Spire Leeds Hospital

Quality Report

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

Ratings

Overall rating for this inspection	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

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

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

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

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

Summary of findings

Overall summary

Spire Leeds Hospital is operated by Spire Healthcare Ltd. The hospital has 88 inpatient and day case beds. Facilities include four operating theatres, one endoscopy suite, one angiography suite, a chemotherapy unit, physiotherapy services, outpatients' departments, and diagnostic and imaging facilities. There is an eight-bedded level two critical care unit, an eight-bedded children's ward, a 10-bedded ambulatory care unit, six oncology day case chairs, and 56 inpatient and day case beds spread across two adult wards.

The hospital provides surgery - including cosmetic surgery, medical care - including chemotherapy, high dependency care for adults, services for children and young people, and outpatients and diagnostic imaging services.

We inspected this service using our focused inspection methodology. We carried out an unannounced responsive inspection on 11 December 2018. We focused on specific services which were highlighted as concerns to CQC from staff and members of the public, and we inspected surgery and services for children and young people. As concerns spanned multiple inspection domains, we looked at all key questions and asked if surgery and children's and young people's services were safe, effective, caring, responsive, 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. As this was a focused inspection, new ratings were only awarded for the key questions that were inspected. The overall rating for surgery changed from good to requires improvement. The overall rating for and children's and young people's services changed from good to requires improvement. We amalgamated these ratings with ratings from our routine 2017 inspection of medical care, outpatients and diagnostic imaging, and critical care services. Our rating of this hospital went down. The rating for the hospital changed from good to requires improvement overall.

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 about surgery services (for example, management arrangements) also apply to other services, we do not repeat the information but cross-refer to the surgery service level.

Services we rate

Our rating of this hospital went down. The rating for the hospital changed from good to **Requires improvement** overall.

We found the following areas of concern in surgery and children and young people's services:

- Key leaders in the service did not have the right skills and abilities to run a service providing high-quality sustainable care. Opportunities to prevent or minimise harm were missed.
- Safety was not always a high priority, and the application of safety systems and processes required improvement. Levels of harm were inconsistently recorded against incident records. Investigation reports were of variable quality, and the completion and sign-off of action plans was inconsistent.
- The application of governance arrangements and systems was not adequate. The hospital could not reliably determine how many serious incidents had occurred, and had not always notified CQC of serious incidents, or had not done so in a timely manner. At the time of inspection, the hospital had been without a governance lead for several months. We saw the frequency of key committees was not always in line with their terms of reference. There was little evidence senior leaders had worked to systematically improve service quality and safeguard good standards of care. Risk registers were not adequately managed and did not reflect key risks facing the service.
- Senior leaders had not supported or promoted a culture of appropriately identifying, reporting, categorising, and learning from incidents. When concerns were raised, or things went wrong, the approach to reviewing and investigating causes was

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often insufficient or too slow. There was little evidence of learning from events or action taken to improve safety in key committee and group meeting minutes we reviewed.

- Senior leaders had failed to meet their duty of candour obligations consistently well. The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Senior leaders were reactive and defensive. When something went wrong, people were not always told in an open and honest way or in a timely manner.
- The culture, policies and procedures had not provided adequate support for staff to raise concerns and have these adequately addressed at hospital level. From November 2017 to October 2018, CQC received five whistleblowing enquiries; and an internal whistleblowing investigation by Spire Healthcare (corporate) had been undertaken with respect to children's and young people's services.
- The service had not sufficiently applied the systems available to identify risks and implement plans to eliminate or reduce them. Risks to patient safety had not been monitored or mitigated over time consistently well.We found senior managers had failed to sufficiently address fasting time compliance. Recent improvements had been made in venous thromboembolism (VTE) prophylaxis, daily and pre-discharge medical review of patients, and medical record keeping compliance; but deficiencies with compliance were observed throughout most of 2018. Where action plans had been implemented, we often found these were not sufficiently robust.
- The hospital had systems to manage information. However, the information that was used to monitor performance or to make decisions was not always accurate, valid, reliable, or timely. We saw that clinical audit measures were not always collated or presented to committees and groups in a timely fashion; and we observed data inaccuracies between key hospital and service reports.
- The service level agreement (SLA) for the transfer of critically ill children had expired in February 2018 and had not been renewed as of January 2019.
- Staff did not always follow best practice when prescribing, giving, recording and storing medicines.
- There was limited evidence of discussions about learning from concerns and complaints in key committee and group meeting minutes we reviewed.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with three requirement notices. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	Surgery was the main activity of the hospital. Where our findings about surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as requires improvement. We found the service was caring and responsive. However, it requires improvement for being safe and effective, and was deemed inadequate for being well-led.
Services for children & young people	Requires improvement 	Children and young people's 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. We rated this service as requires improvement. We found the service was caring, effective and responsive. However, it requires improvement for being safe, and was deemed inadequate for being well-led.

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Services we looked at
Surgery; Services for children & young people

Summary of this inspection

Background to Spire Leeds Hospital

Spire Leeds Hospital is operated by Spire Healthcare Ltd. It is a private hospital in north Leeds, West Yorkshire. The hospital primarily serves the communities of North and West Leeds, Ilkley in West Yorkshire, and Harrogate and surrounding areas in North Yorkshire. It also accepts patient referrals from outside this area.

The hospital opened in 1989 and has been under varied ownership during that time. Since 1 October 2010, the hospital has been in the ownership of Spire Healthcare. The hospital has had a registered manager in post since 1 October 2005. The hospital director has been in post since 2005.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, four other CQC inspectors, and specialist advisors with expertise in surgery, theatre management, paediatrics, and healthcare leadership and governance. The inspection team was overseen by Sarah Dronsfield, Head of Hospital Inspection.

Information about Spire Leeds Hospital

The hospital had two mixed gender adult wards, one for day cases with 18 beds and one for overnight inpatient stays with 38 beds; a critical care unit (level 2 care) with eight beds; a children's ward with eight beds; an oncology day unit with six day case chairs; an ambulatory care unit with 10 outpatient and day case beds; and a large outpatients' area, including physiotherapy.

The hospital also provided a range of diagnostic and imaging radiology services including digital radiography, digital mammography and ultrasound. There was magnetic resonance imaging (MRI) and computerised tomography (CT) scanning. There were also on-site pathology services providing pathology and blood transfusion services to other hospitals in the group. We did not inspect these services.

The hospital is registered to provide the following regulated activities:

- Surgical procedures.
- Treatment of disease, disorder or injury.
- Diagnostic and screening procedures.
- Family planning.
- Management of supply of blood and blood derived products.

The hospital also offers cosmetic procedures, such as dermal fillers. We did not inspect these services.

We last inspected services at the location in January 2017. At that time, we found medical care (including older people's care) services to be outstanding overall, and children and young people's services, surgery, critical care, and outpatients and diagnostic imaging services to be good overall.

Since our last inspection, we received concerns which prompted us to carry out an unannounced focused inspection on 11 December 2018.

During this inspection we inspected surgery and children's and young people's services and for each, asked if services were safe, effective, caring, responsive, and well-led.

During our inspection of surgery, we visited two surgical wards, an ambulatory care unit, and operating theatres. During our inspection of children and young people's services, we visited the children's ward, and the theatre and outpatients' area where children and young people are seen and treated. In total, we spoke with 44 members of staff including registered nurses, health care assistants,

Summary of this inspection

reception staff, medical staff, operating department practitioners, managers, and senior leaders. We also spoke with seven patients and six relatives. We reviewed 13 sets of patient records.

Activity (1 November 2017 to 31 October 2018):

- In the reporting period November 2017 to October 2018, there were 2446 inpatient admissions, and 7327 day-case admissions, and 8905 visits to theatre (8282 adults and 623 children and young people). Of these, 65% of patients were self-funded or insured, and 35% of patients were NHS-funded.
- 26% of all NHS-funded patients and 25% of all other funded patients stayed overnight at the hospital during the same reporting period.

As of January 2019, 303 consultants had practising privileges at the hospital; of these, 93 consultants had children and young people admitting rights. The term "practising privileges" refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there.

From November 2017 to October 2018, 133 consultant surgeons actively admitted patients for surgery at the hospital, and 74 anaesthetists had practising privileges. Two regular resident medical officers (RMO) worked a one week on and one week off rota. The accountable officer for controlled drugs (CDs) was the registered manager.

There were 72 registered nurses working at the hospital; 50 of these were contracted by the hospital, and 22 were bank staff. Most registered staff worked on wards (46) and in theatres (16). There were five contracted registered children's nurses and five bank staff in post in children's and young people's services. Data provided by the hospital showed there were eight vacancies for contracted staff across the hospital; three vacancies on the wards, four in theatres, and one in children and young people's services.

Track record on safety (reporting period November 2017 to October 2018)

- There had been no never events reported in the period November 2017 to October 2018. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- 731 incidents had been reported across the hospital in this time frame. Of these, 544 (78%) were classified as no harm, 83 (11%) as low harm, and 73 (10%) as moderate harm; one (expected) death was also reported. No cases of severe harm were reported.
- Senior leaders reported 40 serious incidents requiring investigation (SIRI; as defined by Spire group criteria) had occurred over this period; but they did not report how many incidents had met NHS-England serious incident criteria.
- There had been no cases of hospital acquired methicillin resistant staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (CD), or E-Coli, at the hospital in the reporting period.
- The hospital received 52 formal (written) level one complaints in the reporting period; three of these had been escalated to level two complaints.

Services accredited by a national body

- Sterile Services - ISO13485:2003 EN ISO13485:2002 accreditation was valid until March 2019.
- The hospital achieved Joint Advisory Group (JAG) on GI endoscopy accreditation in April 2017.
- The pathology department was accredited with the United Kingdom Accreditation Service (UKAS).
- The hospital attained Macmillan Quality Environment Mark level 5 in February 2018.

Services provided at the hospital under service level agreement

- Cytotoxic drugs service
- Interpreting services
- Radiation protection service
- Cataract surgery
- Maintenance of medical equipment
- RMO provision

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- NHS care and treatment and organ retrieval
- Multidisciplinary teams for cancer patients
- Transport services
- Medical secretary provision

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 

Our rating of safe went down. We rated it as **Requires improvement** because:

- Safety was not always a high priority, and the application of safety systems and processes required improvement. There was a deficit in the identification, classification, and management of patient safety incidents. Levels of harm were inconsistently recorded against incident records Investigation reports were of variable quality, and the completion and sign-off of action plans was inconsistent.
- Staff did not always complete and update risk assessments for each patient. We saw that adult patients who had undergone surgery were not always reviewed daily, or prior to discharge, by a consultant. Despite compliance improvements in hospital audit data, venous thromboembolism (VTE) assessments we reviewed during our inspection showed not all patients were assessed fully. National early warning score (NEWS) audit results showed variable compliance with measures, which were under hospital target.
- The children and young people's (CYP) service had not risk-assessed the nursing and treatment of paediatric patients in adult areas consistently well. In addition, the service level agreement for transfer of critically ill children had expired in February 2018.
- Medical staff in the surgery core service had not kept detailed daily records of patients' care and treatment consistently well. We saw this was a reoccurring common theme in incident records and investigation reports we reviewed; and the service had identified this as an ongoing problem. Following our inspection, senior leaders reported they had implemented several methods to improve compliance, and we saw audit compliance had improved.
- Staff did not always follow best practice when prescribing, giving, recording and storing medicines.
- The service had suitable premises and equipment and looked after them well; however, we found emergency equipment checks were not completed consistently well.
- Overall, we saw ward and theatre staff kept equipment and the premises visibly clean and used control measures to prevent the spread of infection. However, we were not assured laminar flow systems were compliant; and we were concerned about hip replacement surgical site infection rates.

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However:

- Staff were compliant with mandatory training requirements.
- At the time of inspection, there were enough medical and nursing staff to keep patients safe and provide the right care and treatment.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- We found nurse-led risk assessments, including for pressure damage acquisition, malnutrition, falls, bed rails, moving and handling, were completed on most occasions.

Are services effective?

Requires improvement

Our rating of effective went down. We rated it as **Requires improvement** because:

- The service often provided care and treatment based on national guidance; however, the service had not adhered to national venous thromboembolism (VTE) prophylaxis guidance consistently well. In addition, we were not always assured of the accurate audit and reporting of CYP service performance indicators.
- Staff gave patients enough food and drink to meet their needs and improve their health following surgery, and during inpatient stays. However, we saw adult patients were often fasted for excessive periods of time before surgery.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care; or who to approach to for support. However, we were not assured consent procedures had been followed consistently well.

However:

- Staff monitored the effectiveness of care and treatment and benchmarked data against Spire peer group averages, and some national measures, to monitor performance.
- Staff assessed and monitored patients regularly to see if they were in pain.
- The service made sure staff were competent for their roles and staff of different kinds worked together as a team to benefit patients.
- Services were available that supported care to be delivered seven days a week and patients were encouraged to be as fit as possible for surgery.

Are services caring?

Good

Our rating of caring went down. We rated it as **Good** because:

Summary of this inspection

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

However:

- Patient satisfaction scores across the 2018 period (quarter one to quarter four) were considered good and were broadly in line with peer group averages. However, some results (such as the proportion of patients who felt able to talk to staff about their worries or fears, and the proportion who felt they were told about medication side effects to watch for) were below peer group averages.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- The hospital planned and provided services in a way that met the needs of local people.
- Services took account of patients' individual needs.
- People could access services when they needed them. Arrangements to admit and discharge patients were typically in line with good practice.
- Overall, the hospital treated concerns and complaints seriously, and investigated them.

However:

- We saw limited evidence of discussions about learning from concerns and complaints in meeting minutes we reviewed.

Are services well-led?

Inadequate

Our rating of well-led went down. We rated it as **Inadequate** because:

- Key leaders in the service did not have the right skills and abilities to run a service providing high-quality sustainable care. Senior leaders could not reliably determine how many serious incidents had occurred, and had not always notified CQC of serious incidents, or had not done so in a timely manner. Senior leaders had not supported or promoted a culture of appropriately identifying, reporting, categorising, and learning from incidents. Opportunities to prevent or minimise harm were missed.

Summary of this inspection

- The culture was not one of fairness, openness, transparency, honesty, challenge and candour. Senior leaders were reactive and defensive. The leadership team had not always been open and honest with patients when things went wrong; and had failed to meet their duty of candour responsibilities consistently well.
- The application of governance arrangements and systems was not adequate. At the time of inspection, the hospital had been without a governance lead for several months. We saw the frequency of key committees was not always in line with their agreed terms of reference and accurate key data was not always produced and subsequently reviewed by committees and groups in a timely manner. We were not assured that the process to report concerns to other external agencies had been followed in a timely manner.
- The service had systems to manage information. However, appropriate and accurate information was not always effectively processed, challenged and acted upon. Risks to patient safety had not been monitored or mitigated over time consistently well. We observed recurrent trends in incidents and meeting minutes we reviewed. We found senior managers had failed to sufficiently address fasting time compliance at the time of inspection. We observed that recent improvements had been made in VTE prophylaxis, daily and pre-discharge medical review of patients, and medical record keeping compliance; but that compliance deficiencies were observed throughout most of 2018.
- We found the hospital risk register and the paediatric risk register were not being appropriately managed. The service had not sufficiently applied the systems available to identify risks and implemented plans to eliminate or reduce them.
- Leaders had not promoted and maintained a positive culture that supported and valued staff and created a sense of common purpose based on shared values. The culture, policies and procedures had not provided adequate support for staff to raise concerns and have these adequately addressed. From November 2017 to October 2018, CQC received five whistleblowing enquiries; and an internal whistleblowing investigation by Spire Healthcare (corporate) had been undertaken with respect to children's and young people's services.

However:

- Ward and theatre staff said they felt supported by their line managers, who promoted a positive culture that valued staff.

Summary of this inspection

- There was a hospital strategy for what leaders wanted to achieve; however, there was no CYP specific mission statement or vision.
- Senior managers engaged with patients, staff, and local organisations to plan and manage services.
- We saw evidence of leaders promoting training, research and innovation.

Detailed findings from this inspection

Overview of ratings

Our ratings for this inspection are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement
Services for children & young people	Requires improvement	Good	Good	Good	Inadequate	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Inadequate	Requires improvement

Notes

This was a focused inspection, new ratings were awarded for the key questions that were inspected.

Following our focused inspection, the overall rating for surgery changed from good to requires improvement. The overall rating for and children's and young people's services changed from good to requires improvement.

We amalgamated these ratings with ratings from our 2017 inspection of medical care, outpatients and diagnostic imaging, and critical care services.

Our rating of this hospital went down. We rated it as **Requires improvement** overall.

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

Our rating of safe went down. We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory training in key skills to all eligible staff, and made sure they completed it.**
- The hospital had a system in place to help ensure staff received mandatory training; training was provided via e-learning, and face-to-face training. The hospital mandatory electronic training system provided reminders to staff to complete their e-learning training. The training system allowed staff to see what training they were required to complete and allowed managers to view overall compliance, for their area.
- Following our inspection, senior managers provided mandatory e-learning training compliance data, dated to January 2019. Data showed 100% compliance across all departments for anti-bribery, compassion in practice, equality and diversity, fire safety, health and safety, infection control, information governance, and manual handling training. Similarly, clinical scorecard data for quarter one to quarter three (January to September) of 2018 showed mandatory e-learning training compliance to be high (quarter one was 83% against a target of 25%, quarter two was 98% against a target of 50%, and quarter three was 99% against a target of 75%).
- During our inspection, we spoke with nine registered nurses and healthcare assistants, one physiotherapist, and an associate practitioner about their mandatory training. They told us they had completed their mandatory training or were booked onto remaining courses.
- Following our inspection, we reviewed mandatory face-to-face training records for nursing (surgical ward) staff. We saw that compliance for the mandatory two-day study course was 65% for study day one and 100% for study day two, for the period January 2018 to December 2018. It was explained that the lower attendance rate for study day one reflected the exclusion of staff who had already attended the training earlier in the year (quarter one); to avoid duplication. Completion of resuscitation training showed good overall compliance. Data provided by senior managers showed that 88% of all adult ward staff had completed adult life support training at a level appropriate for their role.
- Data supplied by the provider following our inspection showed that, overall, life support training was adequate among theatre staff.We reviewed compliance with life support training among 28 theatre staff and found they had completed a minimum level of life support training appropriate for their role. Six staff (21%; predominantly support workers) had completed adult basic life support (BLS), 15 (54%; predominantly perioperative practitioners and theatre team leaders) had completed adult immediate life support (AILS), and one (4%) had completed advanced life support (ALS) training. We also noted that eight staff (29%; predominantly support workers) had completed paediatric basic life support (pead. BLS) and 13 staff (46%) had completed paediatric immediate life support (PILS) training.

