior to treatment.
- The oncology and endoscopy services also used an Early Warning System (EWS) whilst people were undergoing treatment. This is a scoring system based on a set of observations such as blood pressure, heart and respiratory rate and when combined produces a score to indicate if a patient is becoming seriously unwell. The service was introducing the national early warning score system (NEWS) to be in line with the rest of the hospital.
- Should a patient show signs of deterioration there were procedures in place, which meant they could be transferred as an emergency to a local NHS Trust to receive critical care. This was supported by a service level agreement.
- However, we were concerned about the safety of the out of hours triage system that was in use for oncology patients. There was no formal triage tool in place which staff on the ward could refer to if a patient called the out of hours helpline feeling unwell. We were told by ward staff that should an oncology patient call the helpline, then the nurse on duty would make a record of the patients concerns and make contact with the patient's consultant for a clinical decision to be made. This system did not promote timely intervention for conditions such as sepsis which require immediate medical assistance. The absence of a triage tool meant that nursing staff manning the out of hours helpline may not have asked important questions about the patient's condition to enable swift and accurate diagnoses to be made.
- We were told that a triage tool was planned to be implemented however, this was not in place at the time of our inspection.

Nursing staffing

- For the oncology unit, nurse staffing was planned in advance depending on capacity with a minimum of 3 registered nurses on every shift.
- The manager for endoscopy services told that staffing levels were maintained with four members of staff being present for each endoscopy list, which included endoscopists, operating department practitioners, nurses or healthcare assistants. For the period of July 2015 to June 2016, the use of bank and agency nurses in the theatre department ranged between 5% and 21%. This rate was below the average of other independent hospitals we hold data for with the exception of April 2016. For the same reporting period, the use of bank and agency operating department practitioners and healthcare assistance was below the average of other independent hospital we hold data for with the exception of October 2016.

Medical staffing

Good

Medical care

- At the time of our inspection, there were 192 doctors or dentists working at the hospital under practicing privileges. Of which 100 (52%) were undertaking their practice at the hospital on a regular basis.
- The hospital had two employed Registered Medical Officers (RMO's) who worked two weeks on, two weeks off, or one week on, one week off. For RMO's working a two week block, there were systems in place to provide a 24 hour rest break, by providing another doctor to facilitate this. Standby doctors were available in the event of the resident RMO being unavailable through either private reasons or when excessive night time working had occurred.
- Individual consultants responsible for patients were contactable whilst the patient was receiving treatment in either the endoscopy suite or the oncology unit.

Are medical care services effective?

Good

We rated effective as good

Evidence-based care and treatment (medical care specific only)

- Policies and procedures were based on national guidance and best practice. We reviewed the hospitals palliative care policy and saw that it was in date being due for review in 2017. We also noted that it referenced appropriate guidance such as that issued by the National Institute for Health and Social Care Excellence (NICE) and in particular the 2011 quality standard [QS13] entitled 'End of life care for adults.' We also noted that due regard had been given to the Department of Health's independent review 'More care, Less Pathway' which put an end to the Liverpool Care Pathway.
- The Endoscopy service had received accreditation form the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in 2015. This meant that the service had been assessed against a set criteria and had demonstrated that it provided care and treatment in line with relevant national best practice guidance such as that issued by the Royal College of Physicians.
- The Ramsay group provide regular updates to its services on NICE guidance. This is disseminated through each hospital and discussed at clinical governance meetings for updates.

Pain relief (medical care specific only)

- All patients had their level of pain assessed prior to commencement of each cancer treatment. This was done using a grading system.
- Should a patient's pain be graded high then nurses would take action to provide advice to the patient or refer them back to the consultant for a pain review.

Patient outcomes (medical care specific only)

- There was a proactive endoscopy lead who under took a variety of audits to assess the effectiveness of the service. We were provided with an example of a sedation audit which looked at sedation levels across consultants and different medications. This audit was on-going every six months to ensure that a mean sedation level was kept across the service to promote patient safety and recovery. These audits were not present on the hospitals overarching audit plan for 2015 to 2016 or 2016 to 2017, which meant we could not be assured of hospital oversight of the outcomes. However, the service had received JAG accreditation, which meant it has assured assessors that it had a quality improvement process that sought to improve patient care and outcomes through systematic review of care.
- We also heard how the service had stopped undertaking endoscopic retrograde cholangiopancreatoghraph's (a procedure use to investigate pancreatic and bile ducts also known as ERCPs) based on an internal review which demonstrated the hospital was not undertaking enough of them to ensure that consultants and staff remained competent in undertaking these investigations in line with JAG guidelines. This demonstrated the service monitored the procedures it undertook to ensure patient needs could be met effectively and safely.
- However, there was no evidence that auditing within the oncology service took place to demonstrate that it was monitoring patient outcomes. We asked to be provided with copies of audits, which demonstrated that the service had benchmarked itself against the National Cancer Strategy and this was not forthcoming. No other audits were provided.

- We did however hear from a member of staff how oncology services had implemented the use of cold caps (caps used during chemotherapy with the aim of reducing hair loss) which had been very popular with patients and good outcomes had been seen. However, there was no data available to support this.

Competent staff

- For our detailed findings on consultant competencies and practicing privileges, please see this section in the surgery report.
- Appraisals were carried out on a rolling year basis and all staff were scheduled to have an appraisal to be completed by the end of the year. For appraisals 67% of nurses and 70% of operating department practitioners and healthcare assistants within the theatre department had received an appraisal. This included staff who worked within endoscopy. Of the 5 members of staff in radiology 60% had completed appraisals in the last year.
- Prior to commencing roles within the hospital both nursing and staff working within the endoscopy suite received an induction and were required to complete a competency workbook as part of their probation period to ensure that they possessed the correct skills and experience to care for patients. We heard from one manager who explained this process in detail and gave examples of how they were supporting a member of staff through this process at the time of our inspection.
- Staff we spoke with confirmed that they received regular competency checks. For the oncology service this included regular checks on the insertion of venous catheters and cannulas for the administration of fluids, medication and chemotherapy. Staff also worked through a chemotherapy competency workbook to ensure they were competent to administer medications.
- Staff were also supported to attend national conferences and events to keep up to date with advances in their area of expertise. This included attendance at the UK Oncology Nursing Service conference and specialist study days for aspects of endoscopy care and treatment.

Multidisciplinary working

- All patients referred to the oncology unit were discussed at the disease specific NHS multidisciplinary team (MDT) meetings held at the local NHS Trust. The purposes of these meetings (attended by a group of health professionals with expert knowledge in specific types of cancer) were to regularly review patients' clinical conditions, assess the adequacy of treatment and discuss any further interventions which may benefit the patient.
- The MDT outcome and action plans were then discussed with patients at Springfield hospital outpatient clinics by their consultants.
- The outcome and action plans of MDT meetings were also discussed at the services chemotherapy unit patient reviews.
- There were close relationships with NHS and hospice partners. This ensured smooth transition of palliative care to local NHS hospitals, primary care teams and hospices.
- Copies of clinic letters to GPs by the referring consultants were sent to the chemo unit prior to patient's first visit to the oncology unit and kept in patients' medical notes. We saw this in all four records that we reviewed.
- The oncology team also had regular liaison with local community palliative teams in Essex including four local hospices.
- The hospitals cancer nurse specialist also attended the local hospice multidisciplinary team meeting which was attended by Consultant palliative doctors, GPs, the palliative hospital team, social workers and physiotherapists.

Seven-day services

- The oncology service operated between Monday and Friday 8am to 6pm. Out of hours, patients had access to a 24 hour oncology helpline. We were however concerned with the safety of the triage system in place and have reported on this under the 'Assessing and responding to risk' section of this (Medical care) report.

Access to information (medical care only)

- Nursing and medical documentation was easily accessible within a secured room in the oncology unit. Staff we spoke with told us that when information was needed it was readily available.

Good

Medical care

- On the ward, for endoscopy patients, records were kept in lockable record trolleys which we easily accessible to staff. Records accompanied patients throughout their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (medical care patients and staff only)

- Nursing staff we spoke with had a good understanding of consent and when consent was required. For example, implied or verbal consent was sought at the start of each treatment episode.
- We reviewed four patient records and saw, in each case, that consent forms were complete and legible. Risks and benefits were discussed with patients and documented on the consent forms.
- We spoke to a patient who had used the endoscopy service on the day of our inspection. They told us that they had been asked to consent to their investigation, had been given appropriate information and time to consider the risks and benefits before having to complete the consent form.
- Staff understanding of the Mental Capacity Act and Deprivation of Liberty safeguards was however limited. It was noted that it would be rare for patients requiring a deprivation of liberty safeguard in place to access oncology or endoscopy services. It is important that staff have an understanding of when they may need to consider a person's capacity in order to support them in making decisions about their care and treatment options.

Are medical care services caring?

Good

Compassionate care

- For our detailed findings on overall hospital patient satisfaction which included endoscopy services please see this section in the surgery report.
- Throughout our inspection we observed care being provided by nursing staff.We saw examples of staff being friendly, approachable and professional. We witnessed people being spoken to with respect at all times.
- We saw people's privacy and dignity was maintained at all times with the use of privacy curtains or frosted glass between chemotherapy pods in the oncology unit.
- We spoke with four patients during our inspection and feedback was positive.
- One patient on the oncology unit stated "the care here has been excellent, the consultants and all the staff are excellent".
- A second patient who had received endoscopy services commented "I can't fault anything the staff have all been very pleasant."
- Oncology patient satisfaction survey results for the period July to August 2016 demonstrated that 100% of patients were satisfied with the care they received and were likely to recommend the service to their friend and family. However, the response rate for this survey was low with only nine (12.3%) patients within the year having responded.

Understanding and involvement of patients and those close to them

- One patient that we spoke with on the oncology unit was able to describe their treatment plan to us in detail which demonstrated they had an understanding of the care being provided to them. The patient further confirmed they were involved in decisions relating to their care and treatment by stating they felt "well included" when discussing the care treatment options available to them.
- The patient we spoke with who had undergone a procedure within the endoscopy unit told us that they felt well prepared for their stay in hospital and nothing came as a surprise.
- Patients were given written information about support services on offer and what they could expect from the oncology unit including consultant contact details and how to contact the unit during and outside of normal opening hours. One patient said, "I have contact details to use if I was to feel unwell when I got home."
- There was variety of written information available to patients which provided details on different types of conditions and treatments in both oncology and endoscopy services. This was also available on the hospitals website

Good

Medical care

Emotional support

- Patients had the support of a cancer nurse specialists whose role was to provide proactive case management together with psychological support and advice on specialist symptom control.
- Oncology services at this hospital were supported by a local cancer charity service. This charity was designed specifically to enable quality of life for people living with cancer. The charity held look good feel better session for patients, offered pamper days and complimentary therapies.
- The oncology service also had links to various wig companies so that should a patient wish a referral could be made.
- There was also a counselling service available to patients as part of the cancer charity service at no additional cost.
- Written information on these services was provided to patients as part of their treatment options and information about the support services available was displayed on walls in the oncology unit.

Are medical care services responsive?

Good

We rated responsive as good

Service planning and delivery to meet the needs of local people

- The Springfield Hospital was a private hospital which provided oncology and endoscopy services to self-funding or medically insured patients. Due to the private business set up, the hospital could provide flexibility and choice to patients choosing to undergo their treatment at the hospital.
- Endoscopy services were also available to NHS patients who has been referred to the services.

Access and flow

- Patients could access the oncology and endoscopy services in a variety of ways which included self-referral or GP referral.
- Patients were seen in outpatient clinics by their consultant to discuss and agree on diagnostic and treatment options.
- Patients who had been diagnosed with cancer and wanted to be treated at Springfield Hospital waited no longer than the national recommendation of two weeks for their first appointment and diagnoses. Data provided by the hospital stated that on average patients received their appointments and diagnoses within three days of referral.
- Data provided also confirmed that on average patients had started their cancer treatment within 10 days of referral, which was significantly better than the national recommendation of 65 days.
- Where surgery was decided as part of a patients treatment plan surgeons and oncologists worked together to provide consistency in care. This meant that following surgery oncologists could act quickly to provide any further treatment.
- Where appropriate, there was access to diagnostic and imaging services and patients were offered these services in a timely manner in order for their treatment plan to be started.
- There were pre-admission systems for endoscopy services before patients were admitted for procedures of investigations.
- The endoscopy service planned theatre lists eight weeks in advance and left open slots so that should a patient require an urgent appointment this could be arranged.
- There was no delay in patients accessing chemotherapy and the service worked flexibly to ensure people's treatment regimens happened as planned.
- Discharge arrangements were in place, which included referral to NHS services or the patients GP.

Meeting people's individual needs

- The oncology unit and hospital (where endoscopy services were located) were accessible. Lifts and ramps were available where appropriate to assist with people's physical disabilities.

Good

Medical care

- There were support mechanisms in place to support people accessing the services who were living with dementia. Staff had access to a dementia champion who provided support and guidance on care planning.
- Services had access to language line to support patients that required interpreters, if their first language was not English, to understand the care choices available to them. These services were planned in advance of patient attendance.
- Endoscopy and oncology services had access to equipment to enable them to provide care and treatment to bariatric patients.
- At the time of our inspection, the hospital did not provide a dedicated palliative care service for patients nearing the end of their life. However, should a patient who had received their care and treatment at the hospital express their preferred place of care to be the hospital, then this was catered for with the support of trained nursing staff from a hospice.
- There were informal links with local hospices and community palliative care teams to support patients at the end of their lives. A member of the nursing team worked closely with one local hospice in order to share best practice and learning with members of the oncology team at Springfield hospital. However, there was no formal SLA in place for the provision of transferring care between Springfield Hospital and the local hospice services. This was something being worked on by the time we returned for our unannounced inspection.
- No specific training had been provided to staff regarding palliative care and understanding of people's needs when they reached the palliative care stage. The Matron informed us on the unannounced that this was something that they were setting up through the local hospice.
- These services were day services and there was access to hot and cold drinks to patients and their relatives. Patients could order meals at any time during their stay.