- Staff we spoke with during our inspection said that consultant staff attended mandatory training at their employing NHS trust, and this was evidenced and monitored through the appraisal process.
- Residential medical officers (RMOs) were employed through a national agency and completed mandatory training with the agency. The hospital received confirmation of the training and kept a record of attendance. We reviewed staff files for two RMOs, which evidenced their qualifications and experience; and we observed they were ALS and European Paediatric Advanced Life Support () certified.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- The hospital had a safeguarding policy, which was accessible on the intranet, which detailed the different types of abuse, and issues which staff should report.
- All staff completed safeguarding adults' level one and level two training and safeguarding children and young people level one and two training as part of their mandatory training programme. Training data provided by senior managers following our inspection showed 100% compliance.
- The paediatric lead nurse had completed level four safeguarding training and represented the hospital at statutory health and social care safeguarding networks across the region.
- In addition, we saw qualified clinical staff who treated and cared for children and young people had undertaken level three safeguarding children training.
- Consultants working at the hospital had to complete level three safeguarding children training and a record was kept of this on the practising privileges record. We were told that the senior management team monitored non-compliance of this and took appropriate action.
- Staff we spoke with on wards and in theatres were aware of what concerns could potentially be a safeguarding concern, and knew how to raise them. If unsure, staff said they would escalate concerns to a senior member of staff, or contact the safeguarding lead for advice.

Cleanliness, infection control and hygiene

- **Overall, we saw ward and theatre staff kept equipment and the premises visibly clean and used control measures to prevent the spread of infection.**
- During our inspection, we observed clinical areas were visibly clean. We reviewed 2018 patient led assessments of the care environment (PLACE) reports for Leeds Spire Hospital and noted 99.5% compliance for cleanliness, which was better than the 98.5% England average.
- The hospital had an infection prevention and control policy. This directed staff to other policies and protocols for guidance about cleaning, decontamination and use of personal protective clothing. The policy was available on the provider's intranet.
- We spoke with the high dependency unit sister who was the infection control lead. They communicated updates in infection control practice through a series of link nurses and at quarterly infection control committee meetings.
- All staff completed infection prevention and control training as part of their mandatory training programme. Training data provided by senior managers showed 100% compliance as of January 2019.
- During the inspection, we saw staff were compliant with hand hygiene policies, including 'bare below the elbows' and personal protective clothing policies. Staff had access to alcohol gel at the point of use. Hand hygiene compliance was monitored through observational hand hygiene audits; clinical scorecard results from quarter one to quarter three (January to September) of 2018 showed 97% compliance on average.
- Staff we spoke with said that they had access to appropriate personal protective clothing (PPE).
- We inspected reusable equipment stored on the ward, and all items appeared to be visibly clean and ready for

use. Staff used a specific label to identify the equipment was clean and ready for use. We reviewed five pieces of reusable clinical equipment and found these to be clean.

- However, during our inspection, we saw a piece of clean equipment (blood glucose machine) stored within the sluice room in theatre; this equipment could have become contaminated. We raised this with the staff during the inspection who immediately removed this from the area.
- We saw processes for segregation of waste, including clinical waste. Staff were able to segregate waste at the point of use. Sharps bins were used by staff to dispose of sharp instruments or equipment. Sharps bins in the areas visited were secure and stored of the floor. This reflected best practice guidance outlined in Health Technical Memorandum HTM 07-01, safe management of healthcare waste.
- Rooms were available for patients requiring isolation. At the time of inspection, there were no patients who required isolation.
- Water flushing records we reviewed showed compliance with water safety plans.
- The hospital carried out surgical site infection (SSI) surveillance. SSI data was presented on the hospital's clinical scorecard for both hip and knee procedures. Scores were RAG-rated (red amber green-rated). We saw targets for RAG rating were calculated according to number of standard deviations above the Spire group average to provide a longer-term rate and identify any statistical outliers.
- Clinical scorecard data supplied by senior managers for quarter one to quarter three (January to September) of 2018 showed the rate of SSIs as a proportion of hip procedures was reported as 2.67% in quarter one, 1.44% in quarter two, and 0.88% in quarter three of 2018. Data was calculated based on year to date cases, with two incidents reported in the first quarter of 2018.
- Clinical scorecard data for the period quarter one to quarter three (January to September) of 2018 showed the SSIs as a proportion of total knee procedures was reported as 0% in quarter one to three of 2018.
- We reviewed Public Health England (PHE) SSI Surveillance data for hip replacements. Data showed that from October 2017 to September 2018 the proportion of eligible hip surgery patients at the hospital who had developed an SSI was the same as the national comparator (0.9%). However, the proportion of eligible hip surgery patients who had developed an SSI as an inpatient, or who required re-admission to the hospital, was also 0.9%. This was worse than the national comparator rate of 0.4% (range 0.3% to 0.6%).
- PHE SSI Surveillance data for knee replacements showed that from October 2017 to September 2018, the proportion of eligible hip surgery patients who had developed an SSI at the hospital was 0%. This was better than the national comparator (1.3%, range 0.7% to 1.6%).
- We reviewed incident data for the period November 2017 to October 2018 and saw 20 instances of surgical site infection (SSI) had been reported in this time frame. Of these, five cases were classified as deep SSIs.
- Within the incident data provided by senior managers, we noted some spinal SSI cases. In the November 2018 clinical effectiveness committee meeting minutes, it was reported that three spinal cases had been flagged as developing infections; and each were operated on by the same consultant. It was noted that investigation was ongoing.
- We reviewed annual theatre ventilation reports and outcomes (published October 2018) and saw ventilation in the sterile services department, and minor operations department had been deemed satisfactory and compliant with the Health Technical Memorandum (HTM) minimum standards. However, we saw that air supply and extract volumes to the four theatres, and anaesthetic and preparation rooms were above or below recommended limits. Non-compliant results from microbiology testing were also seen in ambulatory care and theatre four. Following our inspection, senior managers provided us with a quotation for the works required. However, they did not submit evidence that this work had been completed. Therefore, we were not assured that all necessary work had been undertaken to ensure that all areas were compliant at the time of inspection.
- Following our inspection, senior leaders said that the required work had been completed post-inspection, and that the theatres were re-audited in May 2019.

However, evidence of this was not supplied. Senior leaders did provide evidence to show that a full deep clear of the theatre suite was undertaken in February 2019.

- Senior leaders reported there had been no Public Health England reportable cases of hospital acquired methicillin resistant staphylococcus aureus (MRSA), Methicillin-sensitive staphylococcus aureus (MSSA), clostridium difficile (C.difficile), or E-Coli, at the hospital in the reporting period November 2017 to October 2018.
- Hospital incident data from November 2017 to October 2018 showed one case of post-operative MRSA and one case of post-operative C.difficile had been recorded. However, following our inspection, senior leaders provided evidence to show these cases had been investigated and found not be hospital acquired.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well; however, we found emergency equipment checks were not completed consistently well.**
- During our inspection, emergency equipment we reviewed appeared clean, tidy, and ready for use. Trolleys we inspected were locked, appropriately stocked, and equipment was in date. However, we observed instances where staff had failed to record daily checks. Following our inspection, senior leaders reported that when daily checks were not recorded, this occurred on days when ward(s) were closed. However, the senior leaders did not provide evidence to substantiate this. Practice has since been changed to add a note to confirm 'closed' in the record, where applicable.
- Following our inspection, senior managers provided audit data that showed resuscitation trolleys on surgical wards one and two had been found non-compliant for the last two internal audits. It was highlighted that resuscitation trolleys were "very dusty" with "missing checks" (October 2018); and this was escalated to the ward sister with a view to undertaking more frequent audits. In December 2018, "surplus equipment", the "wrong form" and "missing checks" were recorded; and it was noted that the ward sister had been emailed again to highlight these findings.
- Following our inspection, senior leaders explained that the missing checks were due to the ward being closed for some periods in December 2018, and therefore checks were not completed. They said that responsibility for checking of this area now sits with a different team in closer proximity to the ward, and when the area is closed, this now recorded on the checklists.
- It is good practice to record and change airway breathing circuits daily (Association of Anaesthetists 2008), and we observed the theatre department used a checklist to record checking of anaesthetic machines. Records we reviewed provided assurance that the machines had been checked daily.
- During our inspection, we observed that staff had suitable access to a difficult airway trolley. However, records we reviewed did not provide assurance this was checked on a weekly basis, as per the unit procedure.
- Staff we spoke with said that they had adequate stocks of equipment and we saw evidence of stock rotation.
- We looked at thirteen pieces of equipment and found them to have been safety tested within review dates.
- We checked five pieces of equipment including blood pressure machines, infusions pumps, and suction machines. All equipment had visible evidence of safety testing and when servicing was next due. We saw that point of care testing equipment was regularly calibrated and checked.
- In the theatre suite, we found clinical equipment was stored with linen. It is good practice to store these separately, and we escalated this at the time of the inspection.
- We also found that cleaning chemicals were left unsecure in the sluice in theatres. These chemicals are hazardous for health, and the inspection team were concerned they could be harmful to patients or visitors who might access the room by mistake. Following our inspection, senior leaders provided a statement that described the theatres were security controlled, patients or visitors would always be accompanied within theatres, and the sluice was within a staff only area. However, that they recognised that additional security would provide assurance, and had rectified this with a lock on the sluice room door as an additional measure for controlling access.

Requires improvement

Surgery

Assessing and responding to patient risk

- **Staff did not always complete and update risk assessments for each patient.**
- We saw that patients who had undergone surgery were not always reviewed daily, or prior to discharge, by a consultant (see safe, records section). In addition, CQC were alerted to three venous thromboembolism (VTE) notifications in 2018, and we saw a lack of daily consultant review featured as a common theme. Venous thromboembolism (VTE) assessments we reviewed during our inspection showed not all patients were assessed fully. Actions required for patients identified as being high risk were not always documented, as per hospital policy.
- Following our inspection, senior leaders reported that they had identified VTE risk assessment compliance as a concern, and had appointed two VTE champions, and had put local protocols in place for escalating any patients considered high risk.
- We reviewed VTE risk assessment audit data for quarter one to quarter three (January to September) of 2018 and found fully completed VTE risk assessment compliance was 90% on average over the period; against a target of 95% and above. Following our inspection, we were provided with a VTE action plan; however, we did not feel this was sufficiently robust (see effective, evidence-based care and treatment section). Nevertheless, data subsequently provided showed audit compliance for VTE risk assessment was 100% for quarter four (October to December) of 2019, and for quarter one (January to March) of 2019.
- We reviewed risk assessments; including for pressure damage acquisition, malnutrition, falls, bed rails, moving and handling, and we found these were completed on most, but not all, occasions.
- Staff used the national early warning score (NEWS) tool to recognise deteriorating patients. Nursing staff we spoke with could articulate how they would recognise a deteriorating patient using the tool and were able to describe when they would escalate to medical staff. We reviewed four sets of medical records which showed NEWS data had been entered appropriately. No patients had required escalation in the records we reviewed.
- However, we reviewed NEWS audit data for quarter one to quarter three (January to December) of 2018, and found the record keeping audit score NEWS full compliance score was 87.3% on average over the period (ranging between 69% and 99%); against a target of 95% and above. Over the same timeframe (quarter one to quarter three (January to September) of 2018), audit data showed patient temperature recording compliance on NEWS (in theatre and recovery) was 71% on average; against a target of 95% and above. Compliance was reported as 60% for quarter one, 85% for quarter two, and 68% for quarter three of 2018. We were not aware of a NEWS action plan being implemented to address these issues at the time of inspection.
- Following our inspection, senior leaders informed us there was “no action plan in place at the time of inspection as action had already been taken to address non-compliance”. They said that staff had completed additional NEWS 2 training as part of mandatory clinical study days. We reviewed this training data and saw that most eligible staff (over 60%) had completed clinical study day one and/or two training between March and September 2018, and the remainder had done so before December 2018.
- However, we reviewed the quarter four (October to December) clinical quality report (dated to April 2019), and observed incomplete actions with respect to NEWS implementation and improvement. For example, it stated that “… for 2019 we have agreed for NEWS 2 to be as follows: Embedding the NEWS2 in practice as the recommended tool for identifying deterioration (including sepsis) in in-patients and ensuring accurate use and trigger processes. This will be picked up within the resus training and management of the deteriorating patient. We do need further assurance regards our compliance as this has featured in some of the RCA analysis over the last 12 months.” In addition, with respect to temperature control monitoring, that “we are still non-compliant in this measure in theatre. The theatre team are looking at implementing an electronic system for the recording of all patients’ temperatures whilst in theatre and recovery areas of the hospital. There had been some improvement but whilst we are using agency staff in theatres there is some risk of

non-compliance. The theatre manager has completed an action plan to improve the recording of temperatures in theatres and it is discussed in the team hugs and departmental meetings".

- Data provided post-inspection showed NEWS temperature recording compliance was 83% in quarter four (October to December) of 2018; against a target of 95% and a network average of 85%. Senior leaders reported temperature recording compliance had improved to 95% in quarter one (January to March) of 2019. We saw the record keeping audit score NEWS full compliance score was 88% in quarter four (October to December) of 2018, against a target of 95% and a network average of 93%". During our inspection, we saw swab boards were used in theatre to record swab counts. Staff also used a paper record, which was attached to the patient's notes. We observed two occasions when the World Health Organisation (WHO) five steps to safer surgery checklist was in use, and on both occasions found it was effective and used appropriately. We also reviewed four sets of completed checklists in patient records, and saw that these were completed appropriately.
- We reviewed internal WHO surgical safety checklist observational audit data, where staff were watched during surgery to see how well they complied with the steps to safer surgery checklist. These results showed 100% compliance for all quarters of 2018.
- We reviewed internal WHO surgical safety checklist documentation audit data for 2018, where patient records were checked after surgery to see if the steps to safer surgery checklist had been complied with. 10 individual records were audited each quarter. We saw overall compliance ranged from 92% to 98% across 2018. Of the 18 measures audited, we saw that 14 areas were 100% compliant across all four quarters of 2018. Main areas found non-compliant related to ensuring the consent form had been fully completed, dated and signed; pre-operative checks; and ensuring 'sign-in, 'time-out' and 'sign-out' sections were signed, with name and time entered. With respect to the 'has consent form been fully completed, dated & signed?' parameter, we saw 40% compliance recorded in quarter one (January to March), 50% compliance in quarter two (April to June) and 30% compliance recorded in quarter three (July to September) of 2018; however, no associated actions were entered on the attached action plans. We saw this parameter had risen to 90% in quarter four (October to December) of 2018. In the quarter three (July to September) of 2018, we saw preoperative checklist compliance was 30%; this had risen to 100% in quarter four (October to December) of 2018. Patient safety briefings were carried out pre-operatively these included introductions from the clinical team, the order of the list, additional equipment anticipated.
- We saw a management of sepsis policy was in place, and the service had a Staff we spoke with said that they had received sepsis training and could articulate the signs of sepsis and were aware of actions required for escalation and treatment.
- Clinical staff undertook regular simulated scenarios, including cardiac arrest call, major haemorrhage and stabilisation in theatres. Two units of blood were available on site, should patients require emergency transfusion. Staff within the hospital had access to a major haemorrhage trolley.
- A registered medical officer (RMO) was on duty 24 hours a day, seven days a week to respond to any concerns staff might have regarding a patient's clinical condition.
- The hospital had a service level agreement with a local NHS trust to transfer adult patients in the event of an emergency or if a deteriorating patient required an increased level of care.
- The hospital operated a 24-hour, on call service for unplanned returns to theatre; a team was available to attend within 30 minutes.
- During our inspection, records we reviewed showed that patients were assessed for surgery in accordance with effective pre-assessment pathways. We saw a pre-operative assessment standard policy document and elective adult surgical admission criterion policy document; which set forth eligibility criteria for admission into the hospital for surgery, were in place.
- At discharge, patients were given contact details for both wards and should they have any concerns. Survey data for quarter one to quarter three (January to September) of 2018 showed an average of 95% of patients felt they were told who to contact if they were worried about their condition or treatment.

Nursing and support staffing

- **The service had enough nursing staff to keep patients safe and provide the right care and treatment.**
- Across the hospital, there was 72 registered nurses; 50 of these were contracted by the hospital, and 22 were bank staff. Most registered staff worked on wards (46) and in theatres (16). The remainder (10), worked in children and young people's services. Data provided by the hospital showed eight vacancies for contracted staff across the hospital; three vacancies on the wards, four in theatres, and one in children and young people's services.
- Following our inspection, data showed that between November 2017 to October 2018, there was a 6% staff sickness rate across ward and theatre staff.
- Over the same period, data showed there was a 5.4% turnover rate among ward staff, and a 17.4% turnover rate among theatre staff. Hospital targets for staffing measures were not supplied. However, following our inspection, senior leaders provided data that showed the average turnover rate across all Spire hospitals for theatre staff in 2018 was 19.5%. As such, the theatre staff turnover rate for the location was below the peer group average. Over the same timeframe, data showed the proportion of staff hours per month undertaken by temporary (bank and agency staff) was 3.4% on wards and 9.6% in theatres.
- Staffing requirements were planned a month in advance and then reviewed on a weekly basis, once the numbers of cases/inpatients were confirmed for that period.
- We saw wards used a safe staffing tool which considered the number and type of admissions, and incorporated patient acuity (including, patients' NEWS scores) and dependency needs. At the time of the inspection, the ratio was one registered nurse to seven patients.
- A weekly capacity meeting was held to review the following week's activity and plan staffing levels accordingly. Staff were flexed according to patient need and bank staff were utilised when required to ensure the appropriate number of staff were on duty.
- Staff held two site meetings every morning, Monday to Friday. The "ten at ten" meeting included ward managers, theatre manager, the RMO, matron, lead pharmacist and clinical services manager. During the meeting, we observed members present reviewed the number of inpatients, expected admissions and discharges. Staff we spoke with said that staffing levels, patient dependency and staff to patient ratios were discussed at the first site meeting and only escalated to the "ten and ten" huddle, if required.
- Within the theatre suite, we saw a poster explaining when staff needed to escalate staffing concerns and complete incident forms. Staff we spoke with said that staffing issues were discussed at the huddle meetings. We also saw an allocation of staff board which clearly showed which staff were on duty and who held which grades of paediatric and adult life support training.
- We observed a ward handover, and heard staff share appropriate clinical information and discuss plans for further care.

Medical staffing

- **The service had enough medical staff to keep patients safe and provide the right care and treatment.**
- All patients were admitted under the care of a named consultant. As of January 2019, 303 consultants had practising privileges at the hospital; of these, 93 consultants had children and young people admitting rights. The term "practising privileges" refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there.
- From 01 November 2017 to 31 October 2018, 133 consultant surgeons actively admitted patients for surgery at the hospital, and 74 anaesthetists had practising privileges.
- Data showed that over 99% of medical staff had their registration validated in the last 12 months; and were recorded as having all five mandatory documents (medical indemnity insurance, appraisal, biennial review, disclosure and barring service certificate, and Hepatitis-B vaccination) in place.
- Consultants were responsible for the care of their patients from the pre-admission consultation until the conclusion of their episode of care. The hospital required them to review patients at weekends and were accessible out of hours.

- Consultants nominated a colleague to provide cover when they were not available. We saw a list of consultant cover on ward two.
- Two registered medical officers (RMO) were contracted by the hospital. There was a RMO on-site 24 hours a day, seven days a week; and a weekly rotation with a Monday handover. There was provision of an on-site residence for the RMO.

Records

- **Records were securely stored. However, we saw staff did not consistently keep detailed records of patients' care and treatment.**
- Following our inspection, we received medical records audits undertaken by the surgery core service; which showed records were audited for completeness. Results were also reported via the provider's clinical scorecard.
- As described earlier (see, assessing and responding to risk section), we observed mixed levels of VTE risk assessment completion at inspection, and audit data showed VTE risk assessment and NEWS documentation compliance did not meet hospital targets. Whilst we saw good overall compliance with WHO surgical safety checklist documentation, we also saw elements of WHO surgical safety checklist documentation audit data were non-compliant; for example, with respect to ensuring consent forms, and 'sign-in, 'time-out' and 'sign-out' sections were fully completed.
- We also saw that non-compliance with completion of consultant medical records was a reoccurring theme in incident records and investigation reports we reviewed. Following our inspection, we observed non-compliance with completion of consultant medical records (including nil entry recorded) featured in the medical advisory committee (MAC) (a meeting run by nominated consultants and the location senior management) and clinical governance committee (CGC) meeting discussions. Senior leaders recognised that performance in this area was poor in these meeting minutes.
- We reviewed clinical scorecard daily patient record audit data for quarter one to quarter three (January to September) of 2018 and found compliance for 'fully signed and dated consultant entries' was 82% on average (ranging between 58% and 90%) over the period; against a target of 95% and above.
- Following our inspection, senior leaders reported that had implemented several methods to improve compliance over the course of 2018, such as sending letters highlighting the issue to consultants, and reissuing the consultant handbook. They reported compliance had risen to 92% in the quarter four (October to December) 2018 audit. To provide additional assurance going forward, senior leaders reported that continued non-compliance would be incident reported; and fed through to the consultant's responsible officer and appraiser.
- We reviewed incident data for November 2017 to October 2018 and saw 51 entries (7% of all incidents reported over the period) were categorised as 'documentation/patient information' or 'clinical documentation' incidents. Of these, most (34, 67%) related to entry of 'inaccurate or wrong details'.
- We reviewed the hospital risk register, which was provided following our inspection. We saw a risk entry had been added February 2018 for "a risk of non-compliance of Spire policy that may result in patient harm"; which was last reviewed September 2018 and was risk-rated six. Under 'key controls' we saw an entry which read "medical records audit … have improved this"; we saw no gaps in controls or assurance were identified ("none at present" was recorded).
- At inspection, we saw patient records were all stored in an office behind the nurse's station. The door was operated by a restricted access keypad and notes stored in a lockable trolley ensuring that when the desk was unattended, records were safety and securely stored.
- In the five sets of patients records we reviewed, we saw records held appropriate nursing staff risk assessments and associated individualised plans of nursing care; for example, in relation to pressure ulcer prevention and falls risks. On most occasions, we found staff used black ink, legible handwriting and documentation had occurred at the time of review or administration of treatment.

Medicines

Requires improvement

Surgery

- **The service did not always follow best practice when prescribing, giving, recording and storing medicines.**
- We observed controlled drugs and medicines were stored securely on wards we visited, with access to controlled drugs restricted to authorised staff. There were no discrepancies in controlled drug register entries reviewed during our inspection.
- We reviewed controlled drug audit data submitted by the hospital. Data for ward one showed 94% compliance for quarter two (April to June) and 92% compliance for quarter three (July to September) of 2018. Non-compliant elements predominantly related to legibility of entries and clear marking of entries made in error.
- However, controlled drug audit data for theatre two showed 82% compliance for quarter two (April to June) and 80% compliance for quarter three (July to September) of 2018. In addition to non-compliant legibility and clear marking of errors, auditors found many entries only had a single signature by a consultant, and there were multiple instances of non-compliance for two signatories.
- We reviewed hospital incident data for the period November 2017 to October 2018 and saw there had been 22 medication errors reported. Of these, we saw 10 entries related to prescribing, dispensing or document compliance errors; six entries related to management and secure storage of medicines; and three entries related to administration errors. We saw that managerial staff had taken action in response to these incidents, and the individuals involved had been spoken with. However, there was not always evidence of wider learning to prevent reoccurrence.
- Following our inspection, we reviewed a hospital-wide pharmacy interventions audit, undertaken from October to December 2018. The aim of the intervention was to refer to any instance in which a member of the pharmacy team queried a prescription or prospective course of treatment with the intent to clarify, confirm or alter the proposed drug regime to safeguard or benefit the patient. Over the reporting period, 72 prescriptions were challenged. We saw incorrect or incomplete prescribing by the RMO (17, 21.25%) and consultants (12, 15%) collectively accounted for just over 36% of the interventions recorded. Interventions made by pharmacy where the prescription was correct but the pharmacy team thought the patient would benefit from a different drug regime accounted for nearly 14% of interventions (10). We saw an appropriate action plan had been developed and further audit was planned based on the findings.
- Data were submitted for a storage and security of medicines audit of ward two, undertaken December 2018. Of 21 applicable observations, 14 (67%) were found compliant and seven (33%) were found to be non-compliant. Non-compliant findings included, migration of patient own drugs into stock, medicine trolleys were found locked on the ward unattended but with no anchor point available during the day, a number of strips of loose tablets and capsules with no outer packaging, expired liquid medication, and oxygen cylinders stored on the floor with wall mounts empty. We saw an action plan had been developed based on the audit findings. Following our inspection, senior leaders reported that the December 2018 (ward two) audit was a baseline national audit, and the first time this had been completed at the hospital. They also provided evidence to show that compliance had improved and was 83% as of January 2019.
- During our inspection, we saw medicines were appropriately and securely stored on the majority of occasions. However, we observed an unattended box of medicines left on the nurse's station, within theatres. This was immediately rectified by a member of staff upon being highlighted by the inspector.
- In the theatre suite, we saw that some medicines (such as intravenous flushes, and saline and water for injection) had been removed from original packaging. Ensuring the use original packaging of medicines is recognised as an added measure of assurance in the selection and checking process. Following our inspection, senior leaders reported that despite not being in their original packaging, the items were individually labelled and logically stored for selection.
- Pharmacy services were available seven days a week, with an on-call service available out of hours. The RMO was able to access pharmacy and supply medicines out of hours. There was a policy for the management of medicines that covered all relevant areas.

- Staff within theatres had access to both paediatric and adult resuscitation medicines.
- During our inspection, we reviewed the medicine administration records of five patients on a surgical ward. We saw arrangements were in place for recording the administration of medicines, and allergies were clearly documented.
- The drugs' fridges we reviewed showed there was a process in place to record daily fridge temperatures. We saw minimum and maximum fridge temperatures were recorded daily and were within the correct range.
- The pharmacy team carried out audits of the storage of medications and controlled drugs. Findings were fed back to the hospital's medicines management committee, which was chaired by representatives from the pharmacy department.

Incidents

- **There was a deficit in the identification, classification, and management of patient safety incidents; and there was not sufficient learning from incidents. The service failed to meet duty of candour obligations consistently well.**
- Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. Data provided post-inspection showed there had been no never events in surgery within the reporting period November 2017 to October 2018. However, we saw that two never events had occurred since our last inspection of the service. A wrong site anaesthetic block had occurred in May 2017, and a wrong (size) implant insertion had occurred in October 2017.
- Following our inspection, we reviewed hospital incident data for the period November 2017 to October 2018 and identified two additional incidents that warranted consideration of classification as never events.
- One incident had occurred in early 2018 and had been classified in the incident log as a "missing item post-procedure (never event)". The incident entry described that despite several re-counts an arterial clamp could not be located. The patient was x-rayed on the table, and the clamp did not appear to be present in the patient. The clamp was never located. We saw the patient had been informed about the incident, and the event had been declared a serious incident requiring investigation. The incident was reviewed at serious incident panel in April 2018 and was discussed at clinical effectiveness committee (CEC) and MAC meetings in May 2018.
- We saw another incident had occurred in Spring 2018, which had been classified as a "never event / potential never event" in the incident log. It concerned a case where, upon taking the final count following surgery, a needle was found to be missing. The incident entry described that the wound and surrounding areas and drapes were all checked. X-ray of the patient was discounted, as it was considered that the needle would not be detected. The missing needle was not found (please see below for further details). We could not find evidence that the incident had been declared a never event or adverse incident; nor did we see discussion of the case in committee meeting minutes we reviewed.
- The hospital had an incident policy, which staff accessed through the intranet. This provided staff with information about reporting, escalating and investigating incidents. The hospital had an electronic reporting system in place and staff we spoke with could describe how they would report and escalate incidents. However, we found that the service failed to identify, classify and manage incidents consistently well.
- In accordance with the Serious Incident Framework 2015, serious incidents (SI) are incidents that require further investigation and reporting. In line with this framework, the hospital's Incident Reporting Policy (June 2018).
- Following our inspection, we asked senior leaders to provide data about the number and nature of serious incidents that had occurred from November 2017 to October 2018. However, we found the data submitted was ambiguous. The spreadsheet provided included a 'count of incident type' column, and a 'grand total'; which detailed 40 incidents had been recorded. However, we observed from reference numbers that some incidents appeared to have been counted more than once. Within the records, we also observed notes entered alongside data points which questioned the

inclusion or exclusion of incidents as SIs. For example, "…doesn't sound like hospital error so if include explain?", and "Raised as SIRI but not DOC [duty of candour] and RCA [root cause analysis] not required. Exclude?"

- Post-inspection, senior leaders said that the serious incident data provided was submitted in error; and they summited a more complete document detailing these incidents (which had been classified under the Spire framework as serious incidents requiring investigation (SIRIs)). They said that incidents meeting NHS-England serious incident framework criteria were monitored and reported weekly to Spire's executive committee and were available on request. However, this data was not provided to CQC following our original request for this information, nor was it provided in support of senior leaders' factual accuracy responses.
- Following our inspection, senior managers provided us with an incident log for the period November 2017 to October 2018. We saw a total of 731 incidents had been reported across the hospital in this time frame. Of these, we saw that in 544 cases (78%) no harm ('none') was reported, in 83 cases (11%) low harm ('minimal harm caused') was reported, in 73 cases (10%) moderate harm (short term harm caused) was reported, and in one case (less than 1%) an (expected) death was reported. No cases of 'severe' harm were reported.
- We analysed incidents where severity was recorded as 'moderate harm', and found most incidents related to surgical site infection (15, 21%), unplanned returns to theatre (12, 16%), unexpected or unplanned transfers (eight, 11%), unplanned admissions within 31 days of discharge (eight, 11%), and healthcare acquired venous thromboembolisms (VTEs) (six, 8%).
- We were not assured that appropriate levels of harm were consistently attributed to or recorded against incident records. Where possible, we cross-referenced the 'SI log' with the incident data log (both provided by hospital staff), to see what level of harm was recoded. We were able to do this for 38 'SIs'. We saw that of the 38 SIs, 13 (34%) were categorised as 'moderate harm', 16 (42%) were categorised as 'no harm', eight (21%) were categorised as 'low harm', and one (3%) related to an (expected) death on the incident log.
- We reviewed 'SIs' classified as no and low harm on the incident log and found multiple instances in which the wrong severity classification appeared to have been applied to the record.
- Likewise, when we reviewed the incident data log, we identified several incidents which were categorised as low/no harm, but appeared to warrant SI (minimum moderate harm) status and had not been classified as such.
- We also identified cases that had been raised as complaints, that we could not identify a corresponding entry for in the incident log. For example, regarding a patient's surgery being delayed causing them to dehydrate and resulting in an overnight stay. Following our inspection, with respect to this specific case, senior leaders said that the case had been fully investigated and actions had been taken to prevent recurrence, details of which had been shared with the patient for reassurance. They said the case had retrospectively been reported appropriately on Datix to ensure data accuracy.
- Prior to our inspection, we became aware of a sizable (and growing) cohort of patients who had their cases independently examined as part of a performance review committee (PRC) hearing; or who had complained about receiving potentially unnecessary or ineffective treatments and surgical interventions. In an interview with senior leaders during our inspection, we were informed that patient cases to date had been incorporated under a single incident reference. They said a serious incident requiring investigation (SIRI) had not yet been triggered from the case(s). However, we reviewed the incident document, and saw it (originally) stated a SIRI was triggered, and the incident was reportable to external agencies, including CQC. It also stated moderate (short term) harm had been caused. In later addendums, we saw that investigation, RCA, external notification, and DoC requirements had been postponed (in all cases) until the final outcome of the PRC; and pending legal review. In the period between CQC being made aware of the situation and our responsive inspection, managerial staff submitted 13 SI notifications to CQC within a three-day period. We found that the service did not declare cases as SIs and failed to notify CQC in a timely manner.

- The hospital's incident reporting policy stated that if an incident was graded as serious an investigation would be undertaken by a person independent of the location of the incident using RCA investigation procedures.
- Following our inspection, we asked senior managers to provide the last five completed SI RCAs for the surgery core service. We found that one of the 'SIs' related to an investigation of a fall. We also noted that the 'SI', despite being included in the incident count, was labelled as "not a[n] SI" on the SI summary spreadsheet provided.
- The other four RCAs provided related to emergency transfers of patients to other (NHS trust) hospital sites. One RCA did not identify any learning from the events and therefore no actions were required. Within the remaining RCAs, we saw variable completion of RCA document sections, and action plans. In associated action plans we saw recommendations, problem encountered, action required, review lead name, progress update and expected evidence sections adequately completed, overall. However, a number of due dates were reported as "ongoing", "ASAP", or had no text entered; and completion dates were often absent. Consequently, we were not assured that lessons learned from these incidents had been completed and embedded.
- The terms of reference (ToR) for the clinical effectiveness committee (CEC), clinical governance committee (CGC), and the theatre users' group (TUG), included the review and discussion of all serious adverse events (SAEs) incidents and near-misses, to ensure full investigation, analysis and learning takes place. We reviewed meeting minutes from these groups for a 12-month period and found limited evidence of discussions about learning from hospital incidents and complaints. We saw that 48-hour flash reports (detailing significant incidents at other Spire locations) were a standing agenda item for discussion in CEC meeting minutes.
- Staff we spoke with said that managers shared learning from local incidents at team meetings in the wards and theatre suite, and findings were shared at one-to-one meetings with their managers. Following our inspection, senior leaders said that learning from local incidents was also shared during daily huddles and in staff newsletters. They also said learning posters had been introduced to share learning in a timely manner, and these were displayed on staff notice boards in all key areas.
- The hospital had a corporate 'Duty of Candour Policy: Informing patients or their representative(s) about unintended or unexpected incidents', which was due for review September 2020. We also found that explanatory leaflets about Duty of candour (DoC) produced by 'Action against victims of medical accidents' and endorsed by CQC, were readily available in the service. DoC is a regulation that relates to openness and transparency. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information, and an apology when things go wrong.
- Staff we spoke to on wards and in theatres said that they were open and honest with patients if things went wrong. However, we found senior leaders had failed to consistently fulfil their duty of candour obligations.
- During our inspection, we reviewed all incidents graded moderate or above (provided by managerial staff, using Spire 'SIRI' classifications) for the period November 2017 to October 2018; and we identified incidents where we might expect DoC to apply. Following our inspection, we requested seven of these incident reports at random. Summary information provided alongside the incident reports described DoC had been applied in two cases, and that four of the incidents did not require DoC; no commentary as to DoC obligation was provided for one incident. We reviewed five incident reports where hospital staff informed us DoC had not been applied or where no comment had been made. Of the five incidents, we found two incidents had triggered a SIRI and the documents noted that DoC applied. In a further two incidents reviewed, we saw 'DoC reporter disclosure' sections (outlining what consultants had told the patients') had been completed. In one case, DoC obligations could not be determined due to lack of information within the incident report.
- Post-inspection, senior leaders reflected on how they could improve on the consistency of how they captured DoC considerations in the future. They confirmed that of

the seven cases submitted, DoC had been formally triggered in three cases, and the remaining four cases had been reviewed to ensure there were no issues in the application of duty of candour in those cases.

- Following our inspection, we identified an incident in the data log that referred to a missing needle post-surgery, and which was classified "never event / potential never event" (as described earlier). We saw from the log that the reporter had disclosed the event to the MAC chair, who had advised that the staff member involved needed to advise the patient, if they had not already done so. A further note entry (at an undetermined time later) showed that when the reporter had spoken to the staff member, the staff member had described attaching the needle to a sponge and remembered seeing this on the scrubs nurse trolley. Therefore, there was (as directly reported in the log) "no need to tell the patient". We could not see further escalation of the incident in data; nor did we see discussion of the case in MAC, CEC, or CGC meeting minutes we reviewed.
- We found that DoC obligations had not been consistently met with respect to a cohort of patients who had their care reviewed as part of a professional review committee (PRC) hearing; or who had complained about their care and treatment. We reviewed an extensive amount of information provided by senior managers before our inspection and following our inspection. Within this, we saw initial response letters were often misleading as to the employment status of a staff member involved. We also saw examples of follow-up hospital responses where complainants' questions had not been addressed at all or had been unsatisfactorily answered. We identified that some ('test case') patients who had their care reviewed by an independent surgeon as part of the PRC hearing (but who had not complained to the service and were unaware of concerns raised about their care and treatment) were only informed of this approximately five to six months after their case had been reviewed. There was also a lack of timely disclosure as to the findings from independent reviews provided in writing to complainants. Senior managers had later offered affected patients a meeting with the hospital matron and a clinician who had not been involved in their care, so that reports and reviews could be discussed, and to give patients the opportunity to ask questions. We saw that senior managers had recently begun to issue relevant patients with independent review findings in writing; hospital correspondence indicated these were summarised versions. We asked senior managers to provide us with all correspondence in relation to these cases, however, patient copies of 'summary' findings were not provided to CQC; therefore, we could not assess their transparency or quality.
- We were not assured that senior leaders had acted swiftly or thoroughly enough to identify other patients who might be affected. Following our inspection, the General Medical Council (GMC) were formally made aware of the issue (a written referral was submitted by senior leaders) and had launched an independent investigation.