Learning from complaints and concerns

- For our detailed findings relating to the learning from complaints and concerns please see this section in the surgery report.
- Data we were provided with in relation to complaints did not extend to breaking down the data by service we could therefore not identify what, if any, complaints received related to oncology or endoscopy services. This meant we could not test through data or the governance system how the services acted on and learnt form complaints. We spoke to one member of staff during our inspection and asked them if they couple provide an example of where a complaint had led to change and they could not.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement

Vision and strategy for this this core service (for this core service)

- For our detailed findings relating to vision and strategy for the hospital please see this section in the surgery report.
- We were provided with a strategy for oncology services dated September 2016. This strategy was not strong and did not confirm that it had been appropriately agreed by the hospital's leadership team. The strategy lacked depth and did not adequately describe how the oncology services were going to implement and achieve the strategy aims.

Governance, risk management and quality measurement (medical care level only)

- The service governance processes are the same throughout the hospital. We have reported about the governance processes under this section of the surgery service within this report.
- However, we found that the local governance arrangements for oncology services were weak. We asked to be provided with copies of the last three governance reports or minutes which related to oncology services. These were not forthcoming. We were provided with minutes from a governance meeting dated September 2016, which did not detail any discussion or debate around governance issues. The minutes were more akin to an agenda and there were no agreed terms of reference for the group.

Good

Medical care

- Furthermore, we could not find reference to oncology services having had any hospital wide oversight during the last two hospital wide clinical governance meetings dated 10 November 2015 or 4 March 2016.
- Oversight or information relating to oncology services had also not been reported to the medical advisory committee as confirmed by minutes of those meetings dated 11 January 2016 and 18 April 2016. There was also no oncology representation at either of these meetings due to apologies being given.
- Auditing arrangements for oncology services were weak with no documented audit plan in place.

Leadership and culture of service

- For our detailed findings relating to the overall leadership and culture of the hospital please see this section in the surgery report.
- Locally there was a leader for oncology and endoscopy services, as well as a manager for the ward. The staff we spoke with told us that managers were approachable and that they could raise concerns without the fear of reprimand and they were confident action would be taken as result.
- Three members of staff we spoke with reported an open culture, and that they would have no problem raising any concerns to the local or senior management team.

Public and staff engagement

- For our detailed findings relating to public and staff engagement for the hospital please see this section in the surgery report.
- Locally the endoscopy services had set up at user group to look at ways in which they could improve services.
- Oncology services undertook patient satisfaction surveys in order to gain peoples feedback on the service. Results were positive with patients feeling that all aspects of care met their expectations.
- Staff we spoke with in the oncology unit confirmed that they had been involved in the design of the new unit.

Innovation, improvement and sustainability

- The hospital was looking to set up a new ambulatory care unit. This meant that endoscopy would be to expand the services it offered to patients because they would have access to stage two recovery area.
- A new decontamination unit was due to be built by December 2016 to support the work of the endoscopy service.

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- There were no reported never events between July 2015 and June 2016 in relation to the surgery department. 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.
- In the reporting period of July 2015 and June 2016, the surgery department reported 206 clinical incidents relating to surgery and inpatient services. This rate is lower than other independent hospitals we hold data for.
- Hospital staff had access to a policy named 'Investigating serious incidents'.The policy outlined what constituted a serious incident, how incidents were reported and who was responsible for carrying out investigations and in what time frame. This document also referenced arrangements for the sharing of information and subsequent learning after an incident had occurred.
- We spoke with three staff in relation to the reporting of incidents and they were able to describe what constituted an incident and the process of reporting, which included electronic reporting on the hospital database.
- 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. We saw that duty of candour was documented within the hospital's policy, named 'investigating serious incidents'. We spoke with six staff members from various grades regarding the duty of candour; only two members of staff were able to describe what duty of candour was.
- We reviewed three serious incident investigations and root cause analysis (RCA) reports. In all cases duty of candour had been carried out and each investigation identified how lessons could be learnt via the dissemination of information to staff. Each RCA had a clear action plan in place. We saw minutes of clinical governance meetings where learning was disseminated. Staff we spoke with were aware of serious incidents and could tell us that they had received feedback.
- The hospital reported two deaths within the reporting period of July 2015 to June 2016, neither of which were unexpected. Mortality at independent hospitals is rare and whilst the rate of mortality for the hospital was high compared to other independent hospital we hold data for, it fell within The Care Quality Commissions estimated variance to be expected between services. Mortality and morbidity was discussed on a three monthly basis at clinical governance meetings.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital utilised an electronic dashboard to monitor safety within the hospital. This gave an

overview of the key areas of risk, taking into account data such as emergency returns to theatre and unplanned transfers. Information from the dashboard was fed to the heads of departments with dissemination of information to staff at ward and theatre department level.

- We were given an example of how learning and changes in practice had taken place as a result of monitoring of the dashboard.The implementation of national early warning scores (NEWS) was implemented approximately 8 months prior to our inspection. This was put in place to effectively detect and monitor patients at the risk of deterioration.

Cleanliness, infection control and hygiene

- Surgical staff had access to an infection prevention and control policy online. Infection prevention training was part of mandatory training. The policy referred to other infection control policies relating to specific circumstances such as isolation, management of patients with tuberculosis and safe handling and disposal of sharps (needles).We spoke with a senior nurse from the ward who described the process for barrier nursing. The aim of barrier nursing is to reduce the risk of spreading certain infections or antibiotic resistant germs to other patients and staff.
- There were no cases of methicillin resistant staphylococcus aureus (MRSA) or methicillin sensitive staphylococcus aureus (MSSA) reported between July 2015 and June 2016.
- There was one reported incident of clostridium difficille (C-diff) between July 2015 and June 2016. This was being investigated by the service.
- There were two incidences of hospital acquired E-Coli. Both related to urology patients and with certain urology conditions, the presence of E.Coli is not uncommon.
- We noted that paper copies of policies covering aseptic technique and hand hygiene within the theatre department were out of date and lacking clear review dates.
- All staff we observed in the department were noted to be bare below the elbow and adhering to hand hygiene techniques prior to and after patient contact.
- Theatre staff were seen to be wearing appropriate clothing and footwear for use in surgical areas. We saw the use of face masks and eye protection during surgical procedures. Gloves, aprons, footwear and theatre scrubs were available for staff use within the theatre area.
- Hand washing sinks were available with sanitising hand gel throughout all the areas we inspected. Information was available for patients and relatives to make use of hand gel when entering the department.
- Infection prevention and control environmental audits were carried out in July 2015 and November 2015. The audit carried out in July 2015 revealed an overall compliance of 74%, highlighting concern in relation to hand hygiene, storage of clinical equipment and poor standards of general environmental cleanliness (42% compliant regarding general environmental standards).The re-audit in November 2015 showed a slight improvement with overall compliance at 87%.The audit identified an action log to address the areas highlighted as non-compliant. This was the most recent audit data we were provided with in relation to surgery and ward areas.
- The hospital carried out four hand hygiene audits between July 2015 and April 2016.It is to be noted that these results pertained to the hospital as a whole and not specifically the surgery department. The results revealed compliance levels of 99% for July 2015, 95% for October 2015, 99% for December 2015 and 92% in April 2016.The audit examined hand washing technique, hand drying, the use of alcohol hand gel and compliance to policy. Audits were based on National Public Health Service guidance. For the month of April 2016 scores were noted to be lower due to staff being unaware of the need to wash hands with only soap and water, prior to and after contact with a patient with clostridium difficile (c-diff).
- The hospital reported 34 surgical site infections (SSI's) between June 2015 and July 2016. The rate of infections for primary and revision of hip surgery, other orthopaedic and trauma, spinal, breast, gynaecological and upper GI and colorectal procedures was above the rate of other independent hospitals that we hold data for. The rate of infection for primary knee procedures was below the rate of other independent hospitals we hold data for.

Requires improvement

Surgery

- The hospital had identified the upward trend in the rate of surgical site infections over the 12 months prior to our inspection. The hospital employed an infection prevention and control link nurse who monitored infection control to prevent and control the spread of infection. In response to the upward trend in infections, a 'hospital action plan for surgical site infections' had been developed. We reviewed the action plan and saw that many actions were ongoing to prevent surgical site infections.
- Practices in theatre had changed due to a raised rate of surgical site infections. Guidance from the hospital action plan included that the opening of sterile packaging of surgical instruments should be done in the laminar flow areas of theatre to prevent the risk of infection.
- Local audit data provided by the hospital revealed that surgical site infection audits were carried between November 2015 and February 2016.Audit results from November 2015 showed a compliance level of 73% overall. Low scoring areas included patients not being made aware to refrain from shaving prior to surgery, there was no evidence to indicate that the patient had been monitored for signs of a fall in body temperature and no notes reflected that patients had been given wound management advice. Results from the February 2016 audit revealed a slight improvement with overall compliance achieving 79%.Scores were lower in the same areas highlighted in the previous November 2015 audit. Surgical site infections were an agenda item at infection prevention and control meetings. We reviewed minutes from January 2016 and June 2016, which referenced an upward trend in surgical site infections.
- Single bedrooms were mostly carpeted. We were told that all carpets were cleaned on a rotational basis. We requested data indicating how often the cleaning of carpeted areas was carried out. Data revealed that a deep clean of each carpeted area was carried out once every six months. Additional cleaning was carried out when required for example, in the event of bodily fluid contamination or confirmed infection.
- We looked at three patient bedrooms and noted that all rooms were visibly clean. En-suite facilities were also clean. During our unannounced inspection we visited a further three patient bedrooms. All were noted to be clean.
- The ward area had two dirty utility rooms. All areas appeared clean and detailed checking schedules four times per day were in place for both rooms. One contained a macerator which disposed of bed pan liners and disposable urinary bottles containing bodily fluids, and the other contained a sterilising machine for bed pans and urinary containers. Bodily fluids were carried around ward areas to the macerator, which could be up to 50 metres away. We were told by a senior member of staff that plans were in place to install a second macerator however there were difficulties regarding plumbing and drainage. We were told this was an ongoing issue that they were looking to rectify.
- One dirty utility room contained a used urine bottle within the sink area. There were five bags of dirty laundry and one bag of clinical waste directly on the floor in the other dirty utility room. We noted that these bags were in place for up to a maximum of one hour prior to removal as the rooms were checked hourly. During removal the bags were placed outside of the utility room, in the main ward corridor therefore posing a possible risk of the spread of infection to other areas.

Environment and equipment

- Entrance to the ward and theatre area was via secure intercom. We saw the intercom in use throughout the day of our inspection with all patient and relatives being greeted by reception staff. Access to the theatre area was via automatic doors, which was overseen by the main reception area.
- We saw that the storage of blood pressure machines, electrocardiogram machines, oxygen cylinders, patient weighing scales and linen trolleys were stored along the edges of the corridors.
- We saw that the main entrance and corridor area to the ward and theatres was full of items. In this area were five wheelchairs, one wardrobe containing blank paperwork, a large metal cabinet and patient trolley bed.
- Access to the difficult airway trolley was restricted during our announced inspection due to a whiteboard and other items stored on top of it. This had been resolved by our unannounced inspection and the trolley

was accessible to staff. This trolley was checked daily and found to be fully stocked with appropriate equipment. The latest guidelines were also on the trolley for staff to refer to.

- Adjacent to the main reception area was an adult and paediatric resuscitation trolley. We reviewed the contents of both trolleys and saw that they contained the appropriate equipment for use in a collapse or cardiac arrest. All equipment in this area had been regularly serviced. Equipment check records for the months of June 2016 to October 2016 revealed that checks had taken place on a daily basis with the exception of six days during this period. Weekly checks of this equipment revealed that one weekly check was missing during this period.
- The ward had a further adult resuscitation trolley located on the opposite side of the ward. We checked equipment on this trolley and saw that the appropriate equipment was in place. We reviewed the checks of this equipment which highlighted that between June 2016 and September 2016, daily checks had not taken place on seven occasions.
- The theatre area contained a fridge and freezer unit. Both pieces of equipment had been temperature checked on a regular basis to ensure the integrity of contents. We noted that for the months of July 2016 and August 2016 checks had been carried out on a regular basis. There was a standard operating procedure (SOP) in place with clear guidance for staff in the event of equipment malfunction.

Medicines

- The on-site pharmacy department provided all prescribed medications for use in theatre and ward areas.
- Controlled drugs were stored securely in the ward area. We reviewed the controlled drugs (CD's) held in the ward area, which revealed all stock tallied to the controlled drugs book. Daily checks of CD's had taken place and drugs were stored in line with legislation. One nominated staff member held the keys for this store at all times.
- We checked five drugs within the controlled drugs cupboard, which were all in date. General ward medications were stored in locked cupboards; we were told that the pharmacy department were responsible for the checking and stocking of this area. We saw that the ward trolley used for medication rounds was locked and secured to the wall with a locked chain.
- Controlled drugs within the theatre area were accessible via one of five keys. More keys were required in this area due to the number of theatre lists that were carried out at any one time to enable clinicians to access to patient drugs in a timely manner. We were told that at the end of the day, all five keys were secured in a central cupboard once operating lists had finished.
- During our inspection, we noted that two controlled drug cupboards had been left unlocked in the anaesthetic room areas. This was escalated to a senior member of nursing staff and addressed immediately.
- We saw that intravenous fluid storage in the theatre department was disorganised. When returning for our unannounced inspection this area was tidy and had been re-organised. Staff told us that they were awaiting delivery of a specific storage cupboard for intravenous fluids.
- On three occasions during our inspection, we found that drugs used for the induction of anaesthesia had been prepared and placed in a syringe in advance and left on the side of the anaesthetic room worktops. This process was referred in a local audit carried out by the hospital in July 2015 stating 0% compliance, indicating that anaesthetic assistants (Operating department practitioners or ODP's) were drawing up drugs on behalf of the anaesthetist. The audit carried out in January 2016 revealed 100% compliance, stating that local policy allowed this process with anaesthetist approval. The Royal College of Anaesthetists (RCOA) advises against this practice. We escalated this matter to the senior management team on the day of our inspection. During our unannounced inspection we noted that this practice had ceased, no drugs were being drawn up in advance. We spoke with the new theatre manager who had recently commenced the role within the department. We were given verbal assurance that this practice had stopped with immediate effect.
- Within the theatre area we looked at an intravenous fluid warming cabinet. Fluids within this area are to be

kept for a maximum of three months prior to disposal if not used. We saw that all fluid within this area had been clearly identified with use by dates, all of which were within date.

Records

- All patient records were in paper format. The hospital were working towards the implementation of electronic patient records however a definitive date for implementation was unknown at the time of our inspection.
- We reviewed three sets of patient medical records during our inspection visit. We found that notes were legible and clearly detailed who had completed each entry on the records for ease of traceability.
- All records contained a venous thromboembolism (VTE) risk assessment and World Health Organisation checklist. Prescription drug charts, patient allergies and patient weight were documented in all records we reviewed. One set of notes we reviewed had an additional sepsis screening tool with actions recorded.
- The medical records department was open between the hours of 8am to 5pm, Monday to Friday. We spoke with the medical records department during our inspection. Notes were available to theatre and ward staff during working hours via direct contact with the medical records department. Medical records were prepared the day before planned surgery and taken to the ward and checked to ensure availability of notes on the day of surgery.
- Urgent requests for medical records, out of hours, were overseen by administrative staff who had access to the medical records department. A tracking system for medical records was in place and medical records department staff reported this system worked well.

Safeguarding

- There had been no safeguarding concerns reported to The Care Quality Commission between July 2015 and June 2016.
- Safeguarding training was included as part of the hospitals standard induction programme. Refresher safeguarding training was carried out on a three yearly basis. We spoke with one nurse who was able to identify what would constitute concerns around safeguarding and how they would escalate and report safeguarding concerns.
- Hospital staff had access to online policies for the safeguarding of adults and children. We viewed both these policies which were in date. Staff had access to these policies electronically and guidance included information relating to female genital mutilation (FGM).
- The department had a named adult safeguarding lead. When speaking with a senior member of staff, they reported that should staff require assistance and support relating to safeguarding, they knew to approach the nurse in charge for advice.
- We were given an example of a patient who was referred to the hospitals safeguarding lead due to suicidal thoughts. An appointment was made with the patients GP.

Mandatory training

- The hospital had a mandatory training policy which was in date and reviewed in July 2015. This document detailed that the general manager of each department had overall responsibility to ensure that mandatory training occurred within their department. Mandatory training took place on an e-Learning or face to face basis.
- Staff received mandatory training in the following subjects: health, safety and fire training (80-100% compliant); infection control (0-100% compliant with ODPs reported at 0% although the 0% represented senior ODPs of which there was only one. ODPs overall had achieved 70% compliance); Moving and handling (68-100% compliant with healthcare assistants reported at 68%); Intermediate life support (ILS) training (60%-100% compliant with children's nurse reported at 60%). Safeguarding vulnerable adults' compliance rates reported between 75% and 100% for training at level two. Safeguarding of vulnerable children training rates are reported in the children's section of this report.
- Mandatory training rate compliance was 72% for theatre staff and 78% for ward staff. This average training rate was lower than the hospital's target of 85% compliance.

Assessing and responding to patient risk (theatres, ward care and post-operative care)

- Adjacent to the nurses' station was a three bedded room for patients requiring close observation.This area was specifically for patients requiring one to one care with higher needs for example; patients at the risk of deterioration, breathing complications and post-surgical complications.
- The hospital had a service level agreement (SLA) in place with the local NHS Trust to enable the transfer of critically unwell patients should the need arise.
- Nurse handover took place at 6.45am and 8.45pm.During our inspection, we viewed a nursing handover sheet which contained all relevant clinical information and priorities relating to patient care and needs.
- The hospital used the national early warning score (NEWS) tool to identify deteriorating patients in the theatre, recovery and ward areas. NEWS is based on a simple scoring system in which a score is allocated to physiological measurements (including blood pressure and pulse) to enable timely detection of patient deterioration.
- Prior to discharge from the recovery area a NEWS score assessment was carried out for every patient. The scoring system enabled staff to identify patients who were becoming increasingly unwell, and provide them with increased support. We saw this system in use on the day of our inspection.
- Three sets of medical records that we reviewed revealed that the use of National Early Warning scores (NEWS) had been accurately calculated and completed. A senior nurse reported that they directly contacted the consultant if a change in NEWS occurred; they reported that the consultants preferred to be informed of any concerns regarding a patient's condition rather than staff going through the RMO on site.
- All staff had access to a sepsis screening tool. Sepsis is a potentially life-threatening condition triggered by an infection or injury. We reviewed this tool, which provided clear directions of the actions to take if sepsis was suspected, including treatment and the need to escalate the patient to a senior clinician immediately, with transfer to the local NHS trust if required.
- Patients were not accepted into the theatre area unless they had been marked identifying the site of where surgery was planned. This process was in place to prevent the occurrence of wrong site surgery.
- We reviewed three sets of medical records, which all contained completed the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists. This included notes on debrief for each procedure.
- We observed a surgical procedure within theatres. Staff accurately updated paper records relating to the World Health Organisation (WHO) safer surgery checklist.

Nursing and support staffing

- As of July 2016, the surgery department employed 23.7 full time equivalent (FTE) registered nurses and 19.2 FTE operating department practitioners and healthcare assistants.
- As of July 2016, the inpatient ward area employed 19.5 full time equivalent (FTE) registered nurses and 11.5 healthcare assistants.
- A senior nurse reported that the standard number of staff on the ward consisted of six or seven registered nurses and four healthcare assistants however, this number was planned in advance taking in to account the number of patients admitted on each particular day.
- We spoke with the matron about how staff levels were calculated. We were informed that theatre lists were reviewed with staff being planned four days in advance using a tool to calculate safe staffing levels.
- For the period of July 2015 to June 2016, the use of bank and agency nurses in the theatre department ranged between 5% and 21%. This rate was below the average of other independent hospitals we hold data for with the exception of April 2016. For the same reporting period, the use of bank and agency operating department practitioners and healthcare assistance was below the average of other independent hospital we hold data for with the exception of October 2016.
- There was a move to reduce the number of agency staff on duty. There were plans for the reduction of agency and block booking regular agency staff who were more familiar with the department and procedures.

- Nursing staff handovers took place at 6.45 am and 8.45pm prior to commencement of the day and night shift. We did not see a handover take place during our inspection but noted that shifts started 15 minutes early to allow time for the handover process.

Surgical staffing

- The hospital had 192 doctors on practising privileges (PP's) at the time of our inspection.
- The surgical department had access to the hospital's Resident Medical Officer (RMO) who provided continuous medical cover and conducted regular ward rounds to ensure that all patients were appropriately treated and safe.
- The hospital had two employed RMO's who worked two weeks on, two weeks off, or one week on, one week off. For RMO's working a two week block, there were systems in place to provide a 24 hour rest break, by providing another doctor to facilitate this. Standby doctors were available in the event of the resident RMO being unavailable through either private reasons or when excessive night time working had occurred.
- Medical staffing cover out of hours was provided by the on-site RMO. In addition, nursing staff on the ward reported that consultants were contactable out of hours by telephone. They provided advice over the telephone or attend the hospital should the need arise. We were told that consultants were supportive when contacted for advice.

Emergency awareness and training

- The hospital had a local business continuity plan in place. We reviewed this document and noted that it was in date with a review date set for the month of our inspection. The document included flow charts for staff. For example; fire, medical emergency, flood, chemical emergency, radiation accident and loss of power. Fire evacuation drills were carried out on a regular basis.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- Policies and procedures were corporate policies from the provider group. All were written in line with best practice guidelines and recommendation.
- We checked two policies within the surgery department named 'post-operative pain' and 'wound care management'. Both policies referenced National Institute for Health and Care Excellence (NICE) guidelines and had been amended to reflect recent changes in guidelines.
- We requested to see the Difficult Airway Society (DAS) guidelines for unexpected difficult intubation. We were provided with two copies of this guideline and noted in one folder, out of date guidelines were in use, dated 2004.The other folder contained the up to date guidelines. The managers immediately changed and updated the guidelines to reflect current practice.
- The service undertook a range of local audits including on records, VTE, surgical site infections (SSI's), blood transfusion, the deteriorating patient and, medicines management.
- The service did not participate in national audits. The service would be informed by their head office if they qualified for any national audit participation. The service undertakes benchmarking though local audits on outcomes and PROMs, which are comparable across the Ramsay Health Care UK Operations Limited nationally.

Pain relief

- Staff assessed levels of patients' pain using a pain management protocol. Pain was assessed on a score of zero to 10.All major joint surgery patients had a spinal, epidural or peripheral nerve block to prevent pain post procedure and aid recovery. Additional pain relief medication was provided in the recovery area and administered when necessary.
- We spoke with two patients in the ward area who both reported that they had been offered pain relief at regular intervals and both felt that staff had done everything they could to reduce levels of pain.
- A review of three medical records in the theatre department showed patients had been prescribed post-operative pain relief.

- Theatre and ward staff had access to the pharmacist at all times who could provide further advice regarding pain relief. In addition they were supported by the resident medical officer.

Nutrition and hydration

- The hospital carried out nutritional and hydration audits in November 2015 and June 2016.The audit results revealed 100% with the presence of written confirmation that the patient had been fasted for the recommended period prior to the induction of anaesthesia.
- Patients were provided with information regarding fasting prior to procedures in the outpatient setting. We spoke with one patient after they had received a surgical procedure who reported that they had received both written and verbal instructions regarding fasting prior to attendance for surgery.
- Fasting could be staggered throughout the day and changed dependent where a patient was on the operating list.
- The department had access to a dietician to provide advice regarding the specific dietary needs of patients. We spoke with a senior nurse who clearly articulated what processes and support was in place should specialist assessment and support be required.

Patient outcomes

- The hospital scored higher than the England average in the following areas of patient-led assessments of the care environment (PLACE) scores for the period of February 2016 to June 2016: dementia, disability, privacy, dignity and wellbeing. The hospital's PLACE scores were lower than the England average for cleanliness, condition, maintenance and appearance.
- The surgical department had 26 unplanned transfers of care to another hospital in the reporting period of July 2015 to June 2016. This equated to a rate of 0.2% of patients being transferred. All of these cases were investigated, which showed no themes or trends on causes.
- The hospital reported 32 unplanned readmissions within 28 days of discharge between the months of July 2015 and June 2016. This equated to a rate of 0.3% of patients having an unplanned readmission within 28 days of discharge. All of these cases were investigated, which showed no themes or trends on causes.
- From July 2015 to June 2016, there were 28 (0.2%) unplanned cases of patients returning to the operating theatre. All of these cases were investigated, which showed no themes or trends on causes.
- The hospital participated in the submission of data to monitor health gains using patient reported outcome measures (PROMs). PROM's data is used to measure health gain in patients undergoing hip replacement, knee replacement, groin hernia and varicose vein surgery in England. Patients were required to state either the level of difficulty/pain/frequency of pain for each of the 12 routine tasks, on a five point verbal scale. The final score produced can range from zero to 48; a score of zero indicates the patient is unable to do any of the 12 tasks, while a score of 48 indicates that the patient is able to do the activities with little difficulty.
- Data collected for NHS patients between April 2014 and March 2015 revealed that the hospitals scores were within the estimated range for primary knee replacement, primary hip replacement and groin hernia. However, some results particularly for knee surgery showed a worsening score on previous years.
- The hospital provided more recent data from April to October 2016 showed 120 out of 129 patients showed an improvement in health gain after knee replacement, with was higher than the national average. Hip replacement data also scored higher than the national average for health gain.
- Data collected for private patents on hip surgery between April and October 2016 showed that out of a possible score of 48, the service scored 44.5 on patients reporting improved activity after surgery. This was higher than the Ramsay Health Care UK Operations Limited average of 42.4. The health gain from this equated to a score of 27.6, which was higher than the Ramsay Group average of 22.9.
- The service provided PROMs for private patients for July to October 2016. This showed that scored 20 on the

results for pre-surgery, against the Ramsay Health Care UK Operations Limited average of 22.6. The post surgery score of 30.3 was worse than the Ramsay Health Care UK Operations Limited average of 37.1.

- The hospital followed up patients 24 hours after discharge by telephone in the aid to highlight any concerns in a timely manner. The ward provided all patients with a contact number for the hospital prior to discharge.
- The surgery department participated in venous thromboembolism (VTE) audits based on National Institute for Health and Care Excellence (NICE) guidance. We reviewed data from August 2015, November 2015 and February 2016, which revealed overall compliance of 93%, 95% and 90% respectively. There were two specific areas which highlighted non-compliance; medical records had not been reviewed or fully completely by a surgeon, and not all patients had received a review of VTE prophylaxis or this was not documented.
- All three audits highlighted the same omissions, which led to the hospital forming an action plan, with implementation in March 2016.The aim of the action plan was to identify the consultant(s) concerned and improve documentation and completion of records. A subsequent audit completed in May 2016 showed a further deterioration in overall performance at 89%. The service managers were unable to tell us why the actions set were not impacting upon a change in practice. We were not assured the local audit process was being effective.
- The hospital were required to submit data to the Private Healthcare Information Network (PHIN). This data was submitted by 1 September 2016 as required. We were told that new processes were being implemented to meet this requirement with additional resources being recruited to ensure that all data was collected for input in to reporting systems.

Competent staff

- The service employs 192 doctors on practising privileges. Of those 52% regularly undertake practice at Springfield Hospital.
- Consultants applying for practising privileges at Springfield Hospital were interviewed with both the general manager and matron prior to formal application. If successful at this stage, the hospital requested a CV, security checks, medical indemnity insurance and references including one from their employing NHS trust. These details were then reviewed by the medical advisory committee (MAC) prior to the recommendation of accreditation. We viewed two MAC meeting sets of minutes and noted that the review of practising privileges was a standard agenda item.
- Reviews of practising privileges took place on an annual basis, which included looking how many procedures had been carried out in the previous year, complications, incidents or complaints that had been received. The consultants also had to present their portfolio of procedures to demonstrate competencies to undertake specific operations. We reviewed the practising privilege review of a plastic surgeon for cosmetic procedure. This was detailed and covered all aspects of their work to ensure they were suitable and safe to undertake the procedures.
- The majority of medical staff worked at the local NHS Trust. Medical staff were required to produce evidence of revalidation to senior management at Springfield Hospital. General medical Council (GMC) registration was also checked by the hospital.
- Staff appraisals were carried out on a rolling year basis. At the time of our inspection, for the current year to date, 67% of nurses and 70% of operating department practitioners and healthcare assistants within the theatre department had received an appraisal. For the same period within inpatient ward areas, 57% of nurses and 73% of healthcare assistants had received an appraisal. We were told by a senior member of staff that the carrying out of appraisals was a 'work in progress'.
- Agency staff were required to complete an induction prior to commencement of work at the hospital. Staff were required to provide evidence of specific competencies such as medicines management and intravenous administration of medicines.
- The hospital had a 'Clinical Supervision' policy in place. The policy was described as an enhancement to both the developmental review and appraisal process. The purpose of the policy was to offer clinicians, including nurses and other clinical practitioners, supervision to aid development and identify potential problems.