Safety Thermometer (or equivalent)

- **The service displayed safety monitoring results. Staff collected safety information and shared it with staff, patients and visitors.**
- The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.
- An equivalent version of the safety thermometer was used in the hospital, utilising a dashboard for standards of care for wards and for theatres. Daily assessments were completed by a registered nurse using a rounding tool; we reviewed the tool and found it included appropriate parameters. Assessments were completed on each patient as part of an hourly or two-hourly rolling assessment programme. Results were then collated and red, amber, green (RAG) rated.
- Collated ward results for December 2018 showed results for falls, pressure ulcers, use of the malnutrition universal screening tool (MUST) tool, pain scores, continence, food and drink, record keeping, and signposting of patients to alcohol misuse and smoking cessation services were rated green. There was one amber result, as there had been one VTE incident. Following our inspection, senior leaders reported that the hospital also contributed to the local safety thermometer with other providers.

Requires improvement

Surgery

- We saw there was a welcome to theatre quality and safety board. The format was four representative 'safety crosses' for never events, five steps to safer surgery, staffing and avoidable cancellations. These results were presented in a pictorial format available in public areas so that they could be viewed by patients, as well as staff. The pictorial representations were easy to understand, and we saw they had been signed off by senior members of staff, and month dated.

Are surgery services effective?

Requires improvement

Our rating of effective went down. We rated it as **requires improvement.**

Evidence-based care and treatment

- **The service often provided care and treatment based on national guidance; however, the service had not adhered to national VTE prophylaxis guidance consistently well.**
- In most instances, we saw that patients' treatment was based on national guidance, such as National Institute for Health and Care Excellence (NICE), the Royal College of Anaesthetists, and the Royal College of Surgeons guidance.
- Of the policies and guidelines in use within clinical areas we reviewed, all were found to be compliant with NICE guidance. Policies and guidelines were stored on the intranet and staff we spoke with could access them.
- During our inspection, we reviewed some surgical service clinical protocols and patient pathways used for patients on surgical wards; for example, operation pathways. We saw the service used standardised care pathways for specific procedures; for example, for hip and knee replacements.
- Wards and departments we visited participated in local audit programmes, and we saw key audit results were displayed in public areas using the hospital's safety cross system, described earlier in this report (see 'Safety Thermometer (or equivalent)' section).
- We reviewed the clinical audit programme for 2018, which detailed the type and level of audits required over the period. Audits were subdivided by organisational dashboard audits (centrally collated), organisational mandated audits, audits stipulated in Spire operational policies, mandated external clinical and non-clinical audits, recommended audits, and local audits.
- The hospital participated in national clinical audits including, patient reported outcome measures (PROMS), Commissioning for Quality and Innovation (CQUINS), and the National Joint Registry (NJR).
- Compliance with best practice guidelines was audited quarterly and clinical scorecards to monitor effectiveness. Examples of indicators audited included, VTE risk assessment compliance, unplanned return to theatre, theatre starves times, prosthesis best practice and surgical site infections in hip and knee arthroplasty. We saw areas rated as red were discussed at the weekly Clinical Effectiveness Committee (CEC), and at Clinical Governance Committee (CGC).
- Senior managers produced quarterly actions plans, which identified areas where audit results and progression were found to be under target (categorised as amber or red). We reviewed the clinical governance scorecard action plan for quarter three (July to September) of 2018. It detailed a description of issues (areas under target), required action, staff leading on actions (person responsible), who the task was assigned to, completion date, learning that had taken place, and comments. However, we found the actions were inconsistently completed and learning descriptors were predominantly reiterations of current practice or actions undertaken.
- Patients assessed to be at risk of venous thromboembolism (VTE) should be offered VTE prophylaxis in accordance with NICE guidance (NICE QS3 Statement 5). We reviewed hospital VTE prophylaxis audit data for quarter one to quarter three (January to September) of 2018. We found the average proportion of eligible hip and knee arthroplasties where chemical VTE prophylaxis was prescribed was 87% over the period (ranging from 70% to 100%); against a target of 95% and above. The proportion of eligible hip and knee arthroplasties where chemical VTE prophylaxis was given within the recommended timescale was 10% over the period (ranging from 0% to 20%); against a target of 80% and above. The proportion of compliant VTE

prophylaxis courses (where prescribed) were given for recommended timescales was 87% over the period (ranging from 70% to 100%); against a target of 95% and above.

- Following our inspection, senior managers provided us with a VTE prophylaxis action plan, dated to October 2018. It detailed eight items, and associated actions agreed within each. We found the action plan was not sufficiently robust. In the 'when' column, one action was reported as 'in place', and the remaining actions were noted as 'ongoing'. In the 'who' column, we saw entries such as "wards" and "all".
- Post-inspection, the trust informed us that they had reviewed and revised prescribing and administration of VTE chemical prophylaxis practice and had aligned this with NICE guidance; and this was implemented October 2018. Senior leaders submitted additional audit data that showed 100%, 90%, and 100% compliance had been achieved, respectively, for the three measures described above in quarter four (October to December) of 2018; and they reported all three measures showed 100% compliance for the first quarter (January to March) of 2019.The service had achieved Joint Advisory Group (JAG) GI endoscopy accreditation in April 2017.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health following surgery, and during inpatient stays. However, we saw patients were often fasted for excessive periods of time before surgery.**
- During our inspection, we saw staff used the malnutrition universal screening tool (MUST); which was used to identify patients at risk of malnutrition, weight loss or those requiring extra assistance at mealtimes. Patient records we reviewed showed good levels of completion.
- Pre-admission information for patients provided them with clear instructions on fasting times for food and fluid prior to surgery. Current guidance recommends fasting from food for six hours and fluid for two hours. During our inspection, records we reviewed showed that patients had adhered to fasting times prior to surgery going ahead. However, on three out of four occasions we observed that patients had fasted for too long; for example, for between 8 and 10 hours prior to undergoing surgery.
- We reviewed fasting audit data for quarter one to quarter three (January to September) of 2018 and found the proportion of patients fasted within guideline was 22% on average over the period (ranging from 10% to 30%); against a target of 65% and above.
- We examined incident data for the period November 2017 to October 2018. We saw that most 'fasting time' incident entries related to cancellation or postponement of surgery, because patients had not fasted correctly. We could only identify four instances in which patients had been fasted for excessive periods of time.
- We saw evidence of 'starve times' being discussed in theatre user group, clinical effectiveness committee, and at clinical governance committee meetings; over a 12-month period. We were provided with a fasting action plan, dated to October 2018.
- Following our inspection, senior leaders reported that work continued to optimise fasting times for patients, and that VTE champions had been appointed to the pre-assessment and ward teams to further promote optimal fasting. They submitted data to show compliance with fasting times had risen to 40% in quarter three (October to December) of 2018, and to 45% in quarter one (January to March) of 2019; against a target of 65%.
- In clinical effectiveness committee meeting minutes, we saw a case had been raised about a patient's surgery being delayed causing them to dehydrate, and this had resulted in an overnight stay (please see safe, incidents section).
- All patients we spoke with said that the food was good and that the water was replenished daily and as required. One patient said that they had "lots of choice", and another patient said that "choices were excellent".
- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted the hospital scored 98% for the food and hydration domain, which was better than the 90% England average.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain**.
- During our inspection, we saw patients being offered pain relief. Patients we spoke with said that staff offered them pain relief at regular occasions and that staff checked that pain relief administered had been effective.
- We observed staff using pain scoring tools to assess patients' levels of pain; staff recorded this information on the NEWS record.
- Clinical scorecard data for quarter one to quarter three (January to September) of 2018 showed average compliance of recording pain scores with every set of observations was 93% on average (ranging between 88% to 100%); against a target of 95%.
- Following our inspection, senior leaders reported they had introduced two new mandatory training days for staff in 2018, which included record keeping and documentation to improve these results.

Patient outcomes

- **Staff monitored the effectiveness of care and treatment and benchmarked data against Spire peer group averages, and some national measures, to monitor performance.**
- We reviewed data from November 2017 to October 2018 and saw there were 8282 (adult patient) visits to theatre and 15 unplanned returns to theatre within the same in-patient episode (equating to 0.18 returns per 100 visits, or 0.18%).
- Following our inspection, senior leaders provided data that showed for 2017 (across the full year) Spire Leeds hospital reported 0.14 returns per 100 theatre visits, compared to a peer group average of 0.12.For 2018 (across the full year), Spire Leeds hospital reported 0.16 returns per 100 theatre visits (12 incidents), compared to a peer group average of 0.11.
- In the same reporting period, we saw there were 12 unplanned transfers of inpatients to other hospitals for a higher level of care; this equated to 0.12 unplanned transfers per 100 discharges (0.12%), or 0.14 unplanned transfers per 100 theatre visits (0.14%).
- Following our inspection, senior leaders provided data that showed for 2017 (across the full year) Spire Leeds hospital reported 0.06 unplanned transfers to a higher level of (two or three) care to another provider per 100 discharges, compared to a peer group average of 0.05. For 2018 (across the full year), Spire Leeds hospital reported 0.04 unplanned transfers to a higher level of care in another provider per 100 discharges, compared to a peer group average of 0.05. Level two care relates to patients who require more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. Level three care relates to patients requiring advanced respiratory support alone or monitoring and support for two or more organ systems; this is the highest level of care and includes all complex patients requiring support for multi-organ failure.
- Following our inspection, senior leaders provided information that showed there were 14 unplanned readmissions within 31 days of discharge in 2017. This equated to 0.14% of all discharges; and was below the national Spire average of 0.18%. Data for 2018 showed 21 unplanned readmissions within 31 days of discharge; equating to 0.21% of all discharges, which was the same as the national Spire group rate (0.21%).
- We reviewed incident data from November 2017 to October 2018 and saw there had been 93 unplanned inpatient admissions following day case surgery (this equated to 1.3% of all day case patients) and 21 unplanned readmissions within 31 days of discharge (this equated to 0.2% of all patients).We saw that 20 patients had an unplanned high dependency unit or critical care admission within following surgery (this equated to 0.2% of all patients admitted). Over the same reporting period, incident data showed 23 unplanned returns to theatre (data included one case that was categorised as a post-operative complication, but which involved a return to theatre).
- Following our inspection, we were provided with data that showed three surgical patients had experienced hospital-acquired VTE from 01 October 2017 to 31 September 2018 (quarter four 2017 to quarter three of

2018). One patient had done so in quarter one (January to March) of 2018 and two patients had done so in quarter two (April to June) of 2018; this equated to a rate of 0.04 and 0.08 per 100 discharges, respectively.

- We reviewed incident data for November 2017 to October 2018 and identified that four patients who had undergone surgery had experienced hospital-acquired VTE in this time frame; and three of these had done so from quarter four 2017 to quarter three of 2018.
- Data we reviewed showed that VTE incidence in hip and knee procedures was 0.71 in quarter one (January to March) 0.77 in quarter two (April to June), 0.48 in quarter three (July to September), and 0.52 in quarter four (October to December) of 2018. As of quarter four of 2018, the year to date rate was 0.52, which was slightly above the hospital target of 0.50, but below the group figure of 0.72.
- In the patient reported outcomes measures (PROMS) survey, patients are asked whether they feel better or worse after receiving hip replacements and knee replacement operations. Managers used clinical scorecards to monitor PROM participation. We saw PROMs participation for hip procedures (proportion of NHS baseline questionnaires completed) was 49% in quarter two (April to June) of 2018, and 77% in quarter three (July to September) of 2018; against a target of 70%. PROMs participation for knee procedures (proportion of NHS baseline questionnaires completed) was 66% in quarter two (April to June) of 2018, and 90% in quarter three (July to September) of 2018; against a target of 70%. Following our inspection, senior leaders submitted data that showed PROMs participation for hip procedures had fallen to 67% in quarter four (October to December) of 2018, and PROMs participation for knee procedures had fallen to 80% in quarter four (October to December) of 2018.
- Following our inspection, managers provided PROM data for hip and knee replacements. The data submitted showed health gain for hip replacement procedures was 23.4 using the Oxford Hip Score parameter (Dec 2016 to Dec 2018), which was better that the NHS average of 18.1.
- Health gain for knee replacement procedures was 14.6, which was lower than the NHS average of 19.1 using the Oxford Hip Score parameter (Dec 2016 to Dec 2018). The data submitted did not show other measurement parameters; for example, EQ-VAS and EQ-5D measures.
- We viewed the most recently available NHS Digital PROM data (reporting period April 2017 to March 2018), released August 2018. Data was not available for the hospital as the minimum threshold for national reporting, as set by NHS digital, had not been reached during the period in terms or eligible patient volumes.
- The hospital contributed data to the Private Healthcare Information Network (PHIN) to collate outcome data across the independent sector that was comparable with the NHS. Data was submitted in accordance with legal requirements regulated by the Competition Markets Authority (CMA). We noted that PHIN had scored the hospital as having "minimal participation" for measuring health outcomes, such as PROMs, for the period July 2017 to June 2018 (the most recent PHIN data period available). Following our inspection, senior leaders reported this was in part due to there being an issue with linking PROMs episode numbers to admitted patient care records received by PHIN and the provider was working nationally with their PROMs supplier to resolve this.
- In 2018, 95% of patients consented to the National Joint Registry (NJR) database, which was above the national average of 92.4%.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them.**
- Staff we spoke with during our inspection described the appraisal process as a valuable experience and felt their learning needs were addressed. They also said they were given opportunities to attend courses to further their development.
- Following our inspection, senior managers confirmed that annual appraisal compliance was 100% for eligible staff; with the exception for staff on long term-sick and parental leave.

- Three staff files we reviewed showed competence certification relevant to their area of work; including gaining consent, medicines, catheterisation and cannulation. Staff working as surgical first assistants had further training and competencies to undertake this role. Following our inspection, managers provided additional evidence of signed competencies for staff within the surgical service.
- Registered staff we spoke with confirmed they had been supported through revalidation by hospital management. Healthcare assistants we spoke with told us that they were supported by the provider in obtaining diploma qualifications, which they said helped with career progression and allowed them to provide more support to patients.
- We spoke with five healthcare assistants and registered nurses who told us they had been on a course that improved their ability to recognise and manage a deteriorating patient.
- We saw that the hospital employed a practice educator to deliver and train in mandatory subjects and scenarios; the practitioner was employed full-time but had only recently commenced employment at the time of inspection.
- New staff had an induction relevant to their role. Staff we spoke with said they had found induction comprehensive and it contained relevant information to help them carry out their role. In addition, that agency staff completed an induction checklist. We were informed that all new starters had a period where they were supernumerary in order to complete their induction.
- There were systems in place to review and withdraw the practising privileges of consultants. We reviewed the hospital's practising privileges database and randomly selected 10 consultant files for review. We found these to be complete.
- During our inspection, senior staff informed us that any concerns about a consultant's practice would be discussed with the hospital director and MAC chair. Practising privileges were withdrawn in line with the hospital's policy in circumstances where standards of practice or professional behaviour were in breach of contract.
- During our inspection, we were provided with a list of 32 consultants who had their practising privileges suspended or removed in the reporting period November 2017 to October 2018. We saw that the majority (28, 88%) had their practising privileges removed for routine reasons; for example, because they had not practised at the hospital within the required timeframe, had insufficient volumes of patients, had moved or transferred to another hospital, or had retired. We saw that two consultants had their practising privileges removed because they had failed to provide appraisal documents. We saw an additional two consultants had been suspended in this timeframe because of concerns raised, and we learned both had subsequently had their practising privileges removed following a professional review committee (PRC) hearing. Where applicable, we saw that the lead independent hospital (another Spire hospital) had liaised with the relevant NHS trust.
- We reviewed MAC meeting minutes for the period November 2017 to October 2018 and saw discussion of practicing privileges was a standing agenda item. Meeting minutes documented which consultants had received biennial reviews of practising privileges, suspension or withdrawal of practising privileges, consultants who had retired or been removed as they no longer attend, and new consultants.
- Following our inspection, managerial staff provided a list of five staff who had been subject to a fitness to practise hearing or internal disciplinary proceedings in the period November 2017 to October 2018.
- As part of their roles, the hospital director and MAC chair were required to liaise with the General Medical Council and local NHS trusts about any concerns and restrictions on the practice for individual consultants. If applicable, any concerns about a consultant would be shared with their responsible officer within their NHS employment.
- The registered medical officers (RMOs) were employed through a national agency. The agency was responsible for their ongoing training and provided continuing professional education sessions throughout the year. The chair of the MAC provided clinical supervision when required. We viewed the curriculum vitae of two RMOs, which evidenced their qualifications and experience.

Requires improvement

Surgery

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- We saw evidence of a multi-disciplinary team (MDT) approach to patient care and treatment. Staff described effective working relationships across all the areas we visited.
- We saw senior staff and team leaders engaged in multidisciplinary forums and groups; such as, at the theatre users' group, and daily 'ten at ten' meeting.
- Consultants accessed the NHS trust multidisciplinary team (MDT) meetings for discussion of patients on specific pathways or with complex needs; meetings included attendance from consultants, specialist nurses and radiologists.

Seven-day services

- **Services were available that supported care to be delivered seven days a week.**
- There was a RMO in the hospital 24 hours a day, seven days a week, with immediate telephone access to on-call consultants. Ward nursing staff could also ring the consultant surgeon, anaesthetist or physician directly if they were required out of hours.
- Staff had access to therapy support seven days a week. The physiotherapy team offered a 24 hour, seven days a week, on-call service; with contact details held at reception and by the senior nurse on duty.
- Pharmacy services were available during normal weekday working hours. Out of hours a 24-hour on-call, seven days a week service was available. The RMO could directly access the pharmacy out of hours, if required.
- Theatre services were available from 7.30am to 9pm, Monday to Friday, and Saturdays from 7.30am to 4pm. There was an on-call rota for theatre staff and senior managers to support the out-of-hours service.
- Clinical staff had access to diagnostic and radiology services, which were available 24 hours, seven days a week to support clinical decision-making.

Health promotion

- **The service encouraged patient to be as fit as possible for surgery and promoted good health.**
- Health promotion information was available within the hospital. This included display boards and information leaflets.
- We saw procedure specific information was given to patients before discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care; or who to approach to for support. However, we were not assured consent procedures had been followed consistently well.**
- Consent is an important part of medical ethics and human rights law. During our inspection, we observed nursing and medical staff obtaining consent, prior to carrying out treatment.
- Records we reviewed during our inspection showed that patients had consented to surgery in line with the provider's policies and procedures, best practice and professional standards.
- Consent was audited as part of the hospital's documentation audit. We reviewed audit data for quarter one to quarter three (January to September) of 2018 and found the proportion of 'fully compliant' consent forms was 97% on average (ranging between 93% and 100%) over the period; against a target of 95% and above.
- We reviewed internal WHO surgical safety checklist documentation audit data for 2018, and saw overall compliance ranged from 94% to 98% (associated data for the quarter three 2018 audit was not supplied). However, for the measure 'has consent form been fully completed, dated & signed?' parameter, we saw 40% compliance recorded in quarter one (January to March), 50% compliance in quarter two (April to June) and 30% compliance recorded in quarter three (July to September) of 2018; and no associated actions were entered on the attached action plans. We saw this parameter had risen to 90% in quarter four (October to December) of 2018.

Requires improvement

Surgery

- The Mental Capacity act (MCA) 2005, is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Following a capacity assessment, if someone is judged not to have the capacity to make a specific decision, that decision can be taken for them, but it must be in their best interests.
- Staff we spoke with had different degrees of knowledge about the Mental Capacity Act, and different explanations of what they would do if they believed a patient lacked capacity. However, all staff we spoke with knew where and how more experienced assistance could be provided, if needed.
- The Mental Capacity Act allows restraint and restrictions to be used, but only if a person has been assessed as lacking capacity, and if decisions are in their best interest. Deprivation of Liberty Safeguards (DoLS) can only be used if the person will be deprived of their liberty in a care home or a hospital. Staff we spoke had some understanding of the legislation around DoLS. We did not see any patients who required DoLS authorisations during our visit.
- Mental Capacity Act training was included in the hospital's mandatory training programme. At the time of inspection, we saw staff were 97% compliant in this.
- We did not see any records where patients had do not attempt cardiopulmonary resuscitation (DNACPR) orders in place.

Are surgery services caring?

Good

Our rating of caring went down. We rated it as **good.**

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- However, we reviewed clinical scorecard data and observed a downward trend in all patient satisfaction measures we reviewed over the period quarter one to quarter three (January to September) of 2018. In addition, we saw average scores for these measures were lower than at our last inspection of the service.
- Following our inspection, senior leaders reported that the trend observed was due to a change of methodology, which occurred across the Spire group in April 2018. Documentation provided by senior leaders stated that the provider (Spire Healthcare Ltd) had moved to digital collection of patient satisfaction measures, replacing paper surveys; and patients were now typically asked to complete their survey a few days after, rather than at the point of discharge. As a result, the provider reported experiencing a slight decline in FFT results across the group, which they believe now represents a truer reflection of our patient satisfaction taking into account the full patient journey; and provides them with better insights to support their ongoing programme of continuous improvement.
- Post-inspection, we reviewed patient satisfaction scores across the 2018 period (quarter one to quarter four) and saw most were considered good, and were broadly in line with peer group averages. However, some results were below peer group averages.
- During our inspection, we spoke with five patients on surgical wards at the hospital. All patients we spoke with were happy with their care.
- In wards and departments we visited, we observed staff caring for patients and found that they were compassionate and reassuring. We heard staff introducing themselves by name and explaining the care and treatment they were delivering.
- Patients we spoke with said that that staff were caring and kind. Patients we spoke with described their care as "excellent", and the attitude of staff as "wonderful and caring" and "very professional". Another patient described the staff as having "time to care".
- Patients we spoke with said that staff answered buzzers quickly, and during the inspection we did not hear buzzers ringing for long periods of time.
- All patients we observed were comfortable, looked well cared for, and had their privacy and dignity maintained.
- Post-inspection data provided by senior leaders showed that from January to December 2018, 97% of patients

on average were 'extremely likely' or 'likely' to recommend the hospital to friends and family. In quarter four (October to December of 2018) the result reported was 98%, against a target of 98%. The national peer group average was reported as 98%.

- Over the same period, 98% of patients on average reported that they felt they were given enough privacy when discussing their condition or treatment. In quarter four (October to December of 2018) the result reported was 98%. The national peer group average was reported as 98%.
- In addition, 97% of patients on average reported that they felt they were treated with respect and dignity. In quarter four (October to December of 2018) the result reported was 97%. The national peer group average was reported as 99%.
- Patient-led assessments of the care environment (PLACE) for privacy, dignity, and wellbeing within the hospital scored an average of 88.6% in the 2018 reporting period. This was higher than the England average of 84.2%.
- The hospital website highlighted that there was adherence to the six c's in caring; which included compassion, caring, competence, courage, and commitment.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- We saw that the ward/unit manager was visible on wards and departments we visited, and patients and relatives could speak with them.
- We heard a conversation between a patient and nursing staff, and heard nursing staff providing comfort and support.
- Patients we spoke with said that staff were available to talk to them as required. Patients we spoke with said they had been "welcomed" onto the wards and staff had been "reassuring and kind".
- Post-inspection data provided by senior leaders showed that from January to December 2018, 79% of patients on average reported that they felt able to talk to staff about their worries or fears. In quarter four (October to December of 2018) the result reported was 82%. The national peer group average was reported as 88%.
- Over the same period, 95% of patients on average reported that they felt they were told who to contact if they were worried about their condition or treatment. In quarter four (October to December of 2018) the result reported was 95%. The national peer group average was reported as 94%.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- A range of information leaflets and advice posters were available on wards we visited. This included information about hospital discharge, specialist services, and general advice about their care and treatment.
- During our inspection, patients we spoke with said that medical staff took time to explain their care and the risks and benefits of treatment. Patients we spoke with said that they were aware of their plans of care and they had been given the time for questions and felt listened to.
- Post-inspection data provided by senior leaders showed that from January to December 2018, 90% of patients on average reported that they felt involved in decisions about their care and treatment. In quarter four (October to December of 2018) the result reported was 91%. The national peer group average was reported as 92%.
- Patients we spoke with said that they were aware of who to approach if they had any issues regarding their care, and they felt able to ask questions.
- Patient satisfaction data for quarter one to quarter three (January to September) of 2018 showed 95% of patients that felt they were told who to contact if they were worried about their condition or treatment (scores ranged from 97% in quarter one to 94% in quarter two and 95% in quarter three of 2018).
- Patients we spoke with were aware of their discharge arrangements and actions required prior to discharge.
- Post-inspection data provided by senior leaders showed that from January to December 2018, 83% of patients

on average reported that they felt they were told about medication side effects to watch for. In quarter four (October to December of 2018) the result reported was 82%. The national peer group average was reported as 87%.

Are surgery services responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- The hospital had effective arrangements in place for the planning and booking of surgical activities, ensuring patients were offered choice and flexibility.
- The hospital worked closely with the local NHS clinical commissioning group and NHS providers to ensure services were planned to meet the needs of the local people.
- Staff held a daily bed meeting to discuss staffing levels and clinical needs; and service leads had the opportunity to discuss service capacity at the daily 'ten at ten' meeting, if necessary. Staff reviewed the number of admissions, discharges and patient dependency throughout the shift to assess on-going capacity.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- We reviewed clinical scorecards for the period quarter one to quarter three (January to September) of 2018 and saw the PHIN composite satisfaction measure (the proportion of patients who agreed their needs were met) was 90% on average over the period (scores were 97% in quarter one, 87% in quarter two and 86% in quarter three of 2018). Following our inspection, senior leaders said that survey results from quarter two and three of 2018 reflected a change in methodology (see caring, compassionate care section).
- Post-inspection data provided by senior leaders showed that from January to December 2018, the average PHIN composite satisfaction measure was 90%. In quarter four (October to December of 2018) the measure reported was 91%. The national peer group average was reported as 93%.
- Patients living with dementia and patients with learning disabilities were assessed at pre-assessment and on admission were issued with a "this is me" patient passport booklet. Although, staff told us patients living with dementia and learning disabilities were not routinely treated at the hospital.
- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted 86.8% compliance for how well the needs of patients with dementia were met. This was higher than the 84.2% England average. Compliance was also better for how well the needs of patients with disability were met (92.7%) compared to the England average (87.6%).
- Wards and departments were accessible for patients with limited mobility and people who use a wheelchair. Specialised equipment for bariatric patients was available, if needed.
- The pre-assessment teams identified patients' needs such as hearing, sight or language difficulties or disabilities. Translation services were available for patients whose first language was not English. British Sign Language interpreters were available and patient information could be provided in braille.
- Over the period November 2017 to October 2018 the hospital had used a translation service 271 times to ensure patient's communication needs were met. Incident data showed that on four of these occasions (1.5%) the patient had been cancelled on the day over this period, as an interpreter had not been booked or could not stay at the hospital for the time required.
- Patients were provided with information leaflets on topics. We observed the leaflets were all in English; however, staff informed us they could obtain leaflets in other languages. In addition, that there were also facilities available to produce leaflets in braille.

- Information about different surgical procedures were available on wards. On discharge, patients were provided with information about their after-care and the ward contact number in case they had any concerns post-operatively.
- Staff were not able to separate male and female patients in the recovery area; however, post-surgery, staff used curtains to screen patients.

Access and flow

- **People could access the service when they needed it. Arrangements to admit and discharge patients were in line with good practice.**
- In the reporting period November 2017 to October 2018, there were 2446 inpatient admissions, and 7327 day-case admissions, and 8905 visits to theatre (8282 adults and 623 children and young people); 65% of patients were self-funding or insured, and 35% of patients were NHS.
- Patients were pre-assessed prior to surgery using the American Society of Anaesthesiologists (ASA) physical status scoring system. Discharge plans were discussed with patients and any potential support on discharge was identified.
- We reviewed referral to treatment (RTT) data for the location from July 2018 to December 2018. We saw the proportion of NHS patients referred and treated within 18 weeks was 98.5% on average over this timeframe.
- Patient admissions for theatre were staggered throughout the day; to help ensure that patients did not experience extended waiting times.
- From November 2017 to October 2018, the average length of stay for elective orthopaedic patients at the hospital was 1.61 days.
- Over the same period, there were 12 unplanned transfers of inpatients to other hospitals (which included three unplanned transfers out to level two and three care), , and 15 unplanned returns to theatre within the same inpatient episode.
- A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. For NHS patients, if a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the NHS standard and the patient should be offered treatment at the time and hospital of their choice. From November 2017 to October 2018, the hospital cancelled 31 procedures for non-clinical reasons, which equated to 0.2% of all admissions. All cancelled patients received another appointment within the following 28 days.
- We reviewed hospital occupancy data for a three-week period in October to November 2018 and saw occupancy levels varied between 43% and 49%.

Learning from complaints and concerns

- **The service typically treated concerns and complaints seriously, and investigated them. However, we saw limited evidence of discussions about learning from complaints in meeting minutes we reviewed.**
- The hospital had a complaints policy. The hospital director took overall responsibility for the management of complaints, assisted by the matron and head of clinical services, and signed all response letters. The hospital director chose a head of department to investigate a complaint.
- The hospital had a process that addressed both formal and informal complaints that were raised by patients or relatives. If the complaint was not resolved at local level, it was made clear that patients had the option to escalate. Private patients could have their complaint escalated to an internal review and if the patient remained unsatisfied, they could take their complaint to the Independent Sector Complaints Adjudication Service (ISCAS).For NHS patients complaints could be escalated to the Parliamentary and Health Service Ombudsman for NHS patients for an independent review.
- We saw information displayed in ward areas about how to complain or raise a concern. Staff we spoke with could describe how they would respond to a compliant or a concern raised, and how they would escalate to their managers. They all told us that with support from their mangers they would try to resolve complaints when first raised. However, they told us they would always advise patients of their right to complain formally and escalate their complaints and concerns.

Requires improvement

Surgery

- Following our inspection, senior managers provided data that showed from November 2017 to October 2018 the hospital received 52 formal (written) level one complaints; and three of these had escalated to level two complaints. Of the formal complaints received, 30 (58%) related to surgical services, including children and young people's surgery.
- The most common subjects complained about in surgery included: clinical care provided complaints (eight, 27%), outcome of procedure complaints (four, 13%), post-operative complications complaints (three, 10%), finance procedures complaints (three, 10%), and incorrect treatment received complaints (two, 7%).
- The timeliness of responding to, investigating and closing complaints using the clinical scorecard was monitored. Data from quarter one to quarter three (January to September) of 2018 showed 83% of complaints on average had been closed in 20 days; against a target of 75%. We saw that 68% of complaints in quarter three of 2018 had been closed within the 20-day target. Following our inspection, senior managers provided commentary that explained five complaints received in quarter three of 2018 belonged to a cohort of patients who had complained about the treatment received from an individual surgeon; and the service were awaiting the outcome of a full investigation before providing a response to these patients.
- We saw discussion of complaints to be standing agenda items in weekly clinical effective committee, monthly heads of department, and quarterly theatre user group, and clinical governance committee meeting minutes we reviewed. However, we saw limited evidence of learning from complaints and concerns in these minutes.
- Staff we spoke with on-site said that themes and trends of local complaints were shared with staff at meetings; however, they expressed difficulty reiterating the types of concerns discussed. Following our inspection, senior leaders said that they used a range of methods for sharing learning from complaints; including 'learning posters', staff forums, staff newsletters and via daily departmental huddle meetings.

Are surgery services well-led?

Inadequate

Our rating of well-led went down. We rated it as **inadequate.**

Leadership

- **Key leaders in the service did not have the right skills and abilities to run a service providing high-quality sustainable care.**
- The service was led by a hospital director, who was supported by a senior management team comprised of a matron / head of clinical services, business development manager, operations manager, and finance manager.
- We had significant concerns about the abilities of the leadership team to promote and maintain a positive transparent and open culture, ensure good governance of the service, and to adequately manage risks, issues and performance (please see relevant sections below).
- Results from the hospital's 2018 consultant survey showed that of the 167 consultants who participated, 89% rated their working relationship with hospital director as excellent or very good, 84% rated their working relationship with the matron as excellent or very good, and 83% rated their working relationship with other members of the senior management team as excellent or very good (compared to a peer group averages of 65%, 62%, and 52%, respectively). There were 161 verbatim comments; 145 rated 'excellent' or 'very good', 14 rated 'quite good', and only two rated 'quite poor'.
- Medical staff we spoke with during our inspection gave conflicting views about leadership of the service, and the senior leaderships team's ability to effectively manage consultant performance, and the medical advisory committee's (MACs) ability to oversee and govern this.
- Additional results from the 2018 consultant survey showed that of the 157 consultants who responded (of a total of 167 consultants who participated), 82% rated feedback from the MAC at Spire Leeds hospital as very effective (49%) or fairly effective (33%); against a peer group average of 70%. Of the remainder, 15% of

respondents felt feedback from the MAC was not very effective, and 3% felt it was not at all effective. Verbatim comments specifically in relation to the MAC included, "please listen and implement recommendations from MAC".

- Resident medical officers said that they felt supported by senior colleagues.
- Both inpatient wards had a ward sister who were supported by the nursing services manager and matron. Ward and theatre managers were allocated dedicated time for management and support of junior staff.
- We found mangers on the wards and departments we visited knowledgeable and professional. They appeared visible and approachable for junior members of staff they supported.
- Most staff spoke positively about the lower-level leadership and management provided in the surgical service.
- Staff survey results from January 2019 showed that the hospital's score for middle management was 86% positive (percentage of positive responses for agreed or strongly agreed), compared to the group average of 75%. Within this, 85% of theatre staff at the hospital scored middle management positively compared to a peer group average of 67%, and 77% of ward nursing staff at the hospital scored middle management positively compared to a peer group average of 78%. Following our inspection, the service reported it had invested in growing its own talent by sponsoring staff to attend the surgical first assistant mentorship programme.

Vision and strategy

- **The hospital had a strategy for what it wanted to achieve.**
- At our last inspection of the service, we saw the hospital produced a local vision which was, "Spire Leeds will support the Spire Healthcare vision and work towards 2020, when our aim is to make Spire Leeds a flagship hospital within the Spire Healthcare group of hospitals".
- Following our recent inspection, the hospital provided us with a hospital-wide 2018 strategic priorities document, which detailed six main aims.
- The ethos of the hospital-wide strategy was to "promote teamwork, excellent communication, and celebrate our success together".

Culture

- **Ward and theatre staff said they felt supported by their line managers, who promoted a positive culture that valued staff. However, senior leaders had not supported and promoted a culture of appropriately identifying, reporting, and learning from incidents, and being open and honest when things went wrong.**
- We found that senior leaders had not supported or promoted a culture of appropriately identifying, reporting, categorising, and learning from incidents. In addition, the leadership team had not always been open and honest with patients when things went wrong; and had failed to meet their duty of candour responsibilities consistently well (see safe, incident section).
- From November 2017 to October 2018 CQC received five whistleblowing enquiries. The hospital had a whistleblowing policy in place.
- Following our inspection, the senior managers said that increased rates of incident reporting helped to demonstrate an improving incident reporting culture. For example, they informed us that in 2018, 714 incidents were reported by staff at Spire Leeds hospital. This compared to 675 incidents reported in 2017, 668 in 2016, and 545 in 2015.They said the rate of incidents reported in 2018 equated to 7.3 per 100 patient discharges, compared to 5.08 in 2015 (rates per 100 discharges for intervening years were not supplied).
- However, in the clinical governance committee meeting minutes (December 2018) we observed it was noted that "during the year we have reported fewer incidents in Datix and a definite decline in reporting in Q3. All departments need to remind staff of the importance of reporting incidents and especially in relation to near misses and minor incidents". At our last inspection of the hospital we said that the process for recording near miss incidents should be reviewed, and shared learning from near miss incidents was to be improved across departments.