- The hospital had an induction policy for all new staff. We reviewed this document, which outlined an induction programme for all new employees. Responsibilities for ensuring inductions were completed lay with the head of department. The policy clearly identified to whom the induction process was relevant to including new employees from outside the organisation, internal staff transfers between units, promoted staff, staff returning after long term sickness and maternity leave, bank and agency staff and locums. We saw three completed inductions forms for new employees, which reflected the policy.
- We spoke with the matron who reported that nursing staff have access to a local tool for revalidation. The majority of staff chose to use the Royal College of Nursing (RCN) tool for this. Data provided to us, prior to our inspection, revealed that 42% of theatre nurses had been through the revalidation process. This was an ongoing process, which the hospital monitored.
- We spoke with two members of staff who both reported that they were given the opportunity to learn and attend additional training to develop them in their role. One member of staff stated 'I am attending a recovery and crisis update course, Ramsay are kindly paying for this and I am keen to learn new skills'.

Multidisciplinary working

- The hospital had a service level agreement (SLA) in place with the local NHS Trust for the transfer of patients. The local NHS hospital was geographically near to Springfield hospital and staff reported good communication with the local trust.
- The hospital worked closely with local clinical commission groups (CCG's) to provide surgical procedures for NHS patients.
- We spoke with the RMO who reported that effective communication took place between the physiotherapists, occupational therapists and consultants.
- Twice daily handovers took place during nursing shift changes. The RMO attended both handovers to ensure important information regarding patients was received and communicated amongst staff.

Seven-day services

- Out of hours, consultants were contactable by telephone and would attend the hospital if the clinical need arose. A senior member of nursing staff reported that the majority of consultants call the ward late evening, to check on the status of their patients.
- Access to radiology and diagnostic imaging was provided via an on call basis out of hours. We saw the rota covering the week and noted this clearly provided contact details of on call staff and covered 24 hours a day, seven days a week.
- The hospital had access to an RMO 24 hours a day, seven days a week. Processes were in place to ensure adequate RMO coverage to ensure safe working. For example, when the on-site RMO had been working excessively during night-time hours.
- Staff could request physiotherapist attendance between the hours of 8am to 6pm. Cover outside of these hours was provided on an on-call basis 24 hours a day, seven days a week.
- The pharmacy at the hospital was open Monday to Friday between the hours of 8am and 7pm with access to dispensing services between the hours of 9am and 6pm. In addition, the pharmacy was open between 9am and 1pm on Saturdays, with dispensing services available, depending on the needs of the hospital. Outside of these hours, an on call pharmacist was available for 24 hour cover. The RMO and senior nurse on duty also had access to pharmacy for medications that were not available on the ward.
- Theatres operated out of hours, at weekends, and on call if required.

Access to information

- Patient records were paper based. Plans were in place to implement a full electronic medical records system however, a date for implementation was not available at the time of our inspection.
- Prior to discharge, patients were given a copy of a discharge summary with a copy sent by post to the receiving GP. In addition, consultants dictated a letter for the GP containing information on treatment and other relevant clinical matters.

- Information for patients regarding weight loss and other health topics were clearly displayed around ward and reception areas.
- Staff had access to both electronic and paper based policies. During our unannounced inspection we requested a staff member demonstrate the computer system in use. The member of staff located a specific policy we requested to see in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had a consent policy in place, entitled 'Consent to treatment for competent adults and children/young people'. The policy covered the areas of valid consent, the Mental Capacity Act 2005 and clearly defined responsibilities in relation to obtaining consent.
- We spoke with six nurses regarding the deprivation of liberty safeguards and the mental capacity act 2005. Out of six staff, only three were able to tell us what this term meant. We spoke with a senior nurse who reported that any patient with dementia had a completed deprivation of liberty form and that advice was always available from the ward manager or matron. During our unannounced inspection, we were told that the department were in the process of implementing further education regarding the Mental Capacity Act.
- The surgery department participated in consent audits looking at the completion of documentation surrounding consent. The audit was based on relevant guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). Overall compliance for the months of September 2015, December 2015, March 2016 and June 2016 revealed 95%, 91%, 97% and 94% respectively. The audit showed that patients were being asked for consent prior to surgical procedures however completion of documentation by medical staff was not consistent. Each audit documented clear actions with dissemination of audit findings with heads of department and the clinical governance committee.
- We reviewed four sets of medical records in the theatre department. All records showed that consent had been gained prior to surgery and documented accordingly.
- The hospital's 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) policy outlined who could make a DNACPR order, documentation and communication of patient wishes and capacity.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Friends and Family Test (FFT) results revealed that the hospital's scores were similar to the England average across the period of January 2016 and June 2016, with a score of 99% to 100% for all months. It is to be noted, however, that response rates in this period fell below the England average. The FFT was carried out for both private and NHS patients..
- The service undertook a patient satisfaction survey throughout the year. The 2016 data provided showed that up to October 2016 the service had received 100% positive feedback on the service. The response rate for the survey was 34.8%.
- The clinical quality indicator feedback identified areas where care could be improved. Of the responses received 66.7% reported that they had an identified staff member whom they could talk to about their worries or fears during or after their stay.
- All staff were observed to speak with patients in a kind and compassionate manner, introducing themselves by name.
- We saw that staff knocked before going into bedrooms, waiting for a response prior to entering and therefore protecting patient dignity and privacy.
- We spoke with three inpatients during our inspection.One patient said, "My privacy has been maintained at all times, you can't fault the nursing staff, they have all been very attentive. Another patient reported, "I have been very well looked after and they answer my buzzer really quickly when I was experiencing pain".

Understanding and involvement of patients and those close to them

Requires improvement

Surgery

- We spoke with three patients regarding their inpatient experience post operatively. One patient stated, "I have been given no end of information about my surgery, both before and after my operation. They have kept me up to date with what is going on and about future plans for physiotherapy".Another patient stated, "They have kept me and my wife informed of the treatment and what to expect".
- One other patient stated, "I have felt involved in decision making regarding my care planning, I have been well informed throughout".
- We saw that staff welcomed patient's friends and relatives in a friendly manner, providing refreshments where required.

Emotional support

- Bereavement and chaplaincy services were provided via the existing service level agreement (SLA) in place with the local NHS Trust.
- Access to a bariatric nurse specialist was available through Ramsay Health Care UK Operations Limited. Specialist nurses in breast care and bowel care were able to speak with patients by phone when required.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The theatre department was located adjacent to the ward.The ward had 64 beds and was designed in a square, with the main reception situated on one corner. During our inspection, there were 60 beds available for patient use as four beds were closed due to ongoing building work.
- The hospital offered services for both NHS and private patients. Patients accessed the service via referral from their GP to a consultant at the hospital.
- All surgical procedures were planned in advance and patients were offered flexibility and choice when arranging admission dates for surgery.

Access and flow

- The hospital had strict inclusion and exclusion criteria and screening of patients took place in the outpatient setting prior to admission. The hospital set strict clinical strict parameters to ensure the needs of patients were met.
- The hospital reported 118 cancelled procedures between July 2015 and June 2016. The cancellation rates per month ranged from 0.4% to 1.6% of all procedures carried out each month. The top reason for cancellation was patient unwell or has an infection, new medical history apparent on admission following Anaesthetist review, and theatre operational issues.
- Surgeries rescheduled after cancellation within 28 days were 36% with a further 30% being booked after 28 days and 34% not being rebooked at all. The data provided to us by the provider provided a detailed reason for each cancelled procedure. The data demonstrated that while the rates of surgeries taking place in 28 days was low, this was not down the service. The majority of reasons were related to patient illness or patient choice. How the service reported on and monitored these rates was positive.
- The hospital quality report for September 2016 showed the reasons for cancelled procedures. Reasons for cancellation included patient feeling unwell prior to procedure, staff sickness, equipment failure and list running late.
- The quality report from September 2016 identified changes to practice because of the cancellations. This included additional information provided to patients at pre-assessment to call to explain they have been unwell before arriving for surgery only to be cancelled on the day. Additional changes were made to management of theatre lists.
- Performance ranged between 75% and 89% for patients beginning treatment within 18 weeks of referral in the reporting period October 2015 to June 2016.However this data was for incomplete pathways and for complete pathways the service was performing at above 92%. The clinical commissioners of services raised no concerns about the performance of the service.
- Times for surgery were monitored by the inpatient booking team.The team would work closely with

consultants to prevent the breach of patients and identify the reason as to why a breach has occurred, and provide additional theatre space if possible. Any continued performance concerns related to specific doctors would be addressed through the practising privilege route.

Meeting people's individual needs

- The theatre department had equipment specifically for bariatric use.This included patient lifting cushions, slings and hoists. The ward arranged for appropriate beds for bariatric patients who required a wider width or additional mattress support for their weight. This was arranged through the pre-admission and pre-assessment process.
- The hospital had access to language line for translation purposes and provision of this service was planned in advance of patient attendance.
- Staff had access to a named dementia champion.Patients with dementia were identified in the outpatients department prior to admission.One-to-one care was then booked in advance to provide extra support.
- Patients living with dementia or with complex needs such as a learning disability were cared for on a one-to-one basis, with the planning of adequate staff taking place in advance of patient admission.
- Each patient room had a nurse calling system in place. We saw that when buzzers were pressed, electronic panels lit up, indicating which room the call pertained to.In addition, outside of each patient room was a green and yellow button which when pressed, would illuminate a light outside the room. We were told this was for ease of location of staff, when green this indicated a nurse was in the room, when yellow this meant either a physiotherapist or occupational therapist was present. We saw this system in use and noted it worked well and in addition protected privacy when treatment and consultations were taking place.
- We saw that all patients within the ward area had access to drinking water within their rooms.
- Food at the hospital was prepared on-site. There were separate menus for NHS and private patients.
- We spoke with three patients regarding food.One stated, "Food has been plentiful and there was a good choice".Another patient reported, "The food is excellent, it has been hot on arrival and there is a good choice". During our inspection we saw the afternoon tea round which included a hot drink and cake. This was well received with two patients we spoke with.
- We saw a patient and relative lounge area adjacent to the garden. We were told by a nurse that patients were encouraged to use this area to engage with family and friends. We noted that the environment was peaceful, with access to drinking water, reading material and sofas.
- Relatives or carers of patients with learning disabilities were welcomed into the anaesthetic and recovery room areas to provide support for patients with additional needs.

Learning from complaints and concerns

- Between July 2015 and June 2016, the hospital received 110 complaints. The complaint rate was similar to the rate of other independent hospitals that we hold data for. This data pertained to the hospital as a whole.
- We were provided with a complaints log covering the period of January 2016 to July 2016. There were 25 complaints related to surgery inpatient or day case care. There were no particular complaint trends identified in relation to inpatient or surgical patients. Complaints included patients being unhappy with the facility, noise from building work, costs of care package and doctors attitude.
- All complaints were investigated in line with the Ramsay Health Care UK Operations Limited policy. The complaints resolved the patients concerns in the majority and the complaints were closed. None of the complaints had been referred to the Ombudsman or Independent Healthcare Sector Adjudication Service (ICAS).
- The outcomes of complaints were discussed at monthly heads of department (HoD's) meetings so that information could be disseminated to staff on a departmental basis. The senior management team discussed the progress of complaints on a weekly basis with all complaints being overseen by the general manager.

Requires improvement

Surgery

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement.

Vision and strategy for this this core service

- The hospital vision was 'to make Springfield the hospital of choice for all stakeholders'. This was underpinned with three strategies; to make the hospital a great place to work.To ensure the hospital is the first choice for customers, including patients, consultants and GP's who refer or those that commissions services at the hospital.Their aim was also to provide an efficient service that would generate profit to re-invest back into the service.
- We saw that the Ramsay Health Care UK Operations Limited vision was clearly displayed in the staff rest-room. We spoke with three members of staff specifically about values, and two were able tell us what the hospital vision was.

Governance, risk management and quality measurement

- The hospital governance issues were addressed through various meetings including the medical advisory committee (MAC) meeting, heads of department (HOD) meeting, senior management team (SMT) meetings and the clinical governance committee.
- The clinical governance committee (CGC) usually met once every three months.We saw minutes from meetings in October 2015 and March 2016, which showed discussions around core topics such as complaints, infection prevention and control, and incidents.
- The medical advisory committee (MAC) met on a three monthly basis.Reports from the clinical governance meeting, SMT and HoD meeting were sent through the MAC. We reviewed the minutes of meetings held in January and April 2016, which were comprehensive in detailing discussions of the meeting agenda items.
- The MAC meeting had a regular agenda item for the discussion of practicing privileges. The meeting minutes provided to us for January and April 2016, did not show any discussions regarding new practising privileges or concerns around doctors with existing practising privileges. There had been no concerns raised regarding practising privileges, but the general manager was able to describe what actions would be taken in the event that concerns were raised regarding a doctor's practice. An example was provided where a consultant was suspended whilst an investigation into their practice was carried out. The consultant was able to return when no concerns were identified through the investigation.
- The MAC meets four times per year. The meeting should be attended by all service specialty leads. The minutes of the two meetings provided showed that attendance did not represent all specialties. There were doctors who regularly sent apologies. This did not demonstrate that the meeting was well attended by those who should be present to discuss issues pertaining to the hospital. We asked the registered manager about attendance to these meetings who told us that attendance could be improved.
- The hospital had a risk register. The risk register covered all services in the hospital. there were 20 risks on the risk register dating back to January 2014. The description of the risks were generic and related more to operational management than service specific risks, which related to the service, and required management or monitoring. For example, a risk entry added in January 2014 that says, 'Ineffective Infection Prevention and Control processes including decontamination of medical devices'. This risk required review in February 2016 but had not been updated. The risks did not detail the current service concerns around hand hygiene compliance or SSI rates. However, this information was received prior to inspection and by the time of inspection risks were up-to-date.
- Another risk entry was added in January 2014, and due to for review in April 2017. This risk was described as 'Failure to Meet Home Office Controlled Drug Licensing Requirements'. No incidents had been reported of concern relating to controlled drugs management, and no concerns had been raised through quality monitoring reviews internally or externally. It is not clear why this is an identified risk on a register for the service. The register was being used to monitor functions of the service, which may present risk but not actual current

service risks. Risks identified during the inspection such as RTT for inpatient admissions not meeting standards, patient record availability and SSI rates were not on the risk register.