- Ward and theatre staff we talked with said they said they felt supported by their line managers and said that morale was good; they were enthusiastic and proud of the work they did for patients.
- The surgical ward management team told us they were proud of the work they did. Following our inspection, the service reported there was a strong culture of recognition and reward at the hospital; which included a monthly staff 'Pay Day Raffle', a free birthday lunch, Christmas parties and family celebrations. In addition, that there were regular health awareness and health promotion events were, which were promoted on social media.
- Senior leaders said it promoted staff health and wellbeing through a range of local initiatives, which included access to a free wellbeing service and free use of the hospital gym and facilities.
- They also reported that they had an established volunteer scheme, with 29 volunteers active at the time of the inspection; and a waiting list for additional members.
- The hospital had a Freedom to Speak Up Guardian in post for staff to raise concerns locally, supported by a national network of Guardians. Following our inspection, senior leaders reported that this individual was also running MDT support and challenge groups to encourage and improve cross departmental working.
- We saw posters in ward areas advising staff how to raise concerns and who to contact if they had any concerns.
- Results from the Spire Leeds benchmarking engagement survey (January 2019), showed that 89% of staff agreed or strongly agreed with the statement that, 'when errors, near misses or incidents are reported, I feel confident that action is taken to reduce the likelihood of it happening again'. This compared to a Spire peer group average of 80%. Within this, 92% of hospital theatre staff (compared to a peer group average of 72%) and 84% of hospital nursing ward staff (compared to a peer group average of 81%) rated the metric positively.
- When asked to rate the statement, 'I feel comfortable raising any concerns about safety, bad practice or other serious risks with my manager', 85% of staff scored their response positively (agreed or strongly agreed), compared to a peer group average of 82%. Within this, 80% of hospital theatre staff (compared to a peer group average of 75%) and 76% of hospital nursing ward staff (compared to a peer group average of 82%) rated the metric positively.
- When asked to rate the statement, 'Senior managers consider staff suggestions for improving patient safety', 84% of staff scored their response positively (agreed or strongly agreed), compared to a peer group average of 65%. Within this, 76% of hospital theatre staff (compared to a peer group average of 56%) and 76% of hospital nursing ward staff (compared to a peer group average of 63%) rated the metric positively.
- As described earlier (see well-led, leadership section) results from the hospital's 2018 consultant survey showed most (between 83% and 89%) rated their working relationship with hospital director, matron and other members of the senior management team as excellent or very good; and results were considerably higher than respective peer group averages.

Governance

- **The service did not systematically improve service quality and safeguard high standards of care.**
- Senior managers could not reliably determine the number and nature of serious incidents (SIs) that had occurred from November 2017 to October 2018. In the incident data we reviewed, we identified numerous instances in which the severity of harm had been incorrectly classified; for example, as 'no harm'. We also identified there had been several reportable incidents that senior managers had not notified CQC about, or had not notified us about in a timely manner. We also saw that senior managers had failed to meet their duty of candour responsibilities consistently well (see safe, incident section).
- We found the serious incident root cause analysis (RCA) investigation reports and action plans we reviewed to be of variable quality, and we were not assured there was a robust process in place to check that actions were implemented following incidents and closed out (see safe, incident section).
- We saw the frequency of committees was not always in line with their agreed terms of reference (ToR). We

reviewed the ToR for the clinical effectiveness committee (CEC), theatre user group (TUG), clinical governance committee (CGC), and MAC; which set out the purpose, aims and objectives of each.

- The MAC ToR stated that the role of the MAC included advising "the hospital director, matron / head of clinical services and the designated consultant for clinical governance … on any matter relating to the proper, safe, efficient and ethical medical and dental use of the hospital". The ToR stated that the MAC was required to meet four times a year, and we saw it had met this obligation for the period November 2017 to October 2018; meeting four times in this period. In addition, the MAC ToR stated that "the MAC Chair or the Hospital Director may request additional meetings if he/she considers them to be necessary".
- We observed there was a gap of four months and 10 days (94 working days, excluding bank holidays) between MAC meetings in the period May to October 2018. During this period, an internal investigation regarding a member of staff in relation to the care provided to a sizable cohort of patients was ongoing at the hospital. In addition, two internal reviews of children and young people's services had been completed, and an internal whistle-blowing investigation had been launched. Following our inspection, senior leaders provided correspondence that the September 2018 meeting was postponed by four weeks due to availability of key members; and as this was the first meeting of the new MAC chair, they wanted to ensure as many members were available as possible. However, we reviewed MAC meeting minutes and saw that both the new MAC chair and old MAC chair were present at the 3 October 2018 meeting; and both were also present at the three previous MAC meetings. We also observed that a member of the MAC had "queried the lack of MAC meetings in July & August" at the 3 October 2018 meeting.
- ToR for the CGC and TUG stated they were required to meet every quarter, within two weeks of the MAC. The CGC had been unable to fulfil this requirement, possibly owing to MAC meeting dates; and we observed the CGC had not met for over five months during a period in 2018. Dates of meeting minutes for the TUG suggested the group had met four times in a 12-month period; but had not always done so within two weeks of the MAC, as stipulated in their ToR. We saw the CEC had met weekly during the period November 2017 to October 2018, in line with their ToR.
- We reviewed monthly heads of department meeting minutes from November 2017 to October 2018, and saw standing agenda items included matters arising, escalations to head office, financial update, business development update, health and safety update, complaints, departmental updates and any other business.
- We reviewed MAC, CGC, CEC, TUG and HoD meeting minutes and found limited evidence of lessons learned from concerns, claims, complaints, and incidents in meeting minutes we reviewed.
- We were not assured key data was produced and subsequently reviewed by committees and groups in a timely manner. We reviewed clinical governance reports for quarter four of 2017 (data period October to December 2017), quarter one of 2018 (January to March 2018), quarter two of 2018 (April to June 2018) and quarter three of 2018 (July to September 2018). The stated purpose of the report was to update the CGC and the MAC on clinical governance information and data on a quarterly basis. We reviewed the clinical governance report for quarter three of 2018 and identified that beyond ("draft") general clinical scorecard data (pages three to seven), nearly all other data (pages eight to 30), bar one item, related to 2018 quarter two data. For example, with respect to medical records, theatres swab and instrument checks, and stop before you block audit data. We also saw that SI data covered the quarter two 2018 period.
- Following our inspection, senior leaders explained the quarter three (July to September) of 2018 clinical governance report and associated data was not to the usual standard produced, as the service did not have a governance lead in post at that time. Senior leaders reported that central support was provided to produce the quarter four (October to December) of 2018 clinical governance report. We saw that the quarter four report (dated to April 2019), showed some improvement. However, we observed several inaccuracies; for example, numerical data in the descriptive national

early warning score (NEWS) section could not be correlated with tabulated figures, supposedly erroneous quarter three NEWS compliance audit data was included, and numerous references were made to 'Q1'.

- We reviewed MAC meeting minutes for 3 October 2018 and CCG meeting meetings for 22 October 2018 and saw that the quarter two (April to June 2018) clinical governance report was discussed. Following our inspection, senior leaders reported that the quarter two clinical governance report had been shared with members of the MAC on 28 August 2018; however, evidence was not provided to substantiate this. We saw that quarter three (July to September 2018) clinical scorecard data was published 2 November 2018; however, as described earlier, this primarily contained quarter two data. We also noted that the next MAC meeting (according to the October 2018 minutes supplied) at which this (quarter three data) was to be formally discussed was not scheduled until February 2019. Following our inspection, senior leaders said that safety and quality was also monitored in a variety of other ways. For example, they commented that the hospital director, matron and MAC chair met on a weekly basis and include other key members of the MAC in improvement activities and with attendance at other meetings.
- We reviewed CEC meeting minutes from November 2017 to October 2018. We noted a change of meeting minutes format and style of reporting from early October 2018 onwards; and we felt that the quality of meeting minutes declined after this time. We also observed that some standing agenda items (as per the committee's ToR; for example, 'agree items for discussion at MAC') were not covered after this time.
- At the time of inspection, the hospital had been without a clinical governance lead for approximately five months. Evidence we collected suggested the hospital's head of clinical services (matron) had temporarily taken on most of these responsibilities. Following our inspection, senior leaders reported they had allocated different managerial staff to fill some functions of the governance lead role when the post was vacant; for example, with respect to risk management and policy review, drug and medical devices alert management, RCA review, and clinical audit. However, we did not see any documented evidence of this in meeting minutes we reviewed. We were concerned that (despite some support) the matron had limited capacity to fulfil governance duties alongside those of their existing role. Senior leaders informed us that a clinical governance lead was appointed in February 2019 and commenced employment in April 2019.
- We were not assured that the process to report concerns to other external agencies had been followed in a timely manner. Following our inspection, the General Medical Council (GMC) launched their own independent investigation.
- Governance processes were described in the hospital's clinical governance and quality policy (dated November 2017), which outlined corporate and local governance structures and reporting channels.
- We reviewed a hospital management structure chart for December 2018, which showed a line of responsibility that went from the hospital director, through the matron and head of clinical services, to the ward managers and theatre manager. There were senior management leads responsible for business development, operations and finance.
- The conditions of practising privileges were monitored for compliance and records maintained of appraisal, indemnity insurance and registration; and discussed at the MAC. During our inspection, senior managers provided us with a list of 32 consultants who had their practising privileges suspended or removed in the reporting period November 2017 to October 2018. We saw that the majority (28, 88%) had their practising privileges removed for routine reasons. We saw that two consultants had their practising privileges removed because they had failed to provide appraisal documents. We saw an additional two consultants had been suspended in this timeframe because of concerns raised; and had subsequently been subject to performance review committee hearings and had their privileges removed. We saw these were reflected in MAC meeting minutes.

Managing risks, issues and performance

Requires improvement

Surgery

- **The service had not sufficiently applied the systems available to identify risks and implement plans to eliminate or reduce them. Risks to patient safety had not been monitored or mitigated over time consistently well.**
- As described in the governance section, governance processes had not been consistently applied to manage current and future risks, issues and performance and improve service quality.
- We identified trends from RCAs included consultants not reviewing patients following surgery and before discharge, and not completing sufficiently detailed and daily medical records. In meeting minutes we reviewed, we saw senior leaders recognised that performance in these areas was poor. We saw this had been an ongoing issue in the 12 months prior to our inspection and we were not assured sufficiently robust actions had been implemented at the time of inspection to improve performance. Following our inspection, senior leaders reported that (in addition to actions already implemented; see safe, records section) to provide additional assurance going forward, continued non-compliance would be incident reported and fed through to the consultant's responsible officer and appraiser.
- We found the risk register was not being appropriately managed. Following our inspection, senior managers provided us with the hospital-wide risk register. We examined entries and saw the register had last been reviewed in early January 2019; and as such, not all entries were contemporaneous with our inspection. The risk register provided following our inspection showed a total of 24 risks recorded. We saw that three of the 'top five' risk register entries had been reviewed following our inspection - between 14 December 2018 and 4 January 2019; and seven entries in total had been reviewed during this timeframe. Conversely, we saw other entries that required review in this timeframe had not been reviewed. For example, a risk in relation to the robustness of pre-operative assessment processes had last been last reviewed in October 2018, and was due to be reviewed by 2 January 2019, but had not.
- We reviewed the risk register (as provided in January 2019) and observed that the hospital's second top risk, failure to maintain single patient record was risk-rated 10, but the target score was recorded as 12. We also saw an additional five risks in which the current risk rating was equal to the target risk rating. We also saw instances of risks scored as five and four classified as 'moderate' risks (under current 'risk level'), and risks rated as six were classified as 'low'.
- Following our inspection, senior leaders reported that an administration error had occurred with respect to the entry 'failure to maintain single patient record' (the then second highest risk on the hospital risk register). However, we saw from CEC meeting minutes that as part of the quality assurance and regulation process, that "all HoDs [heads of department] must review their own risks" and the "top 5 Risks to be reviewed by SMT [senior management team]". Suggesting that the error had been overlooked by the two levels of management.
- With respect to five instances where the current risk rating was equal to the target risk rating, senior leaders said that this demonstrated effective risk management; as the risk remained on the register but showed that sufficient action had been taken to provide assurance that the risk was well managed. However, we observed this contradicted other representation made; for example, in relation to a risk not present on the risk register. We also saw in the quarter four (October to December) 2018 clinical governance report, dated to April 2019, that the hospital risk register had subsequently been reviewed and streamlined and was said to hold 19 current risks. Suggesting the removal of risks that had been sufficiently mitigated (24 risks were identified in the January 2019 risk register).
- Regarding the inconsistent categorisation of risks (for example, as low or medium) against risk scores, following our inspection senior leaders confirmed that the observations were correct, but were not made in error. Senior leaders explained that a change of process in 2018 introduced a new risk matrix across the Spire group, which was automatically updated and populated by the incident management system (Datix). However, this could not be applied to existing risks, meaning older risks were listed (and categorised) under the old framework; resulting in discrepancies. However, they said that this was not a cause for concern, as the risk levels (scores) were correct and risks were reviewed on this basis.
- We observed recurrent trends in meeting minutes and data provided by senior managers following our

inspection; for example, with regards to fasting times, Venous thromboembolism (VTE) prophylaxis, daily and pre-discharge medical review of patients, and medical record keeping. We found senior managers had failed to sufficiently address fasting time compliance at the time of inspection. We observed that recent improvements had been made in VTE prophylaxis, daily and pre-discharge medical review of patients, and medical record keeping compliance; but that significant deficiencies with compliance were observed throughout most of 2018, and these required close monitoring to ensure improvement sustainability and embeddedness of actions. Where action plans had been implemented, we found these were not always sufficiently robust; for example, with respect to the VTE action plan, and the clinical governance scorecard action plan for quarter three (July to September) of 2018. We also observed these issues were not sufficiently identified or categorised on the risk-register.

- We saw risk of non-compliance with Spire policy on the risk register (which included timely review by a consultant and medical records audits as key controls; these were not identified on the register as risks per se). The 'non-compliance' risk was rated as "low" and scored six; and gaps in controls were recorded as "none at present".
- We saw a risk register entry regarding "anaesthetist[s] are not agreed on best practice when it comes to change of operating list order". The ward coordinator liaising with anaesthetist and consultant to determine fasting time and list order was presented as a key control; however, fasting time compliance was not identified on the register as a risk per se. The risk had last been reviewed 21 December 2018, the target risk rating was recorded as three and the target risk level was also reported as "low".
- We could not identify risks on the register in relation to VTE prophylaxis, incident reporting or duty of candour.
- We saw that a risk in relation to failure of infrastructure and equipment advised that if laminar flow failed that specific operations (such as breast and joint procedures) should be stopped. Gaps in controls or assurances stated, "none at present"; the risk was rated "low" and scored three. However, we were not assured that laminar flow systems were compliant at the time of our inspection (see safe, infection prevention and control section).
- Senior managers produced quarterly actions plans, which identified areas where audit results and progression were found to be under target (categorised as amber or red). We reviewed the clinical governance scorecard action plan for quarter three of 2018. It detailed a description of issues (areas under target), required action, staff leading on actions (person responsible), who the task was assigned to, completion date, learning that had taken place, and comments. However, we found the actions were inconsistently completed and learning descriptors were predominantly reiterations of current practice or actions undertaken.
- We reviewed monthly heads of department meeting minutes from November 2017 to October 2018, and saw standing agenda items included matters arising, escalations to head office, financial update, business development update, health and safety update, complaints, departmental updates and any other business. Under the 'escalations to head office' heading, we saw one system issue had been escalated to the director of human resources; otherwise entries detailed "nil" or "none".
- The senior management team had processes in place for challenging issues of performance within the consultant body and sharing any concerns with the consultants' substantive employer. However, some medical staff we spoke with were not assured of the robustness of these processes. Effective checks were made to ensure disclosure and barring checks were undertaken pre-employment.

Managing information

- **The service had systems to manage information. However, appropriate and accurate information was not always effectively processed, challenged and acted upon.**
- The hospital had systems to manage information. However, the information that was used to monitor performance or to make decisions was not always

accurate, valid, reliable, or timely. We saw that clinical audit measures were not always collated or presented to committees and groups in a timely fashion (see well-led, governance section).

- The service did not have effective arrangements to ensure that data or notifications were always submitted to external bodies as required and in a timely fashion (see safe, incidents section).
- All staff were required to complete information governance training every year. Following our inspection, senior managers provided data that showed 100% of all hospital staff had completed information governance training.
- Computers were available on wards. During the inspection, all computers were locked securely when not in use. Paper records were stored securely.
- Staff had access to a shared electronic folder, which they said detailed information key messages from the senior management team; including incidents, concerns, and duty of candour requirements. Within theatres we also saw a paper folder, which contained key safety alerts, we observed that staff had to sign to state they had read the alert.
- However, key committee and group meeting minutes we reviewed contained limited learning from incidents, complaint, and concerns (for example, see well-led, governance section).
- All staff had access to IT and confidentiality policies relating to the safe transfer of data and images between services. Paper records were available for each patient that attended the wards and departments. Staff we spoke with said that they could access records out of hours with ease.
- The head of clinical services/matron was the Caldicott Guardian for the hospital.

Engagement

- **The service engaged with patients, staff, and local organisations to plan and manage services.**
- During our inspection, we saw a formal process was in place to collect patient or relative feedback. This included written responses on discharge, and we saw boxes where patients were encouraged to leave feedback. We saw examples of positive feedback on the walls in the wards.
- Patient satisfaction data was also collected through local departmental feedback questionnaires, complaints, compliments, through Patient Led Assessments of the Care Environment (PLACE) audits and social media feedback.
- We observed a downward trend in all patient satisfaction measures over the period quarter one to quarter three (January to September) of 2018. Following our inspection, senior leaders reported that the trend observed was due to a change of methodology, which occurred across the Spire group in April 2018. We reviewed patient satisfaction scores across the 2018 period (quarter one to quarter four) and saw most were considered good and were broadly in line with peer group averages. However, some measures (for example the proportion of patients who reported they felt able to talk to staff about their worries or fears, and the proportion of patients that felt they were told about medication side effects to watch for) were below peer group averages. We saw that senior managers had instigated a '15 step' hospital/departmental challenge and had developed a patient satisfaction action plan for quarter three to quarter four (July to December) of 2018, to help improve patient satisfaction scores. The 'Patient Satisfaction Action Plan 2018' contained eight key themes, six of which were RAG-rated green and two were rated amber. Following our inspection, senior leaders said that of the 29 actions listed under the 8 key themes, and all but 6 of these actions had been completed at the time of our inspection.
- We saw some examples of senior managers responding to patient feedback. For example, we saw the hospital cancellation policy had been updated to help ensure patients did not experience short notice cancellations.
- We saw examples of staff being able to make suggestions about the environment and hospital to improve patients and staff experiences. The hospital had a suggestions group, which met quarterly.
- Staff used the "ten at ten" meeting, to share key messages and good practice.

Requires improvement

Surgery

- The hospital had a Freedom to Speak Up Guardian in post for staff to raise concerns locally, supported by a national network of Guardians. Following our inspection, senior leaders reported that this individual was also running MDT support and challenge groups to encourage and improve cross departmental working.
- The service reported it had a programme of GP training and engagement events, and worked closely with these community partners to provide access to rapid healthcare.
- Staff within the theatre suite, had recently commenced sharing of a staff newsletter to share key updates, learning and social events.

Learning, continuous improvement and innovation

- **We saw limited evidence that the service was committed to consistently improving services by learning from when things went wrong. However, we did see evidence of the service promoting training, research and innovation.**
- As described earlier, we found lack of transparency and openness of when things went wrong, variable completion of RCA action plans, and limited evidence of discussions about learning from incidents and complaints in meeting minutes we reviewed.
- Following our inspection, senior leaders provided evidence that demonstrated use of new and innovative medical techniques to improve the health and wellbeing of patients; many of which had been reported in the local and national press. For example, with respect to urological implant surgery, liver surgery, spinal surgery, and use of new materials for a total ankle replacement surgery.
- The hospital achieved Joint Advisory Group (JAG) on GI endoscopy accreditation in April 2017.
- The hospital attained Macmillan Quality Environment Mark level 5 in February 2018.

Requires improvement

Services for children & young people

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

Are services for children & young people safe?

Requires improvement

Our rating of safe went down. We rated it as **requires improvement.**

Mandatory training

- **The service provided mandatory e-learning training in key skills to all staff and made sure everyone completed it.**
- The hospital had a system in place to help ensure staff received mandatory training; training was provided via e-learning and face-to-face.
- Following our inspection, we requested mandatory training compliance data for children and young people's service staff. Senior managers provided data that showed 100% of current paediatric staff had received all the elements of e-learning mandatory training; which included equality and diversity, health and safety, compassion in practice, information governance manual handling and fire safety training.
- Consultants who had substantive posts in the local NHS trust accessed their mandatory training through the trust. Compliance was evidenced and monitored through the appraisal process.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**
- Data we reviewed on site and following our inspection showed 100% of children and young people's (CYP) staff had received children's safeguarding training at level three; which included elements of multi-agency training as per intercollegiate guidance 2015.
- The CYP lead nurse and matron had undertaken safeguarding training children level four, which was appropriate to their level of practice; and allowed them to deliver children's safeguarding training.
- The lead nurse also represented the hospital at statutory health and social care safeguarding networks across the region. We saw a meeting was attended in November 2018, where lessons learned from a local serious case review had been shared.
- The lead nurse for the service received external safeguarding supervision with a designated nurse in the local safeguarding children partnership. We saw there was a formal supervision contract for this on a three-monthly basis.
- We reviewed supervision documentation from a session undertaken in March 2018 where there was a clear discussion around a specific case with learning points raised. There were plans to provide group supervision for the new paediatric team at the hospital, when fully established in January 2019.
- Consultants working at the hospital had to complete level three safeguarding children training and a record

was kept of this on their practising privileges record. We were told that the senior management team monitored non-compliance of this and took appropriate action if compliance was not maintained.

- We reviewed incident data from November 2017 to October 2018 and saw evidence of instances in which anaesthetists had been advised not to participate in procedures, when it became apparent that they had not undertaken level three safeguarding training.
- Over the same period, we saw seven safeguarding events or concerns had been reported on the incident log; and saw appropriate actions had been taken.
- Staff we spoke with were familiar with potential safeguarding concerns, and what constituted abuse. They also knew about female genital mutilation (FGM) and their responsibilities around this, the effects of domestic abuse and the importance of appropriate information sharing.
- Staff in the CYP service followed Spire's corporate safeguarding policy and a local hospital version; which included out of hours telephone numbers for local authority safeguarding teams. Staff could tell us that young people between 16-18 years would still need protection under the Children's Act 2004 if concerns arose about their welfare.
- Records for patients who had been referred through the NHS route included information regarding safeguarding concerns, such as those children and young people who were subject to a plan of protection. This had proven to be a challenge with privately insured patients and there was the reliance on verbal information from families. Senior managers were seeking further advice with regards to this.
- An internal whistleblowing investigation report submitted to the CQC post inspection highlighted an incident whereby a member of CYP staff had not fully completed the safeguarding section of the children's pathway and the child in question was subject to a child protection plan. This meant that staff did not have the correct information to include in observation of parenting and planning for discharge. . Following our inspection, senior managers said that this had occurred because there was non-disclosure by the parent that the child in question was subject to a child protection plan.
- Staff we spoke during our inspection understood their responsibilities around young people who are looked after by the local authority. In addition, we reviewed two safeguarding children referrals which had been appropriately escalated to the local authority. The information had been documented in full in the children's records and on an electronic incident recording system; for reference and audit purposes.
- Staff had guidance around 'the missing child' which was in a flowchart format and appended to the children safeguarding policy, which directed what actions to take. We saw that there had been a missing child 'lock down' exercise in March 2018; this highlighted the need to ascertain which doors staff had responsibility for.
- During our inspection, staff we spoke with said that hospital policy was always followed for the chaperoning of children. We reviewed incident data for the period November 2017 to October 2018, and identified an incident had occurred in late Spring 2018; in which a consultant had performed procedures on two young child patients without a chaperone or registered children's nurse present. Incident entries showed relevant senior staff were notified and an investigation (root cause analyses, RCA) was recommended. However, we saw no evidence this had been undertaken on the incident log we reviewed. Following our inspection, senior managers said that an RCA was not required, as this was an isolated incident. In addition, an email was sent to consultants to remind them to follow process.

Cleanliness, infection control and hygiene

- **Overall, we saw ward and theatre staff in the service kept equipment and the premises clean, and used control measures to prevent the spread of infection; however, we were not assured laminar flow systems were compliant (see surgery core service report).**
- The environment and equipment were seen to be visibly clean.
- The 'Infection Prevention & Control Newsletter Spire Leads' (November 2018) showed that paediatric environmental audit scored 97% compliance.

Requires improvement

Services for children & young people

- The hospital had scored highly (99.5%) in the 2018 Patient-Led Assessments of the Care Environment (PLACE) audit for cleanliness, which was better than the 98.5% England average.
- The hospital had an infection prevention and control policy. This directed staff to other policies and protocols for guidance about cleaning, decontamination and use of personal protective clothing. The policy was available on the provider's intranet.
- All staff completed infection prevention and control training as part of their mandatory training programme. Training data provided by senior managers showed 100% compliance as of January 2019.
- Personal and protective equipment, such as disposable gloves, was widely available.
- During our inspection, we observed children and young people's service staff adhered to uniform policy to prevent infection which included bare below the elbows. We also saw that staff used hand gel frequently and washed their hands before and after contact with a child.
- Hand washing advice was available in poster format in the child's folder by their bed and by sinks in clinical areas.
- Staff we spoke with said toys were cleaned weekly and deep cleaned monthly by nursing staff. At the time of inspection, we saw the children's toys were last deep cleaned on 16 November 2018.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well. However, the children's ward was not always secure.**
- We reviewed the findings from an internal whistle-blowing investigation. The investigation upheld an allegation that paediatric patients were sometimes nursed on the adult ward due to too many bookings being accepted; and because of this, the paediatric ward security door could not be locked, and adult patients were allowed on the ward. However, the report emphasised that children were nursed in an individual room on the adult ward when; for example, there was pressure on beds because patients were not ready for discharge, if CYP staffing was compromised due to last minute sickness, or when temporary building work was being carried out. We noted that the allegation that the paediatric ward security door could not be locked, and adult patients were allowed on the ward, was not specifically addressed in the whistle-blowing investigation report.
- At inspection, we observed the entry door to the CYP unit did not close in a timely manner after opening. Staff we spoke with said this had been an ongoing problem. We escalated the failure of the door to close in a timely manner to the hospital executive team on the day of inspection. Following our inspection, we were informed that an alarm had been fitted to door to alert staff if it remained open.
- The hospital scored above average (97%) against other organisational sites and nationally in the 2018 PLACE score for environmental condition, appearance and maintenance.
- Resuscitation paediatric emergency care bags (PECs bags) followed the child, when required. For example, when a child was admitted as an outpatient to the ambulatory care unit the PEC bag was taken from the theatre recovery to support the child whilst on the unit.
- A paediatric resuscitation bag was located in the x-ray department, which was next door to outpatients. Staff undertook daily checks of the resuscitation equipment in this bag. Checks were documented daily. During monthly checks, the seal was broken to check internal contents, and then resealed. We saw two gaps in the checks; however, we were told the department was closed on these days.
- Quarterly equipment audits had been completed for the CYP service area. We reviewed audits which showed 100% compliance from quarter one to quarter three (January to September) of 2018.
- During our inspection, we saw ten pieces of equipment which had been tested for electronic compliance and were in date.

Assessing and responding to patient risk

- **Risks were not always managed positively. The service had not risk-assessed the nursing and treatment of paediatric patients in adult areas consistently well. We saw that safer surgery**

checklist documentation was not completed consistently well. In addition, the service level agreement for transfer of critically ill children had expired in February 2018.

- We were concerned there had been occasions where children and young people below the age of 16 years had been nursed in an adult area without this being adequately risk assessed. Staff we spoke with said that patients aged 16 and 17 years were treated and nursed in adult areas, if they had been risk-assessed and placed on an adult care pathway.
- However, on the day of inspection, our surgical core service inspection team observed a younger child having a minor procedure in an adult area (ambulatory care ward); and staff told us that children were sometimes treated there. We fed this back to senior leaders at inspection. Post-inspection, senior managers responded to say that the child (in their early teens) was being treated there as the main outpatient department was particularly busy that day. They said than an RCN was present at all times; they did not describe if a risk assessment was completed or not.
- Post-inspection, senior managers said that there had been a total of six patients under the age of 16 years of age admitted to an adult area during the period June to September 2018; and summary information with respect to the circumstances of cases was provided. Information identified that in three cases children were nursed on the adult ward due to children and young people's service staff sickness or cancellation of shifts. In four of these instances it was explained that at least one RCN nursed the patient, with adult nurses with paediatric competencies available for support, where applicable. In two cases (both occurred on the same day, when the children's ward was being refurbished), it was explained that three RCNs were on duty.
- In four of the six cases, senior managers did not describe if a risk assessment was completed or not. A documented risk assessment of a child nursed in an adult area is required by Spire policy (procedure for the care of children and young people in Spire healthcare, April 2018). In the third case, it was stated that a risk assessment was completed, and it was considered that in light of the surgical procedure, more specialist nursing advice was available on the adult ward. In another case, it was stated that care on the adult ward was pre-planned to provide more specialist nursing advice and a risk assessment had been completed. In two cases (noted as occurring die to the children's ward being refurbished), it was not stated if a risk assessment had been completed or not.
- We saw that a task specific risk assessment for work activity in relation to "relocation of the children's services to ambulatory care on the first floor", which was "in place whilst the refurbishment work is underway on ward one [children's ward] and patients will be returned back to the ward on completion", had been completed by the service on 12 October 2018. Control measures included children never being left alone, transfer of all essential equipment, and ensuring staff and patients did not use the area as a thoroughfare; and the risk was subsequently scored as four. However, the day in question in relation to two cases noted above occurred some weeks before this task specific risk assessment had been implemented.
- We reviewed incident data for the period November 2017 to October 2018, which showed an incident took place in early 2018 in which a lone-worker nurse was responsible for a CYP service patient. The entry described that the patient had additional needs. The entry noted that the patient was subsequently nursed on the adult ward. Lessons learned included increasing "communication between all departments when ward one is closed and when there is a lone worker in paediatrics". In addition, the CYP team was advised to "escalate to nurse manager immediately on discovering ward one is closed if lone worker". We could not find evidence that the case had been discussed in paediatric steering group meeting minutes.
- If a child deteriorated and required more specialised care, they would be transferred to an NHS trust hospital. Senior managers provided us with a document evidencing they had a service level agreement (SLA) with a recognised retrieval team which transferred deteriorating children and young people to other hospital centres. However, we reviewed a SLA for the critical care transfer of paediatric patients from the hospital to another (NHS trust) hospital centre; and saw that this agreement commenced February 2017 and had not been reviewed one year from the commencement date (February 2018). As of January 2019, the SLA had

not been renewed. We saw evidence that showed attempts had been made by service leads during the course of 2018 to renew the agreement with the provider.

- Following our inspection, senior leaders provided World Health Organisation (WHO) five steps to safer surgery checklist audit data and associated documentation for 10 paediatric patients who had surgeries or interventions for the period 1 December 2018 to 11 December 2018. Senior leaders reported observational and verbal checks to be 100% compliant. Audit data did not include team brief and debrief compliance.
- We reviewed associated documentation and saw this to be sufficiently completed, overall. However, we noted three instances in which the sign out section had been signed but a sign out time had not been entered; and this did not correspond with the audit results. Within these three cases, we also saw one 'stop before you block' and one 'prosthesis check' section had not been completed. We saw team brief sections marked as completed in nine of the ten cases, and team debrief sections marked as completed in eight of ten cases; in two cases, these had been marked 'not applicable'. We saw in all ten cases that the patient had been asked to confirm the operation (hence the verbal check was complete); but that the planned procedure was not documented on the safer surgery checklist in seven cases.
- We saw that it was hospital policy to ensure that staff had an enhanced disclosure and barring service (DBS) check at least every 10 years.
- Following our inspection, senior managers provided a paediatric resuscitation scenario schedule for the period February 2018 to December 2018. The schedule showed seven paediatric resuscitation scenarios had taken place in this timeframe; however, details about staff attendance were not provided.
- Staff used paediatric early warning scores (PEWS) charts to monitor children's vital signs. Staff told us that PEWS charts were audited. The PEWS tool was developed through the Spire Hospital Group and was age specific. Baseline observations were taken by staff whilst the child was in the pre-assessment clinic.
- Following our inspection, senior leaders provided PEWS audit data and associated charts for eight paediatric patients who had surgeries or interventions for the period 1 December 2018 to 11 December 2018. We reviewed these charts and found that all areas were completed well.
- We viewed the CYP clinical scorecard data for the period quarter one to quarter four (January to December) of 2018 and saw audit data for full completion of PEWS records was 99% on average over the period. Average compliance for temperature recordings was seen to be 100% over this timeframe.
- The paediatric medical records audit showed 'PEWS score for all observations recorded on the ward' was 100% in quarter three (July to September) of 2018, and 95% for quarter four (October to December of 2018). 100% compliance was observed for the metric 'PEWS score for all observations recorded in PACU' across both quarter three and quarter four of 2018. 'PEWS Score calculated correctly' was seen to be 100% in quarter three, and 80% in quarter four of 2018. Hospital targets for each PEWS metric were 95%. Staff we spoke with knew of the sepsis policy and the risk assessment specific to children in the PEWS tool. We saw that this was a corporate policy which followed national guidance.
- Data supplied by senior managers showed 21 theatre staff had completed either basic or immediate level resuscitation training to care for children. In addition, all anaesthetists involved in a children's list had provided the hospital with evidence of completion of paediatric immediate life support training (pILS) or, more commonly, the European paediatric life support (EPALS) certificate.
- Clinical paediatric scorecard data for the period quarter one to quarter three (January to September) of 2018 showed 97.4% of consultants who treated children were fully compliant with resuscitation training requirements. Residential medical officers (RMOs) were employed through a national agency and completed mandatory training with the agency. Senior managers received confirmation of the training and kept a record of attendance. We reviewed staff files for two RMOs, which evidenced their qualifications and experience; and we observed they were EPALS certified.

- CYP admissions were discussed by the CYP team prior to admission, to determine whether they met the suitability criteria required.
- We viewed the CYP clinical scorecard data for the period quarter one to quarter three (January to September) of 2018 and saw audit data showed completion of pre-assessment questions, environmental risk assessment compliance, safeguarding risk assessment compliance and outpatient risk assessment compliance were all 100% over the period. Inpatient risk assessment for 16 to 18-year olds treated on an adult pathway was shown to be 98% over this timeframe.
- Since October 2018, the CYP service had suspended surgical procedures for children aged under three years of age and limited services to day-case only paediatric patients this was due to significant staffing issues, whistle-blower allegations, and the subsequent induction of new staff to the service. We were initially told that services would re-commence January 2019; we also saw references to this in different hospital meeting minutes. We were initially told that services would re-commence January 2019; we also saw references to this in different hospital meeting minutes. Following our inspection, we requested information about how the service planned to gain assurance that the service will meet surgical standards for children; and associated information was provided. Information provided by senior managers stated that no complex care or enhanced pain management paediatric patients were to be cared for in the hospital in 2019. In addition, any change in service provision was to be reviewed by the central clinical team and signed off by the medical advisory committee (MAC). In February 2019, senior leaders informed us that services for children under three years of age had recommenced and this had been risk-assessed. At that time, we requested details of associated risk-assessments and evidence of assurance processes undertaken. We saw that surgeries were limited to lower risk procedures that followed established pathways; and that more complex procedures, and those requiring overnight stays, remained voluntarily suspended.

Nursing and support staffing

- **At the time of inspection, we found nurse and support staffing was adequate within the confines of the care being provided.**
- At the time of inspection, we were informed that the paediatric unit was closed during evenings and weekends, and that the service had scaled back surgical provision; confining this to day-case patients aged over three years of age; this was due to significant staffing issues, whistle-blower allegations, and the subsequent induction of new staff to the service. Prior to October 2018, the service had undertaken more complex surgeries requiring overnight stays and had served patients over one year of age (or weighing at least 10kg). During our inspection, staff we spoke with said that they worked around service needs and did not have specific shifts. We were told that shifts were staggered to ensure that paediatric staff were present when children were on the wards.
- Staff we spoke with during our inspection said that no staffing incidents within the service had been reported in the 12 months prior to our inspection. Staff told us this had previously been a problem, as staff did not complete incident forms when staffing level concerns were raised.
- However, we saw that there had been concerns raised about unsafe staffing by previous members of staff; which was investigated as part of a Spire internal whistle-blowing investigation. We reviewed the internal whistle-blowing investigation report and found these concerns had been partially upheld. The investigation identified failings around the allocation of staff (in terms of specific competencies), ambiguity regarding division of responsibilities with non-children and young people's nurses, and confidence of staff to care for complex cases. However, the report went on to say that they found no evidence that the care given to the children in these complex cases was compromised, as support was sought and provided via both the RMO and other staff on duty who were competent in epidural care. Daily agreed staffing requirements for the paediatric ward were outlined in clinical policy 11 (April 2018): Procedure for the care of children and young people in Spire healthcare.
- The investigation noted two comparatively recent consecutive dates in 2018 in relation to whistle-blower concerns about safe CYP staffing; it was noted that a member of staff had called in sick on the dates in question. In response to this, the report stated that "there were adequate RCNs allocated to care for the

children at Leeds and there was no evidence that staffing levels were unsafe at any time". However, we reviewed staffing rosters for these dates and found that one registered children's nurse was allocated to the paediatric ward, with the support of a healthcare assistant, and a registered children's nurse was allocated to work in recovery (as mandated by policy, a registered children's nurse with post anaesthetic care unit competencies and appropriate airway management training). The whistle-blowing investigation report noted that "periodic" support was provided over this period by two senior members of staff (registered adult nurses with paediatric competencies). Post-inspection, senior managers maintained that safe staffing was maintained at all times. However, we found this was not the case and staffing was not compliant with Spire policy (procedure for the care of children and young people in Spire healthcare, April 2018); which is clear that paediatric surgical day/inpatient wards should be staffed by two registered children's nurses when there are four or more patients. Post-inspection, we asked the service to provide assurance of how it would meet safe standards for children's surgery, and its response made clear that a minimum of two registered children's nurses should be present on the unit, and a registered children's nurse should also be available for recovery. We also saw these staffing requirements reflected in clinical governance committee meeting minutes (December 2018) and in an entry on the hospital risk register (dated to January 2019).