- The entries on the risk register that we received prior to inspection were not descriptive, and did not reflect current service activity or risk. However, by the time of inspection risks on the register were up-to-date. There were no clearly defined control measures in place to mitigate the risks in their current form or long terms plans to mitigate, reduce or eliminate the risk of impact. Therefore, the risk register process was not effective.
- The hospital undertook regular audits in relation to basic care and practice. However, as seen from the audits on hand hygiene action plans from the audits, whilst showing as completed, did not show a positive impact or improvement on the results in further audits. There were also plans in place to address surgical site infection (SSI) rates, yet the rates had continued to see a steady risk. In theatres the practice of ODPs drawing up anaesthetics had been raised July 2015 as a compliance issue, yet this practice was observed to still be taking place during this inspection, and had to be addressed by senior management.Therefore, we were not assured that the governance process for improving outcomes from audits was effective.
- We spoke with staff in the theatre department who told us that staff meetings occurred on a monthly basis.We requested to see the minutes from these meetings however none were available past February 2016.Staff told us that there had been no minutes from the senior management team (SMT) since February 2016.The SMT did not routinely attend departmental meetings and these were chaired by departmental managers. The SMT attended on an ad hoc basis. We requested the minutes of these meetings after our inspection which revealed discussion around national audits, satisfaction surveys, policies and equipment took place. Staff were given the opportunity to provide feedback at monthly meetings. The minutes we viewed were for the months of May 2016, June 2016 and September 2016.

Leadership / culture of service related to this core service

- The surgery service was led by a theatre manager and a ward manager. The leads reported to the hospital matron and hospital general manager.
- We spoke with a senior member of staff in the theatre department who reported that the department had lacked a full time manager for the six months prior to our inspection.As a result, they felt that staff had lacked direction and did not feel listened to when concerns were raised. However, the service informed us that the deputy manager had been acting up to the role of theatre manager during this period. Staff were looking forward to the new theatre manager starting, and they commenced their role during our inspection.
- We spoke with a recovery nurse within the theatre department who reported that one particular senior member of nursing staff was an enormous asset to their team, particularly due to the recent lack of departmental manager in post. This member of staff was supportive, kind and approachable at all times.
- We spoke with a member of administrative staff who said, “I love working here, everything about the hospital is great, I feel really well supported in my role and the ward manager and nurse in charge are all very approachable”.
- Staff surveys were completed annually. The results from the last survey completed in April 2016 showed that the hospital was performing worse than the Ramsay Health Care average in all 11 areas assessed, which included ‘career development’ and ‘the corporate leadership team.
- There had been a number of changes to senior staff in theatres on the ward. These changes were welcomed by the senior management team, who felt that change was required. We received feedback their concern from a senior level was the culture of staff on the ward and this required improvement. The General Manager described the change in culture as a “work in progress” but that it was starting to show signs of improvement.
- Between July 2015 and June 2016, the rate of staff sickness for nurses within the inpatient area was below the average of other independent hospitals we hold data for. For the same period, the rate of sickness amongst healthcare assistants was above the average during all months, with the exception of July 2015.

Requires improvement

Surgery

- Between July 2015 and June 2016, the rate of theatre nurse, operating department practitioner and healthcare assistant turnover was below the rate of other independent hospital we hold data for.

Public and staff engagement

- The hospital sought patient feedback via a number of methods. Patients were able to submit feedback via the hospitals website or using complaints or compliments forms.
- During our inspection we saw feedback forms on display in the reception area.These were aimed at both staff and patients and named 'customer service excellence recommendation'.We were told that the aim of the forms was to highlight anyone who has provided a good service, either a patient recommending, or, a staff member recognising excellence in another member of staff.
- The reception desk had a supply of 'would you recommend us' cards on display for patient use with contact numbers to provide feedback.

Innovation, improvement and sustainability

- The service is a BUPA Accredited Breast Care Centre and BUPA Accredited Bowel Care Centre.
- The service was planning a further expansion to their ward and theatres to provide a wider range of services in the county.

Requires improvement

Services for children and young people

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

Are services for children and young people safe?

Good

We rated safe as Good.

Incidents

- For our detailed findings relating to children and young people's services please see this section in the surgery report.
- There were no serious incidents or never events for children and young people's services in the last 12 months.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results

- For our detailed findings on children and young people's services please see this section in the surgery report.

Cleanliness, infection control and hygiene

- For our detailed findings on cleanliness and infection control for the ward area, outpatients and theatres, where children are seen and treated please see the surgery or outpatient report.
- There was a separate children's play area with toys. We saw that all the boxes of toys had "I am clean" stickers showing that the toys had been cleaned on the morning of our inspection.
- At the time of our inspection, building work was nearing completion that will result in a dedicated ward area for children and young people. A new infection control process was to be implemented whereby toys are "checked out" to an individual child and cleaned when they are returned before they will be given to another child to play with.

Environment and equipment

- For our detailed findings on the environment and equipment in the ward, theatres or outpatients please see the surgery or outpatients reports
- The ward area was secure with a keypad lock at the entrance and an intercom system to allow access to patients. Staff could monitor visitors that access the ward.
- A paediatric resuscitation trolley was located on the ward. We saw that staff checked equipment daily. There were no gaps in the records.
- Suitable resuscitation equipment was available. There were four paediatric "grab bags" located in outpatients, radiology, on the ward and in theatres. These contained children's oxygen masks and intubation tubes for ease of access to appropriate equipment in the case of a medical emergency.
- The hospital policy stated that they should be checked weekly. We looked at the check sheet on the ward and saw evidence that weekly checks had been completed. The check sheet for the grab bag in outpatients showed weekly checks from January and we saw thatweekly check were missing for 11th April and 18th July.

Medicines

- For our detailed findings on medicines management please see the surgery report.

- We saw that there was a paediatric medicines box containing children's medicine in the theatre recovery area.
- No children were admitted at the time of our inspection. Staff told us that all children were weighed and wore colour-coded bands indicating their weight during pre-assessment. We saw cards that staff could refer to assist with dosage calculations for medication.

Records

- We looked at two sets of paediatric patient's notes and saw that they were legible and completed appropriately.
- Risk assessments of care, including surgical pre-assessment were detailed in the patient records. Outpatient records detailed the findings of care and also who was present whilst the child was being seen.
- Patient notes for children and young people were kept in a locked drawer in a secure office behind the reception desk
- For audit outcomes in relation to records please see the surgery section of this report. The audits undertaken did not identify which records related to children which meant the service was not aware of their performance rates for completing of children's records appropriately.

Safeguarding

- Ramsay Health Care UK Operations Limited had a policy in place for the safeguarding of vulnerable children, which was in date and reflected national guidance.
- All children's nurses, matron, clinical Heads of Department, senior nurses on the ward and in the outpatients department, radiographers and physiotherapists who see children and theatre recovery staff had undertaken level three safeguarding training.
- For all staff in the hospital who have contact with children 84% were trained to safeguarding level two and 33% were trained to safeguarding level three. However, the primary staff treating the children had all received level three training.
- The children and young people's lead, two clinical ward staff, and two outpatient's staff had completed additional e-learning and face to face training through the National Society for the Prevention of Cruelty to Children (NSPCC).
- The children's and young people lead was the named nurse lead for children's safeguarding within the hospital. They also had responsibility for adult safeguarding. Staff could identify this person and felt well supported by them.
- The matron was the overall responsible lead for safeguarding children in the hospital, and would liaise with a level four trained person within Ramsay Health Care UK Operations Limited for guidance.
- Safeguarding folders were located in every clinical area that cared for children. The folder contained details of the safeguarding lead and their contact details. It also included a flow chart showing how to make a safeguarding referral. This was up-to-date and in line with national guidelines.
- Three members of staff confirmed that they knew what constituted a safeguarding incident and how to responsibly report one.
- The safeguarding lead attended the local safeguarding boards and attended a local safeguarding operational group, which is a professional development group with representatives from the NHS, private and community health sectors.
- Safeguarding leads from the hospital and a local hospital in the group provided an out of hours service via telephone where by staff could call for help and support with any safeguarding concerns.
- Medical staff who work with children are required to provide evidence of safeguarding children training, as part of their portfolio to be granted practicing privileges. The sample of doctors checked had all received level three safeguarding children training.

Mandatory training

- For mandatory training performance please see the surgery section of this report.
- Basic paediatric life support training (BPLS) training rates for the service included ward staff nurses (95%), theatre nurses (94%), healthcare assistants (93%), senior ODPs (100%), ODPs (88%), and paediatric nurses (88%).
- Paediatric intensive life support training (PILS) training rates for the service included ward staff nurses (97%), theatre nurses (88%), senior ODPs (100%), ODPs (92%), and paediatric nurses (100%).

- The children and young people's lead and hospital RMO had completed training in emergency paediatric life support (EPLS).

Assessing and responding to patient risk

- There was an up-to-date 'Care of the Child' policy. The hospital statement of purpose was to admit patients from one year old. All admissions were assessed and agreed by the children's and young person's lead nurse and admitting consultant.
- A registered children's nurse completed pre-operative assessments for all children and young people up to the age of 18. Any health concerns that were highlighted at pre admission were raised with the consultant anaesthetist for further assessment.
- All children had a WETFLAG calculation done on admission. WETFLAG stands for weight, electricity, tube, fluids, lorazepam, adrenaline and glucose. The purpose of WETFLAG is towork out appropriate weight based drugs and equipment for the child so the information is readily available should there be a medical emergency. We looked at three patient care pathways and saw that the WETFLAG data was completed appropriately.
- The hospital used a paediatric early warning score (PEWS) to identify a deteriorating patient. PEWS is a nationally standardised assessment of illness severity in children and determines the need for escalation based on a range of patient observations such as heart rate,prompting nursing staff to get a medical review at specific trigger points. A PEWS flowchart was available for staff to refer to. We reviewed two patient's notes and saw that the PEWS chart had been completed.
- The hospital had a procedure in place that at all times during a child's admission there was a senior registered nurse (child branch) and an anaesthetist with current Advanced Paediatric Life Support (APLS) skills on duty. Therefore, there was always suitably qualified staff available to ensure a child could be kept safe up to and during transfer.
- There was a service level agreement (SLA) in place for a child transfer to the local acute NHS hospital if their condition deteriorated. We saw a flow chart that showed the process to follow if a patient required a transfer.
- The hospital had an SLA with the Children's acute transport service (CATS). This was a specialised service designed to quickly and safely transport critically ill children between hospitals in the North Thames and East Anglia regions.

Nursing staffing

- Staff planned surgeries for children and young people on Mondays and Wednesdays each week. This was to ensure that nurse staffing was sufficient to meet the needs of children on these days. However, operations could be scheduled at other times if required and assessed as safe to do so.
- The hospital employed two registered children's nurses, and employed regular bank staffwho were also registered children's nurses (child branch). Admissions were organised ensuring that a RCN was always available to care for children in the hospital.
- Agency staff were used very rarely. Agency staff used were registered nurses (child branch) and had previous experience of working in the hospital.
- The children and young person's lead told us that surgical procedures were cancelled if there was no registered nurse (child branch) on duty for example due to staff sickness. This had not been necessary in the last 12 months.
- Staffing was calculated dependent on the number of paediatric admissions and the complexity of the surgery. The children's and young people's lead told us that as a minimum there would be one registered nurse (child branch) and one healthcare assistant. When patients were admitted for higher risk surgery for example tonsillectomies, this number was increased to two registered nurses (child branch) as recommended by the Royal College of Nursing.
- In recovery an adult registered nurse that had access to a registered nurse (child branch) for advice and support cared for children and young people.
- Adult registered nurses who were supported by the registered nurse (child branch) staffed the outpatient department. Staff told us that no procedures were undertaken unless a registered nurse (child branch) was present.

Medical Staffing

Requires improvement

Services for children and young people

- The hospital had 192 doctors on practising privileges (PP's) at the time of our inspection of which 52% undertook regular practice. It was not clear from the data provided how many of those staff operated on or treated children and young people.
- A resident medical officer trained in emergency paediatric immediate life support (EPLS) was available 24 hours a day seven days a week.
- The hospital had a named paediatrician employed by the local trust who had practising at the hospital whom staff could contact with any medical concerns. If they were not available, they would nominate a colleague who had practicing privileges at the hospital therefore ensuring that there was always paediatric medical cover available.
- Staff told us that the patient's consultant was contactable for consultation for the duration of the child's admission. Staff reported that they felt able to contact consultants if advice was required and consultants were very responsive.

Emergency awareness and training

- Please see the surgery report for details of emergency awareness and training.

Are services for children and young people effective?

Requires improvement

We rated effective as Requires Improvement.

Evidence-based care and treatment

- The policies used by the service for children and young people were developed by Ramsay Health Care UK Operations Limited.The policies were written in line with national guidance. We reviewed three policies relating to the care of children and young people. All of the policies referenced relevant guidelines and legislation and were up-to-date with review dates on them. For example, the Management of Children's Medicines Emergencies policy contained Sepsis six update in line with guideline changes.
- The paediatric admission pathway reflected evidenced based practice with PEWS and relevant risk assessments embedded in the pathway.
- The service did not participate in national audits for the care of children and young people. The service would be informed by their head office if they qualified for any national audit participation.

Pain relief

- The hospital used child friendly pain charts to assist children to express any pain they were experiencing.
- We saw that pain scores had been recorded in two patient records that we reviewed.

Nutrition and hydration

- The hospital carried out nutritional and hydration audits in November 2015 and June 2016.The audit results revealed 100% with the presence of written confirmation that the patient had been starved for the recommended period prior to the induction of anaesthesia.
- < >
  Fasting could be staggered throughout the day and changed dependent where a patient was on the operating list.
- The department had access to a dietician to provide advice regarding the specific dietary needs of patients.

Patient outcomes

- There were no national audits undertaken by the hospital involving children and young people.
- Children and young people had a dedicated pathway for day surgery and overnight stays.
- The hospital had no unplanned transfers to local NHS trust in the last 12 months for children and young people.
- There were no specific audits undertaken locally on the care or treatment of children or young people. There was a range of audits undertaken in the hospital in relation to records management, blood transfusion, VTE, and pre-admission. However, these did not detail any reference to checks on patients under the age of 18 years of age.

Competent staff

Requires improvement

Services for children and young people

- For evidence on bank/ agency staff induction, practicing privileges please see the surgery section of the report.
- All staff attended a 'clinical caring for children' course. This was evaluated during the personal development review, which makes up part of the annual appraisal.
- Of the registered nurses (child branch) one of the two had not received their appraisal but this was scheduled for completion before the end of the year.
- The children's and young people's lead told us that training sessions were available around caring for children. An example was a training programme for theatre staff in paediatric pain management, which was in the development process. This aimed to support theatre staff with post-operative pain management for children and young people.
- The national provider had established that the skill level of healthcare assistants should be standardised across the organisation and healthcare assistants at the hospital were studying for their healthcare certificate.

Multidisciplinary working

- Five staff members stated that staff from all services worked well together. We observed that there was a good rapport between staff throughout the different specialities.
- There was a nominated paediatric link in theatres, physiotherapy, outpatients and radiology. The paediatric link in each department worked with the children and young people's lead to ensure that services provided in these department met the needs of children and young people.

Seven-day services

- Surgery for children and young people was carried out on selected days. Provision for their care was planned around these admissions.

Access to information

- All staff could access policies through the hospitals internet. Staff reported that they had access to these. One member of staff told us that printed copies of new policies or updated policies were left in the rest room for staff to read.
- Children's discharge was nurse led. Patients and their carers were provided with leaflets containing details about postoperative care, pain medication and the telephone number of the ward to call with any questions or concerns.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had an up-to-date consent policy, which outlined the process for gaining valid consent from children and young people for examination and treatment.
- The policy described, 'Gillick competence', which is a legal requirement to determine whether a child had sufficient understanding and intelligence to enable them to understand fully the proposed procedure. A member of staff told us that they carried out an assessment during pre- assessment to determine the child understood their procedure but this was not recorded formally as to whether it was or was not considered.
- There were specific consent forms for children and young people. We reviewed two child consent forms, which, consultants had completed correctly in both cases.
- Staff told us that parents were required to countersign consent forms for all patients under 18. However according to the Department of Health's r if a 16 or 17-year-old is capable of giving valid consent then it is not legally necessary to obtain consent from a person with parental responsibility for the young person in addition to the consent of the young person. It is, however, good practice to involve the young person's family in the decision-making process, unless the young person specifically wishes to exclude them and if the young person consents to their information being shared.

Are services for children and young people caring?

Good

We rated caring as Good.

Compassionate care

Requires improvement

Services for children and young people

- The service undertook a survey dedicated to enabling children to give feedback on the care they had received. This was presented in an age appropriate way enabling children to give direct feedback.
- No children were admitted to the ward at the time of our inspection so we were not able to observe staff caring for patients. We were provided with patient survey data, which was a survey questionnaire sent to 10 patients and families about their experience. All responses received were very positive about the care and treatment provided. Comments included 'totally excellent, many thanks', and 'care was excellent', and 'nothing could have made it better'.
- Staff told us that parents were encouraged to stay with their child at all times. This meant that the child had family close by to provide support and security.
- Parents/carers had access to the theatre recovery area so they could be available to comfort and reassure their child as they came round from anaesthetic. The family and child were supported by a children's nurse at all times.

Understanding and involvement of patients and those close to them

- During pre-admission clinic children and their patients were given a full explanation of theprocedure, teddy bears with cannulas and age appropriate photographs were available to help children understand and express any concerns.
- All patients aged 16 and 17 years old were pre assessed by a registered nurse (child branch). During this assessment they would discuss with the young person whether they would prefer to be treated under children and young people's service or the adult service.

Emotional support

- Each child had an allocated registered nurse (child branch) for the duration of their stay. This meant that the child and their family would have a familiar contact to provide care and support.
- The hospital had access to a specialist nurse for learning disabilities through the local NHS trust. Advice on learning disabilities or complex needs could also be sought through head office if required.

Are services for children and young people responsive?

Good

We rated responsive as Good.

Service planning and delivery to meet the needs of local people

- The hospital undertook children's surgery on Monday and Wednesday each week dependent on demand. However, operations could be scheduled at other times if required and assessed as safe to do so.
- The hospital held children's pre-admission clinics every Saturday to reduce disruption to schooling and parent employment commitments. Ad hoc appointments were available if necessary.
- The hospital only operated on patients under the age of 18 years who were self-funded or funded through insurance. The service did not take on NHS patients under the age of 18.
- Building work was underway which will result in a separate area with five rooms and a nurse's office specifically for children and young people.

Access and flow

- Prioritisation of the theatre list meant that all children were booked in on two days with dedicated staffing to be able to care for the children's needs. Children would either be first on the list either on the morning or afternoon list. This ensured that there were staff and equipment set up and readily available to meet the needs of the child.
- The admitting consultant and the lead registered nurse (child branch) agreed all admissions for children and young people. All children had a pre-admission assessment appointment with a registered children's nurse.
- There were no cancelled procedures within the service between July 2015 and June 2016.
- Access to the service for a patient under 18 was without delay. The service was able to accommodate a child on their dedicated days each month and ensure this was

undertaken in a timely manner. We were informed that the wait times were often two to four weeks for referral for surgery and one to two weeks for an outpatient appointment.

Meeting people's individual needs

- Children and young people were admitted to the general ward for day surgery. Rooms were single occupancy rooms with en-suite facilities. Children who were staying overnight had a twin room, where possible so that there was a bed for their parent to stay with them.
- There was no separate recovery area for children. Two bays in recovery were adaptable to becoming a children's bay as required and had curtains, which were used to separate children and adult areas. The children's and young people's lead told us that following the completion of the building work that there would be a separate area in theatre recovery for children.
- Staff gave a tour of the hospital to children and their families during the pre-assessment appointment. Staff explained the child's procedure in an age appropriate way using photographs and teddy bears when necessary. Information leaflets were available for families to take away.
- At the time of our visit, the hospital did not have a separate children's ward area although work was in progress to create one. The service had assessed the needs of children and how these could be met as best as possible until physical building changes were made.
- Staff told us that the hospital made adjustments for children with complex needs. Staff spent more time to assess how to accommodate the child's needs. For example, they would consult with the parents as how best to deliver the care plan. The hospital made provision for them to be admitted later in the day and to be discharged as early as possible.
- A children's menu was available with child friendly meals available up to 9.30 pm. A choice of menu options was available. A limited choice of food was available all night including sandwiches, toast and biscuits.
- A fridge was available for patient's food. This was particularly useful for very young children as parents could bring age appropriate food that their child preferred.
- Diagnostic imaging and physiotherapy appointments were coordinated to reduce the number of hospital outpatient appointments required where possible.
- Age appropriate duvet covers were available for children during their admission.
- Wi-Fi was available to allow young people access to entertainment and social media.
- Staff had access to translation services were via telephone for patients that did speak English as a first language.
- Staff who were involved in the care or treatment of children had all received online training on how to support a patient with complex needs, or a learning disability. The staff would also liaise with the families and specialist nurses prior to taking on any patient to ensure their needs were met.
- Staff advised children and their parents to contact the ward with any minor concerns after surgery after discharge. The ward would then contact the consultant for further advice if necessary. Aftercare information and contact details were in the discharge pack given to patients

Learning from complaints and concerns

- The children's and young persons' lead told us that there had been no complaints about the service over the last six years.
- The hospital had a compliments and complaints policy and a procedure, which outlined the process taken following the receipt of a complaint. There was age specific documentation for children and young people. There had not been any recorded complaints about the service.

Are services for children and young people well-led?

Requires improvement

We rated well-led as Requires Improvement.

Vision and strategy for this this core service

- The hospital vision was 'to make Springfield the hospital of choice for all stakeholders'. This was underpinned

with three strategies; to make the hospital a great place to work.To ensure the hospital is the first choice for customers, including patients, consultants and GP's who refer or those that commissions services at the hospital.Their aim was also to provide an efficient service that would generate profit to re-invest back into the service.

- We saw that the Ramsay Health Care UK Operations Limited vision was clearly displayed in the staff rest-room.
- There was plans to improve the service for children and young people in place. The hospital was building a designated more secure area for children to offer a more bespoke service.

Governance, risk management and quality measurement for this core service

- The service governance processes are the same throughout the hospital. We have reported about the governance processes under the surgery service within this report.
- There were no items on the risk register relating to the children's and young people's service. Items of risk could have been identified, for example the not completing of audits or monitoring outcomes in relation to the care and treatment of children and young people.
- A paediatric consultant represented the children and young people service on the medical advisory committee (MAC). However, we did not see reference to children and young people's service in the MAC meeting minutes, and attendance from the lead was limited in these meetings. The minutes reviewed from January and April 2016 did not show that a representative of the service attended. We were not assured that there was sufficient MAC oversight of children's services at the MAC.
- The discussion of children's services was a standard agenda item at the clinical governance meeting agenda. A paediatric anaesthetist and the lead nurse for children and young people were on the committee. We reviewed four clinical governance meeting minutes and saw that the service was represented and discussed.

Leadership / culture of service related to this core service

- There was a lead nurse for children and young people's services in post. They worked with registered nurses (child branch) and reported to the Matron and hospital General Manager. There was a named lead for children's services on the MAC.
- On the day we inspected the service there were no children admitted to the hospital so we were unable to talk to many staff in children's and young people's services. However, we spoke with staff in departments throughout the hospital about children's and young people's services who spoke positively about working at the hospital, and the priority that children's services was given.
- Staff surveys were completed annually. The results from the last survey completed in April 2016 showed that the hospital was performing worse than the Ramsay Health Care average in all 11 areas assessed, which included 'career development' and 'the corporate leadership team. There were no concerns or trends noted regarding turnover or sickness rates for the children's service.

Innovation, improvement and sustainability

- We saw evidence of building work nearing completion that will provide a separate children's area of the ward. Included in the building work will be the establishment of a separate recovery bay for paediatric patients.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as Good.

Incidents

- There had been no reported never events for the outpatient or diagnostic imaging department between July 2015 to September 2016. 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.
- There had been 142 clinical incidents reported within outpatient and diagnostic imaging services between July 2015 and June 2016. This number of clinical incidents is above the rate of other independent acute hospitals that we hold this type of data for.
- There had been 17 non-clinical incidents reported in the outpatient and diagnostic imaging department between July 2015 and June 2016.The number of non-clinical incidents is similar to the rate of other independent acute hospitals we hold data for.
- We spoke with a manager who told us that they were aware of this high number of reported clinical incidents and that it had been looked into and was down to over reporting of incidents that did not require reporting. For example, staff were reporting an incident if a patient attended an outpatient appointment and it was later determined they had a mid-stream urine infection following routine urine testing. This type of event did not require reporting. Staff we spoke with told us that this learning from over-reporting had been disseminated to them.
- Data provided to us prior to our inspection revealed that the rate of clinical incidents had fallen quarter on quarter in the period of July 2015 to June 2016, which meant that incidents were no longer being over reported and learning had been disseminated effectively.
- The diagnostic imaging service also fed into the hospitals risk management system. The manager of the imaging department knew the legal requirement to submit IRMER notifications in the event of certain radiation incidents. They was a policy in place to support this titled, “Radiation Protection in Diagnostic radiology; Volume One”. However, this was out-of-date as the policy showed that it had last been reviewed in 2000 and no further review date was specified.
- There had been two radiation exposure related incidents reported between July 2015 and June 2016, which related to reaction to contrast media (dye injected into the blood stream). Records showed that these had been reported and investigated appropriately.
- All staff we spoke with knew how to report incidents through the hospital’s electronic reporting system, and they were able to give examples of the type of incidents which required escalation and reporting.
- Staff told us that they had access to the hospital’s incident reporting policy which provided guidance on

what constituted an incident, and definitions of different types of reportable incidents, such as never events. However, this policy was due for renewal in August 2016 and had not been updated.

- We checked two serious incident reports, which showed that investigations were carried out following incidents, reported and lessons learnt identified. There was also evidence lessons learnt were disseminated throughout the hospital, and action was taken to improve safety beyond the affected team or service.
- For example, there had been an incident within another department where a patient had attended for knee surgery with diarrhoea. The manager of the outpatient department and four members of staff we spoke with were aware of this incident and could tell us the subsequent practice recommendations from the incident investigation. This included the importance of telling patients at pre-assessment to contact the hospital if they are unwell on the day of surgery opposed to just arriving.
- Whilst there had been no reason to apply duty of candour, a manager was able to tell us the principles of duty of candour and when and how they would apply it. 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.
- Six members of staff, including a manager, confirmed they had not been provided with training on duty of candour. However, all staff we spoke with were familiar with the term duty of candour.

Clinical Quality Dashboard

- There was no performance dashboard in use for the outpatient and imaging departments; however, there was a hospital-wide electronic dashboard to monitor safety within the hospital. We have reported on this fully under the surgery service within this report.

Cleanliness, infection control and hygiene

- Between July 2015 and June 2016, the hospital had not reported any cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Methicillin Sensitive Staphylococcus Aureus (MSSA). These are all types of healthcare-associated infections that could cause harm to patients.
- Every area we visited was visibly clean and tidy. Throughout departments there were sufficient hand washing facilities and personal protective equipment, such as gloves were readily available. Staff demonstrated that they adhered to universal infection control principles. For example, we saw staff practice good hand hygiene before and after patient contact.
- Clinical waste was disposed of appropriately and in line with the hospital's waste disposal procedures. Orange clinical waste bags were used, there were foot-operated waste bins, and sharps bins, which were correctly assembled, signed and dated and not over-filled throughout departments.
- Staff told us that they had access to the hospital's infection control policy, that infection control training refresher training was incorporated into mandatory training, and they knew who the lead nurse at the hospital was for infection control and prevention. We checked the hospital's infection control policy, which was up-to-date.
- Cleaning staff were employed by the provider and we were told there were cleaning schedules in place. There were regular infection prevention and control audits carried out within outpatient and diagnostic imaging department to ensure that standards of cleanliness and hygiene were maintained. This included a comprehensive infection control and prevention audit, and specific audits for hand washing and sharps (needle) handling and disposal. We checked the last two results for each of these audits which showed mostly good practice and identified areas for improvement and action required.
- For example, a comprehensive infection control audit was regularly carried out in the outpatient department, which included the auditing of aspects of the environment, clinical equipment, decontamination, waste disposal and hand washing. In January (91%), February (92%) and May 2016 (98%) results showed that the department was compliant with expected standards set by the provider and that they were improving over time.

Good

Outpatients and diagnostic imaging

- The results of the last four hand hygiene audits, which were carried out between July 2015 and April 2016. This audit looked at hand washing technique, hand drying, the use of alcohol hand gel and compliance to policy.For the month of April 2016 scores were noted to be lower due to staff being unaware of the need to wash hands with only soap and water, prior to and after contact with a patient with C.diff. These results related to the hospital as a whole and not specifically the outpatient and diagnostic imaging department.
- There was a urology treatment room within the outpatient department, which was used for cystoscopies, and at times bladder irrigation. A cystoscope is used to visualise the inside of a bladder.There was an up-to-date policy on the decontamination of flexible endoscopes in place which staff had access to, the treatment room had separate dirty to clean areas for scope cleaning, and two scope washers.
- A manager confirmed they had undertaken recent training for decontamination of endoscopes delivered by the provider, and had attended a recent training study day on the subject, which was delivered by the manufacturers of the scope washer.
- We spoke with five members of staff specifically about decontamination, all confirmed that only staff trained in urology endoscopy and endoscopy decontamination worked in the urology treatment room.

Environment and equipment

- Each area we visited was tidy, well organised and free from clutter. We saw that there were adequate storage facilities and suitable levels of equipment for safe monitoring and effective treatment. For example, there were blood pressure machines and thermometers in consultation rooms.
- We randomly checked single use equipment throughout the hospital and found that this equipment was properly stored, in date and packaging was intact.
- There was a resuscitation trolley in both the outpatient and diagnostic imaging department, therefore a resuscitation trolley was available on both floors.
- We checked the trolley in the outpatient department and found that this was fully stocked with in date equipment. Staff were required to check this equipment on a daily basis. We reviewed the records for July, August and September 2016, which showed that resuscitation equipment had been checked daily during this period.
- Records confirmed that equipment throughout the hospital had been serviced recently and electrical equipment had been safety tested. There were contractual arrangements in place with suitable persons from outsourced services for servicing and safety testing.

Medicines

- We checked two medicine records of people who used the service and found that medicine had been prescribed and administered safely.
- We saw that medicines were stored securely in the urology treatment room. This included oxygen cylinders.
- The hospital had an onsite pharmacy, which supplied clinical areas with medicines and checked all hospital prescriptions. The pharmacy was open Monday to Friday 8am to 7pm although the closing time was dependent on the needs of hospital. The dispensary, which was located within main reception, was open to the public Monday to Friday between 9am and 6pm and on Saturday between 9am and 1pm.
- There was an appointed Controlled Drugs Accountable Officer (CDAO) who supervised the management and use of controlled drugs within the hospital.
- There was a system in place to respond to Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare Products Regulatory Agency (MHRA); this ensured dissemination of this information to all heads of department for actioning and response if required.

Records

- All patient records were in paper format, with the exception of radiology scans which were electronic. A manager told us that the hospital was working towards the implementation of electronic patient records however they were unclear when this would take place.
- We asked a senior member of staff if we could see the healthcare records of ten people who had used the outpatient department service on the day of our visit; of which five needed to be NHS patients and five privately

funded patients. However, this member of staff told us that they only had access to the NHS patient records because the relevant consultants had taken away their privately funded patients records off site. However the managers informed us post inspection that records from some consultants were kept on site and should have been available to view, though we did not see these on inspection.

- Records of all patients should be maintained by the service, whilst ensuring the consultant maintains their original copy as required. This risk was discussed at the medical advisory committee (MAC) in January 2016 yet records remained unavailable for private patients.
- Of the five NHS patient healthcare records we looked at, we found that all of these records were accurate, complete, legible and up-to-date. These records were all stored securely behind locked doors.
- The staff told us that when the department had finished with the records then they would be moved to the clinical records department within the hospital. They also confirmed that they could access a patient's previous NHS records via consultant's secretaries at the patient's local NHS trust.

Safeguarding

- There had been no safeguarding incidents raised by outpatient and diagnostic imaging between July 2015 and June 2016.
- Adult safeguarding training was part of the hospitals induction programme and refresher safeguarding training was provided to all staff every three years.
- We spoke with seven members of staff who confirmed they were up-to-date with adult safeguarding training. They were also able to give us examples of what constituted a safeguarding incident and demonstrated that they would manage this appropriately.
- Staff told us they had access to policies and procedures for the safeguarding of adults. We checked one of these policies, which was in date and reflected local council safeguarding procedures.
- There was a dedicated adult safeguarding lead for hospital who staff knew of.Staff told us that out of hours they would contact the senior hospital manager on call if a safeguarding incident occurred.

Assessing and responding to patient risk

- We spoke with five members of staff within the outpatient department who confirmed that patients, at times, attended outpatient department clinics without the hospital conducting an assessment of the patient's needs. One senior member of staff told us, "It is often our administrative staff who do a quick assessment of the patient's needs from the referral for example if they had dementia - but things do get missed". This member of staff told us that this happened in the past whereby a patient with complex needs, such as a serious mental health illness had attended the department without staff prior knowledge. Another member of staff gave us a similar example.
- A senior member of staff told us that consultants were responsible for accepting referrals and informing nursing staff if patients had additional needs, however, they told us that this "didn't always happen". They told us that it is not uncommon that a patient arrives in the outpatient department for an appointment with a copy of their referral letter, and that the staff were unaware of the appointment all together.
- We asked a manager whether these unexpected attendances were monitored and they told us they were not. Therefore, we were not assured the hospital was assessing and responding to patient risk appropriately.
- There were systems and processes in place to enable the effective management and transfer of a deteriorating patient should the need arise. This is reported on fully under the surgery service within this report. We spoke with three members of staff and they demonstrated that they were aware of policy and procedure for the management of the deteriorating patient.
- Throughout the departments we saw notices for staff which reminded them of the cardiac arrest teams telephone number; "2222" in the event of such an emergency.
- A manager gave us an example of a recent incident whereby a patient unexpectedly fainted in the outpatient department and how staff responded quickly and appropriately in the emergency. This showed that staff could identify and respond appropriately to changing risks to people who use the service in relation to deteriorating health and wellbeing.

- Pre-assessment staff told us that only certain patients attended a pre-assessment clinic, based on set criteria. Patients that were required to attend pre-assessment were all patients undergoing joint surgery, those who had complex medical history or certain risk factors and patients aged 70 and over.
- All patients received a health questionnaire prior to attendance and then the pre-assessment team assessed the need for a face to face or telephone assessment.
- We checked five patients' records who had undergone a pre-assessment on the day of our announced visit. We saw that necessary and comprehensive risk assessments were in place for each patient, including assessment for MRSA screening and mobility assessment.
- There was a Service Level Agreement (SLA) in place with an NHS trust which ensured access at all times to a Radiation Protection Adviser. There was a supporting document in place, which outlined the roles and responsibilities of this advisor. Within radiology, there was also an appointed Radiation Protection Supervisor.
- Within the hospital, there was also an allocated Laser Protection Supervisor, who had attended laser protection training. There was also a laser protection handbook for staff to refer to.
- Throughout the radiology department there were safety notices displayed to remind people not to enter certain areas or if they were pregnant.
- There were checklists in place to ensure that the right person got the right radiological scan at the right time. The checklist also included pregnancy assessment for female service users.

Mandatory training

- There was a mandatory training policy in place, which stated that it was the manager of each department's responsibility to ensure that staff in their department were compliant with mandatory training. Managers we spoke with knew this was their responsibility.
- Mandatory training was delivered annually, via e-learning and on a face to face basis. All staff received mandatory training and the subjects covered included: fire safety, infection control, data protection, basic life support, safeguarding children and vulnerable adults, deprivation of liberty and Mental Capacity Act.
- Records showed that 89% of staff within the outpatient and imaging department were compliant with mandatory training.

Nursing, support and Radiology Staffing

- The hospital did not use a standardised tool to determine nursing staffing numbers required for the outpatient departments. A manager told us that staffing numbers were arranged in accordance with expected outpatient attendances and they were based on "managers calculations", which "worked well".
- We spoke with 12 members of staff and they all told us that staffing numbers were safe in both the outpatient and imaging departments and that there was always a senior member of staff on duty in each department.
- We also observed care during our visit and saw that there were a sufficient number of staff on duty to meet people's needs with a good staff skill mix.
- In total 12.6 Full Time Equivalent (FTE) registered nurses and seven health care support workers were employed by the hospital in the outpatient department. This equated to a ratio of 1.6 registered nurses to one health care assistant.
- As of the 1st July 2016, there were no nursing or healthcare assistant vacancies in the outpatient or radiology department. There was no staff turnover during the reporting period of July 2015 to June 2016.
- Between July 2015 to June 2016, the rate of nurse staffing sickness was below the average of other independent acute hospitals we hold data for.For the same period, the rate of sickness for healthcare assistants was variable, significantly rising above the average in May 2016 to approximately 30%. It is to be noted that the rate of sickness returned to an average level the following month.
- Regular bank staff, who had been approved by managers, were used at times. A manager told us that this assisted them to offer a flexible service in relation to

varying levels of service demand. The use of bank registered nurse and health care assistants was below the rate of other independent hospitals we hold data for during July 2015 to June 2016.

- A manager told us that all bank staff underwent a formal induction, which we have explained further under the effective section of this service report.
- Records showed that there were no agency nurses or health care assistants working in the outpatients department in the last three months of the reporting period July 2015 to June 2016.

Medical staffing

- Medical staff were predominantly employed by other NHS organisations in substantive posts and had practising privileges to work at the Springfield Hospital. A practising privilege is defined as 'permission to practise as a medical practitioner in that hospital' (Health and Social Care Act, 2008).
- The hospital employed 192 consultants holding practising privileges of which 100 (52%) routinely undertake their practice at Springfield Hospital.
- The outpatient and diagnostic imaging department had access to the hospital Resident Medical Officer (RMO) as required. We have reported on the RMO under the surgery service section within this report.
- Staff told us that when consultants were not in the department, they could be accessed via the consultants' secretary. They told us that access to consultants was never an issue. One member of staff gave us a positive example of this where they had contacted a consultant regarding a future outpatient department appointment, which determined what investigations were required given the patient's comorbidities.

Emergency awareness and training

- The hospital was not a major incident receiving centre and therefore there was no major incident training or policy. However, there was a fire plan and evacuation policy.
- There was an up-to-date local business continuity plan in place, which we checked, for emergencies; for example in the event of a radiation accident, loss of power, flood and fire. Senior staff in the outpatient and diagnostic imaging department were familiar with this document and could access it via the intranet.

Are outpatients and diagnostic imaging services effective?

Good

We currently do not rate effectiveness of outpatient and diagnostic imaging services

Evidence-based care and treatment

- We looked at five healthcare records of people who used the service. These records showed that people's needs were assessed and care was planned and delivered in line with recognised guidance, legislation and best practice standards. This included a pre-admission assessment which had been completed for venous thromboembolism, moving and handling, skin integrity, infection control and falls risks.
- There were relevant care pathways in place for these people, which were specific to their need. For example, a 'urology inpatient stay pathway' in place, which was started at pre-admission stage.
- There were relevant care pathways in place. For example, there was a 'surgical inpatient stay pathway' and a venous thromboembolism care plan,which reflected national best practice issued by the National Institute of Clinical Health and Excellence.(NICE, Venous Thromboembolism: reducing risks for patients in hospital, CG92, 2015).
- A senior member of staff told us that pathways, policies and procedures were formed centrally through head office at Ramsay Health Care, with input from clinical leads locally such as from Springfield Hospital where required.
- A manager gave us an example of a recent policy that had been developed that they contributed to. This was relating to standard operating procedures (SOPs) for the outpatient department.

- We looked at the last meeting minutes from the Heads of Department meeting held in May 2016 and this showed that review of changing legislation and corporate policy was part of the meeting agenda and the issue was discussed fully.

Pain relief

- Staff told us that pain was assessed at pre-admission stage for every patient who attended pre-admission clinic, and relevant information about pain management post-operatively was discussed and supporting literature given. We checked three patient's pre-admission healthcare records, which showed this had happened. We observed leaflets within the clinic about pain management.

Patient outcomes

- The outpatient department did participate in national audit such as "Patient Reported Outcome Measures" (PROMs) for inguinal hernia, primary knee replace and primary hip replacement, which showed good outcomes. We have reported on these findings further under the surgery service section within this report.
- The radiology department took part in quarterly magnetic resonance imaging (MRI) and computerised tomography (CT) audits between July 2015 and June 2016. The audit was carried out using the Royal College of Radiologists framework and was in place to monitor the quality of images.Overall, both the MRI and CT department achieved 98% indicating images were to a high quality with accurate clinical opinions and wording of reports.
- This department also carried out audits to ensure compliance with the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) and best clinical practice guidelines.The audit randomly selected 10 patient images and assessed completion of documentation in relation to patient identification (ID), examination, date, documentation that consultant had evaluated the images and secure storage of images. For both August 2015 and February 2016, the results revealed 100% compliance.
- An annual audit to ensure compliance with The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) and The Ionising Radiations Regulations 1999 (IRR99) was carried out in March 2016 and revealed 100% compliance with all the set criteria.
- A manager told us that there were minimal local audits conducted in the outpatient department and that this was limited to infection control. However, they also informed us that hospital-wide audit programme had recently commenced which included a record keeping and venous thromboembolism audit. We have commented on this fully under the surgery service within this report.

Competent staff

- Staff appraisal rates were calculated on a rolling year basis.In the previous year to our inspection, 38% of nursing staff and 39% of healthcare assistants had received an appraisal.For the current year, the appraisal process was ongoing and at the time of our inspection 71% of nursing staff and 85% of healthcare assistants had received an appraisal.
- Consultants applying for practising privileges rights at Springfield Hospital were interviewed with both the general manager and matron prior to formal application. If successful at this stage, the hospital requested a CV, security checks, medical indemnity insurance and references including one from their employing NHS trust. These details were then reviewed by the Medical Advisory Committee (MAC) prior to the recommendation of accreditation.
- Reviews of practising privileges took place on an annual basis, which included looking how many procedures had been carried out in the previous year, complications, incidents or complaints that had been received.
- All staff received a formal induction period, which was underpinned by the corporate induction policy. We checked this policy, which was in date, and it reflected a comprehensive induction programme which took place over a three month period, with a six monthly and yearly review thereafter.

Good

Outpatients and diagnostic imaging

- We spoke with seven members of staff all of which confirmed they had completed an induction programme when commencing employment for the provider.
- Seven members of staff we asked confirmed that they were encouraged and given opportunities to develop. All of these staff members told us that they had received role-specific training. For example, one registered nurse told us that they had recently attended a pre-assessment training day run by the provider.

Multidisciplinary working

- We observed effective multidisciplinary team (MDT) working between staff within the hospital. There was a good rapport, mutual respect and effective communication between staff from all disciplines and across the hospital.
- For example, we observed this during an outpatient clinic whereby outpatient department nursing staff and the consultant whose clinic it was communicated clearly with one another and evidently knew each other well.
- Staff told us that staff from all levels and departments work effectively together. One member of staff told us, "We are one big team working for the patient and we all get on very well here".
- There were a number of up-to-date service level agreements (SLAs) in place with local NHS trusts and other providers, and a senior member of staff told us that they often called the local NHS trust in relation to referrals and they have a, "good relationship" with the staff at the trust.

Seven day service

- Springfield hospital offered outpatient appointments between the hours of 8am to 9pm, Monday to Friday and 8.30am to 3.30pm on Saturdays.
- The pharmacy at the hospital was open Monday to Friday between the hours of 8am and 7pm with access to dispensing services between the hours of 9am and 6pm.In addition, the pharmacy was open between 9am and 1pm on Saturdays, with dispensing services available, depending on the needs of the hospital.

Access to information

- All staff we spoke with confirmed that they had access to the hospital's policies and procedures via the hospital intranet system.
- We checked five patients healthcare records, which showed that the hospital communicated with the patient's GP following attendance at the outpatient or diagnostic imaging department. This was via letter format and involved a summary of the consultation, the outcome of any investigation and recommendations.
- Staff told us that patients were able to contact the outpatient and diagnostic imaging department during working hours if they had any queries about appointments and care and treatment, and staff would assist them or contact their consultant's secretary as required.
- Staff could access systems required for patient care such as electronic imaging and pathology reporting. No concerns were reported on accessing this information through the NHS system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were hospital policies which covered the legal aspects of consent, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2007). These were accessible to staff via the intranet and staff confirmed they could access these. Staff we spoke with were familiar with these terms and confirmed they had received training on these subjects.
- We also saw that there were leaflets given out to patients during their pre-admission assessment on "consent".

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as Good.

Compassionate care

- The hospital participated in the national Friends and Family Test (FFT) for all patients. The results from this test from between January 2016 to June 2016 and

showed that an FFT score of 99-100% was similar to the England average of 99%. Response rates however were below the England average when compared to other independent sector NHS patients.

- We asked a manager why they thought FFT response rates were low (between 4% and 7%) and they told us that patients took the form away to complete. They said they had recently reminded all staff again to hand the form to all NHS patients and encourage them to complete it before leaving the department.
- The hospital also offered another patient satisfaction survey online which was managed by an external research organisation. The organisation issued "hot alerts" to the hospital matrons and general managers following receipt of information of concern. These alerts were then disseminated to departmental managers, who could contact patients quickly and directly if considered serious.
- All patients who consented to a reply after they had raised a concern through the survey got an email or telephone call from the quality improvement lead to demonstrate the service was taking action.
- We observed staff act in a caring and dignified manner towards patients throughout departments. One patient came to the wrong department and we observed a member of outpatient department staff escort the patient to the correct area.Although staff were busy we saw that staff were attentive to patient's needs.
- We spoke with three patients who used the service and all told us that staff were caring. One person said, "The nurse smiled, welcomed me to the outpatient area and showed me where the coffee was - no complaints", and another said, "Yes staff are always lovely here I have been a few times now".
- Staff ensured that people's privacy and dignity was respected at all times. We saw one patient ask a question at the reception area and one of the nurses invited them in to a consulting room to discuss the matter further in privacy.
- All patients were seen in individual consulting rooms, which had vacant/engaged signs in use. We also observed staff knocking on doors and waiting for an answer before entering.
- There were chaperoning notices throughout the departments, which reminded staff and provided information to patients and their carers that they could request a chaperone. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.Four members of staff confirmed that same sex chaperoning could be arranged as required. There was also an up-to-date policy on chaperoning in place which staff had access to electronically.
- All staff received training in customer service during annual mandatory training, which covered the importance of treating patients with dignity and respect.

Understanding and involvement of patients and those close to them

- We spoke with three people who used the service and asked them whether they understood and felt involved in their care. All three patients told us they did. One person said, "I was offered a variety of treatment options and I talked about them in detail with the doctor, they [the doctor] have explained every yes".
- Staff told us that patients received sufficient time during consultations to ensure that they received all the support and information they required.
- We asked two patients about this and they confirmed they did not feel rushed during their appointment and had time to ask any questions they had.

Emotional support

- We found that people who used the service were empowered and supported to manage their own health, care and wellbeing and to maximise their independence. For example, one of the patient's healthcare records we reviewed showed that during pre-admission the patient received necessary smoking cessation advice, and they were given relevant information leaflets about their condition and treatment plan which supported the appointment.
- One of the pre-admission nurses also explained to us how they had been in contact with the occupational therapist that day in relation to a patient they had seen in their clinic, to ensure that the patient had all the relevant equipment and support in place they required for after their surgery.

Good

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as Good.

Service planning and delivery to meet the needs of local people

- The outpatient service was supporting the local NHS services by providing 43% of their service capacity to NHS patients. This figure pertained to the period of July 2015 to June 2016.
- The outpatient department was spread over two floors, with stair and lift access to each floor. The diagnostic imaging service was located on the bottom floor. The outpatient department consisted of 21 consulting rooms and four minor treatment rooms, one of which was used for bladder cystoscopies.
- A manager told us that the outpatient and diagnostic imaging services were arranged depending on local service demand, and that the hospital worked closely with local commissioners and other providers to provide services tailored to local need. For example, since service activity had increased recently there was significant structural work planned for the outpatient department to expand the service. This included a further four consultation rooms, another treatment room, offices and further storage space.
- We saw that each department and area was clearly signposted and that staff were attentive to escort patients to areas if they were not sure where they were meant to be.
- People who used the service confirmed that they had received information about the service prior to their appointment; this included their consultant name, directions to the hospital and contact details. We saw that this information was also on the hospital website.

Access and flow

- The service was open Monday to Saturday from 9am to 7pm, and up until 9pm during the week, dependent on service demand. Appointment times for private patients were agreed between the patient and the hospital, therefore waiting times were dependent on patient preference.
- The outpatient department exceeded its recommendation of 92% for referral to treatment (RTT) waiting times in less than 18 weeks for the period of July 2015 to June 2016 for incomplete patients. These figures were pertaining to NHS patients only.
- Targets for non-admitted patients' treatment beginning within 18 weeks were removed in June 2015.It is however, positive to note that for the period of July 2015 to June 2016, the outpatients department exceeded its target of 95% of patients in all months during this period.
- We spoke with three people who used the service and they told us that they received an appointment in a timely way following referral and that they did not wait long to be see when they arrived in clinic. A manager confirmed that next day appointments could be arranged as necessary.

Meeting people's individual needs

- We spoke with three people who used the service and they all told us that they were offered choice in date and time of appointment. Staff also confirmed that the use of bank staff allowed the service to increase staffing numbers at times to allow people choice in appointment.
- We were concerned that referrals were not assessed appropriately, which we have reported on further under the safe section of this report. A senior member of staff confirmed that people living with dementia, learning disability, mental health conditions, and, or, substance misuse conditions attended the department, and that at times people did attend the hospital for an outpatient appointment without the hospital being aware of this. This meant that there could be missed opportunities to identify and plan care in advance to meet people's individual needs.
- The hospital had a specific team who offered additional support to patients living with dementia. This was service was available from pre-assessment stage. Four members of staff we spoke with were aware of this team and knew how to contact them.

Good

Outpatients and diagnostic imaging

- Staff also told us they could access interpreters through language line as necessary, to ensure people could understand and be involved in their care decisions.
- Four members of staff confirmed that the hospital worked with the transport service where people who used the service had mobility issues who were receiving NHS funded care.
- There were also procedure specific consent information leaflets, for example a "patient information for consent" regarding "laparoscopic cholecystectomy" procedure. This information leaflet was in date and contained extensive information about gall stones, risks and benefits of surgery, what happens if surgery is not wanted by the patient, what the operation involves, health education about smoking cessation, complications of surgery and anaesthesia and recovery.

Learning from complaints and concerns

- The hospital had received 110 complaints between July 2015 and June 2016. This was reported for the whole hospital and was not broken down by service.None of these complaints had been referred to the Ombudsman or ISCAS (Independent Healthcare Sector Complaints Adjudication Service) in the same reporting period.
- The outcomes of complaints were discussed at monthly heads of department (HoD's) meetings so that information could be disseminated to staff on a departmental basis.
- The senior management team discussed the progress of complaints on a weekly basis with all complaints being overseen by the general manager.
- There had been a number of complaints raised in relation to the cost not always being transparent to some patients undergoing an outpatient department consultation.We were told that the hospital had subsequently worked to provide information leaflets and posters to clearly outline costs and ensured these were available to patients within the department. We observed these throughout the departments.
- Complaint leaflets were accessible by patients and placed in the outpatient and diagnostic imaging department. In addition, patients were able to submit feedback via the hospital's website.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as Requires Improvement.

Vision and strategy for this this core service

- There was a vision in place for the hospital, "to make Springfield the hospital of choice for all stakeholders", which was supported by the following three main principles; "making Springfield Hospital a great place to work; being the hospital of choice for our customers; and making a profit to reinvest".
- This vision was supported by a, "Business Unit Plan 2016/17" which was formed to demonstrate the hospital's current position and be the framework for the hospital's future strategy, and an "Annual plan 2015/16" which set out the hospitals yearly strategy.
- The hospital also had a set of values which included; "integrity; ownership, positive spirit, innovation and team work", which were displayed on the hospital's website.
- We asked five members of staff if they knew the hospital vision and what the values were and all staff were able to demonstrate they were familiar with these concepts.

Governance, risk management and quality measurement

- Where our findings on surgery also apply the outpatient and diagnostic services, we do not repeat the information but cross-refer to the surgery section.
- A manager confirmed that there was not a risk register in place specifically for the outpatient and diagnostic imaging department. Whilst there was a hospital-wide risk register there were no entries on this register for the outpatients and diagnostic imaging departments. However this manager also recognised that the records availability concerns were known to the service, and should have been on the risk register but was not.
- We saw that there were new Standard Operating Procedures (SOPs) for the outpatient department which were being introduced in the weeks following our visit.

These were not yet embedded in the service. These were national SOPs issued by the provider and the departmental manager confirmed that they had input in the development of these procedures.

- We found that the policy for radiation protection in diagnostic radiology and for incident reporting was out-of-date.
- There was a lack of evidence to show that the outpatient department was assessing and monitoring the effectiveness of the service. This is because there were a limited number of local audits, which took place to show performance.
- Records of all patients should be maintained by the service, whilst ensuring the consultant maintains their original copy as required. This risk was discussed at the medical advisory committee (MAC) in January 2016 yet records remained unavailable for private patients.
- Six members of staff told us that it was routine practice for consultant's to take away their private patient's records. This meant that some medical records generated by doctors holding practice privileges were not available to staff who may be required to provide care or treatment to the patient, and this could create a concern due a lack of a clear process in place to ensure the records can be accessed.
- There were however regular outpatient and imaging department meetings which were minuted. We spoke with six members of staff all of which either confirmed that had attended the most recent meeting for their department or had received circulated meeting minutes.

Leadership and culture of service

- The outpatient and imaging departments were led by two different managers. These members of staff were supported by the hospital senior management team.
- The managers we spoke with confirmed they had undertaken additional training in management, and demonstrated that they had the skills, knowledge and experience to lead their areas.
- Seven members of staff we spoke with confirmed that departmental managers and senior hospital managers were visible and approachable. For example, we saw that the outpatient manager walked around the service in the morning to say good morning to staff and to see if there were any issues.
- We found that leaders encouraged appreciative, supportive relationships among staff. One manager told us, "I tell staff that I am just the facilitator for the department, they drive and keeps standards high".
- Senior management team leadership has been reported on under the surgery section of this report.
- Staff we spoke with spoke highly of their seniors and told us that they felt well supported, respected and valued by them. They also told us that they felt able to raise concerns openly to their leaders.
- One member of staff gave us an example of when they had raised and concern and where a manager had taken appropriate action. This related to staffing numbers on a particular day.
- Following discussion with one of the departmental managers they demonstrated to us that they would take action to address staff behaviour and performance that is inconsistent with the vision and values, regardless of seniority.
- Throughout our visit we observed a good rapport between staff of all levels and disciplines. All staff we spoke with enjoyed working at the hospital and were proud of the service offered to patients. One member of staff told us, "I absolutely love this job, that's why I have stayed so long, I feel I really make a difference to patient experience".

Public and staff engagement

- Where our findings on surgery also apply the outpatient and diagnostic services, including how public and staff engagement was managed, we do not repeat the information but cross-refer to the surgery section. We identified no concerns regarding public or staff engagement of the outpatients or radiology services.

Innovation, improvement and sustainability

- There had been building works approved for the outpatient department to expand the service. This included the development of a further four consultation rooms and one treatment room, and further space for storage and offices.

Outstanding practice and areas for improvement

Outstanding practice

- The hospital was well established and accredited for oncology services. The service had achieved accreditation for breast and bowel cancers and were see as centres of excellence in the private independent sector for treatment of these conditions.
- Access to the oncology service was quick, and without delay. Patient feedback in relation to Oncology was consistently excellent.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should improve local and hospital level governance arrangements for oncology, children and young people's services to ensure there is sufficient oversight of the service.
- The provider should ensure that the changes to the out of hours triage system that was in use for oncology patients is embedded and effective in delivering safe patient care.
- The provider should ensure that all staff receive an annual appraisal.
- The provider should review the process for ensuring that audit actions are effectively implemented to improve outcomes on performance.
- The provider should review and improve the process for the risk register within the service to ensure that it reflects current risks, and ensure that these risks are appropriately monitored and managed within the service.
- The provider should improve process around infection control to reduce surgical site infection rates, and improve compliance with infection control and hand hygiene audits.
- The provider should ensure that patient records are available and accessible to the service for all patients who receive treatment at Springfield Hospital.
- The service should consider undertaking more specific and dedicated audits in relation to the care and treatment of patients under the age of 18 years.