- Following our inspection, we reviewed the whistle-blowing report action plan, and saw that it included an action to ensure CYP service staff reported staffing incidents. Completed actions (dated to January 2019) described that a red flag for staffing incidents had been introduced and this had been communicated to staff at ward meetings. We reviewed December 2018 ward meeting minutes and saw that safe staffing policy and incident reporting procedures had been discussed; and the 'Safe Staffing Policy' had been signed as read by staff.
- Senior managers said additional assurance of the improvements made included a hospital-wide daily multidisciplinary team meeting attended by the hospital director, matron and all heads of department; at which staffing levels were discussed.
- As of January 2019, there were five contracted registered children's nurses (with one vacancy), and five bank staff in post in the CYP service.
- We reviewed data provided by senior managers which showed that between November 2017 to October 2018 there had been an 83.7% turnover among children and young people's services staff; which meant (except for two members of staff) there was a new team in place.
- Over the same period, data showed there was a 6% staff sickness rate for children and young people's services staff.
- Over the same timeframe, data showed the proportion of staff hours per month undertaken by temporary (bank and agency staff) was 12% in children and young people's services.
- At our inspection, we saw the service was led by a designated senior nurse for children who had been in post for several years. New registered children's nursing staff included one band five equivalent who had been in post since the beginning of September 2018, and one band five equivalent who had commenced employment with the hospital one week before our inspection. We saw that the hospital had appointed another registered children's nurse with four years' post-qualifying experience, who was due to commence employment in January 2019. A position was vacant for a junior sister / deputy paediatric lead within the service.
- The pre-assessment clinic (outpatients' department) was supported by one registered children's nurse. This nurse's training and appraisal needs were managed through a joint approach by the lead paediatric nurse and outpatients' manager who was a registered nurse by background, not a registered children's nurse.
- At the time of our inspection, three bank staff worked in the service. We were told that all were children's nurses and had familiarity with the service. There was a permanent theatre recovery nurse in post, supported by a bank nurse who was a registered children's nurse by background, to cover if needed. We were informed that a registered children's agency nurse was used on occasion; and the individual was familiar with the hospital and procedures.

- The lead paediatric nurse worked Monday to Friday. Staff took time off in lieu when required and the rota was flexed to accommodate activity.
- During our inspection, we observed that if a controlled drug (CD) was required, two nurses needed to be off the ward as the CD cupboard was situated outside of the ward. However, this had been risk assessed by the pharmacy department and controls had been put in place.
- We were told that if it was considered that bank or agency staff were required then the request was approved and not challenged. There had been three bank health care assistants recently recruited, who were student nurses in the local teaching hospital trust.
- During our inspection we were told that an online rota was introduced three months ago. Staff confirmed that the online rota did not consider patient acuity, although did include bed occupancy. The rota was calculated using patient numbers and the CYP lead liaised with the hospital matron as required to determine staffing needs against patient dependency needs. Post-inspection, senior staff said that these discussions were documented in a paper diary running alongside the electronic system, and in email correspondence. However, we did not see evidence of these.
- At inspection, we were told that the service had been identified by a local university as an appropriate placement for first- and second-year nursing students. There were none present at the time of our inspection. We saw these staff had been considered supernumerary on the rotas.

Medical staffing

- **The service had enough medical staff to keep patients safe and provide the right care and treatment.**
- As of January 2019, 303 consultants had practising privileges at the hospital; of these, 93 consultants had children and young people admitting rights. The term "practising privileges" refers to medical practitioners not directly employed by the hospital, but who have been approved to practice there.
- All medical staff had their registration validated in the last 12 months. Data for the period November 2017 to October 2018 showed that over 99% of medical staff on average were recorded as having all five mandatory documents (medical indemnity insurance, appraisal, biennial review, disclosure and barring service certificate, and Hepatitis-B vaccination) in place across the period. There was a registered medical officer (RMO) on-site 24 hours a day, seven days a week and a weekly rotation with a Monday handover. There was provision of an on-site residence for the RMO. Staff told us that informal clinical supervision was provided to RMO staff by consultant staff.
- All CYP patients were admitted under the care of a named consultant. The surgical consultant reviewed and saw the patient on arrival before surgery. During inspection, staff told us that most consultant staff saw the child post-surgery. Post-inspection, senior managers reported that all paediatric patients were seen by a consultant following surgery.
- A paediatrician was not onsite whilst children were having surgery; they were managed by their surgical teams. However, we were told that medical staff had access to a consultant paediatrician at the local NHS trust at all times.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- Records were paper based and kept securely in the staff office. Computer based information was not visible to the public.
- During our inspection we reviewed eight sets of children's records. These were legible, and the signature of the reviewing nurse or doctor clearly documented. All records we reviewed were kept in an orderly manner with letters and results clearly included.
- Records contained risk assessments such age appropriate paediatric early warning scoring (PEWS) which identified that a child's health had deteriorated. These ensured that children were cared for according to their condition and moved if necessary.
- We reviewed the children and young people's service clinical scorecard for quarter one to quarter three (January to September) of 2018 and saw completeness of PEWS to be 98% compliant over the period.

- Care plans and nursing assessments were in line with the nursing and midwifery council (NMC) guidance on record keeping. This included conversations with patients, parents and information given.
- If parents/carers brought in national parent held records, then these were completed to inform health visitors and GPs of treatment and care.
- Paediatric records were audited on a quarterly basis for key metrics such as fasting times, temperature control and use of paediatric early warning scores (PEWS), these were reported on through the provider's national CYP scorecard and locally in the paediatric steering group report. Additional measures were also audited as part of the paediatric medical records audit (with approximately 20 sets of notes audited per quarter) and these were also reported in the in the paediatric steering group report. Due to an administration error, data for quarter two (April to June) of 2018 was not available. Post-inspection, we reviewed audit results for quarter three (July to September) and quarter four (October to December) of 2018 and saw good overall compliance across the 23 metrics assessed; with all but one above target.

Medicines

- **The service had systems in place to follow best practice guidance when prescribing, giving, recording and storing medicines. Records we reviewed showed patients received the right medication at the right dose at the right time; however, we were not able to corroborate our findings with audit data.** For our detailed findings on medicines, please see the safe section in the surgery report.
- The hospital had procedures to ensure the safety of controlled drugs administration. Two qualified nurses checked the medication against the numbers in the controlled drug book.
- We saw that the controlled drugs cupboard was not positioned on the paediatric ward but on the adjoining ward. We were informed that this was because Home Office guidance had stated that the walls were not thick enough to attach the cupboard. Post inspection senior managers supplied us with the guidance which evidenced this.
- We were told that the controlled drugs cupboard was not accessed frequently, due to the current low acuity of patients. We reviewed a risk assessment undertaken by the pharmacy department in June 2018. This concluded that the current arrangement was low risk, and if staffing meant that one ward nurse would be left on the ward, then a pharmacist would attend to assist.
- We reviewed eight CYP medicine records which had been completed legibly and signed for. We saw staff completed medicine records which included information on children's allergies. Children's weights were clearly documented, which ensured that the correct dosage of medication would be prescribed.
- We observed that post-operative analgesia was prescribed routinely so that staff could respond quickly if a child was in pain.
- The CYP lead nurse told us that although she was a nurse prescriber, she had not prescribed medicines for some months. She told us this was due to a conflict of what was prescribed by the local teaching hospital trust and what was advised in the Paediatric British National Formulary. The issue was on the children and young people's risk register (dated to November 2018), and at that time was yet to be resolved by the local medicine management group. We did not have clarity about the timescale for resolving this. We saw from incident and steering group meeting minutes that this had been ongoing since early 2018.
- The Spire Leeds Hospital had a pharmacy department who were available for information and advice. The department was available seven days a week with an on-call service out of hours.
- We saw there was a process to record the maximum and minimum temperature checks of the drug fridge. These had been completed. Staff knew what actions to take if the temperature fell out of range.
- During our inspection we observed that medicines such as paracetamol and intravenous fluids were stored neatly, safely and away from public access.
- We reviewed incident data for the period November 2017 to October 2018 and identified three medication incidents had occurred in the CYP service between January 2018 and September 2018. Two incidents related to prescribing errors; incorrect doses had been

prescribed, but not administered. One incident related to a parent been given the wrong take-home medication; this was noticed by the parent when they arrived home. The medicine was not administered and returned to the hospital.

- Following our inspection, we requested that senior managers provide medicines audit data for the CYP core service. We could not see that service specific data had been provided (see Surgery core service report). Post-inspection, senior managers responded to say this was not available due to the nature of the service, with theatres and medicines being shared for both adults and children; and combined audit results were provided for all service users groups. However, we observed a risk entry specific to paediatrics which stated, "there is a risk that prescription errors may lead to patient harm", which was scored nine at the time of viewing (23 November 2018). We were therefore uncertain as to how the service intended to monitor key controls, assurances and gaps in controls for this risk.

Incidents

- **The service did not categorise, investigate or manage patient safety incidents consistently well; and we were not always assured that actions had been implemented where identified. In addition to the findings detailed below, please refer to the Surgery report, incidents section.**
- We saw there was a corporate incident policy which was dated June 2018. Staff we spoke with at inspection knew how to access this.
- During our inspection, staff we spoke with knew how to raise incidents on the electronic incident system. The new CYP nurses had not needed to do this at the time of our inspection, but said they would do so if concerns arose.
- We saw that morbidity and mortality issues would be discussed at the paediatric steering group. However, there were no cases prior to and at the time of our inspection. At the time of our inspection, the hospital did not undertake complex surgery or procedures on the under three age group, which had reduced the risk of mortality.
- Following our inspection, we reviewed three CYP service completed serious incident (SI) root cause analysis (RCA) reports. Two of these took place in early 2018. One occurred summer 2017, however, the case warranted inclusion as it formed part of the internal whistle-blowing investigation that took place during the latter half of 2018; which was reported on in January 2019.
- In one case (concerning a child developing post-operative blisters), we saw care or service delivery problems, lessons learned, and recommendations were presented. However, observed some actions had not been signed off; and identified other idiosyncrasies, such as actions being signed off with documented evidence of development and implementation still ongoing. In another case (concerning the transfer of a child to another hospital) we found that the RCA detailed there was "no clinical lesson to learn", nor were there any recommendations or actions resulting from the event; which made us question the appropriateness of the RCA. In the third case (in relation to safeguarding concerns) we reviewed the RCA and saw high priority actions had been implemented. The two actions listed on the action plan had not been signed off (completion dates had not been entered); but there was evidence of these being completed. However, we could not identify this incident on the list of SIs provided by senior managers for the reporting period November 2017 to October 2018.
- Post-inspection, senior managers indicated that some of these cases were not classified as a serious incident (in line with NHS England framework), but as a serious incident requiring investigation (SIRI, in line with Spire policy). This was not in line with our request for information following the inspection (please see surgery report).
- We reviewed paediatric steering group minutes for 2018 and saw these documented incidents and complaints; and observed evidence of discussions about actions taken in response to incidents.
- We saw that incidents were on the agenda for staff ward meetings, although due to staffing difficulties during 2018, there were several months when these had not been held.
- The hospital received national safety alerts. We had been told that these had been shared if there was relevance to hospital areas.

Requires improvement

Services for children & young people

- CYP ward and theatre staff we spoke with understood the Duty of Candour. The Duty of Candour is a regulation which requires medical and nursing staff to be open and transparent if there had been an error in care and treatment. They said that if nurses or clinicians made a mistake they would explain this and apologise to the patient and their parents.
- We reviewed incident data for the period November 2017 to October 2018. We saw 38 incidents which were categorised as involving a patient aged under 18 years of age and we identified an additional seven incidents (from key word searches) that involved child patients. Of these 45 incidents, we saw that 18 (40%) related to cancellations (most of which were identified as unavoidable), seven (16%) related to safeguarding events or concerns, and five (11%) related to 'other' incidents. Of these 'other' incidents, we saw two related to anaesthetists not having compliant training (and surgery being postponed), one related to a staffing incident, one related to a post-operative/anaesthetic complication and one related to equipment failure. Of the 45 incidents, we saw that six were categorised as 'low harm' and 39 were categorised as 'no harm'.
- However, when we reviewed incident data we found that the severity of some of the incidents had been incorrectly categorised. For example, we saw an incident which involved a return to theatre, and another incident which involved paramedics being called to the patient's house following day case surgery, were categorised as 'no harm'.

Safety Thermometer (or equivalent)

- **The service displayed safety monitoring results. Staff collected safety information and shared it with staff, patients and visitors.** Children and young people's service data was combined with surgery core service data; please see Surgery core service report.

Are services for children & young people effective?

Good

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

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance; however, we were not always assured of the accurate audit and reporting of CYP service performance indicators.**
- We saw that CYP staff had access to corporate and local policies. The children's policies we reviewed reflected national guidance; and had been ratified, with clear dates for review.
- There was a local audit schedule; with outcomes reported through the provider's national CYP scorecard and locally in the paediatric steering group report. However, information provided post-inspection showed children's services dashboard data was not always accurately presented in key reports. Different data for the same CYP service performance indicators were presented in the quarter four 2018 Clinical Quality Report (dated April 2019), and the March 2019 paediatric steering group report. For example, we could not reconcile data across most metrics for quarter one (January to April 2018); and we could not reconcile quarter four (October to December 2018) and year-end data for unplanned transfer to another hospital, avoidable cancellations.
- The World Health Organisation (WHO) five steps to safer surgery checklist was in use at the hospital. This reflected evidence-based practice for surgical procedures. As described earlier (see safe, assessing and responding to risk section), we reviewed documentation for 10 paediatric patients who had surgeries or interventions for the period 1 December 2018 to 11 December 2018. Evidence showed that observational checks had been completed. In addition, we reviewed associated documentation and saw this to be sufficiently completed, overall. However, we noted three instances in which the sign out section had been signed but a sign out time had not been entered; and this did not correspond with the audit results. We also noted that step one (team brief) and step five (team de-brief) were not included in the audit data presented, and some omissions were noted in the documentation in these respects. As previously described, we saw an incident documented where chaperoning had not occurred (see Safe domain, incidents section). The outpatient children's nurse audited tongue tie procedures and chaperoning to check compliance.

- There was a paediatric care pathway for day cases and those children who required admission overnight. This supplemented other documentation such as the paediatric early warning scoring (PEWS) tool.
- The service audited compliance with policies. For example, we saw staff audited hand washing compliance and put in actions where the results did not meet standards.
- The outpatient's children's nurse had implemented a pathway for infant tongue tie, which included a time constraint of not undertaking these after 16:00 hours; so that if there were immediate post procedures concerns, parents had access to timely advice.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.**
- Staff told us that the hospital kitchen would provide a range of meals for children, which they could choose and included diets where there was a known allergy.
- We reviewed patient led assessments of the care environment (PLACE) reports for 2018 and noted the hospital scored 98% for the food and hydration domain, which was better than the 90% England average.
- Fasting guidance, approved by the paediatric anaesthetist (May 2018), was available for staff to access. The guidance identified up to 3ml/kg of fluid should be encouraged up to one hour prior to surgery; for example, a one-year old child weighing 11kg would be allowed up to 33mls of fluid.
- We saw that fasting times were audited, and compliance data was presented on the service's clinical scorecard. From quarter one to quarter four (January to December) of 2018, an average compliance of 71% was recorded; we saw this had risen from 59% in quarter one (January to March), to 79% in quarter four (October to December) of 2018. The hospital target rate was 60%. The peer group average rate for 2018 was 76%.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.**
- Child-friendly pain charts were embedded into the PEWS tool, which helped younger children explain their pain.
- We reviewed the CYP clinical scorecard for the period quarter one to quarter four (January to December) of 2018. We saw compliance for the proportion of pain scores with every set of observations was 100% over this timeframe.
- We reviewed eight patient records during our inspection and saw all patients had scored zero for pain. We did not identify any patients during our inspection that were in pain, where this had not been recognised and acted on. We saw that CYP staff had previously attended a pain management day at the local hospital trust, but we were not clear if new CYP staff had had the opportunity to attend this.

Patient outcomes

- **The service collected CYP patient outcome data and benchmarked data against Spire peer group averages to monitor performance.**
- Measures of CYP patient clinical outcomes were limited to infection rates, readmission rates, unplanned returns to theatre and transfers to NHS care.
- Staff informed us that the hospital did not participate in national audits (benchmarking of the hospital's performance externally from the Spire group) in relation to the care of children and young people, due to the low numbers of children treated.
- Data showed the unplanned return to theatre (during same surgical admission) rate was 0.16 for 2018; which was higher that the peer group average of 0.03. Over the same period, data showed there had been no incidences of unplanned returns to theatres following surgical readmission; which was in line with the peer group average (0).
- The rate of readmission within 31 days of discharge was 0.16 in 2018; which was lower than the peer group average of 0.43.
- The rate of unplanned transfers to another hospital was 0.16 in 2018; which was higher than the peer group average of 0.05.

- The data showed there had been no cases of surgical site infection within 31 days of surgery in 2018; which was better than the peer group average rate of 0.20.

Competent staff

- **The service made sure staff were competent for their roles.**
- At the time of inspection, paediatric surgery was limited to day case procedures for children over three years of age. We saw existing nursing staff and nursing staff who had been recently inducted into the service were competent for their roles; given that surgery had been limited to low risk cases at that time.
- New registered children's nurses on the ward underwent a mentorship programmes to ensure they were orientation to the Spire environment, and their training needs were highlighted and addressed.
- Managers appraised staff's work performance and provided support and training to deliver safe and effective care. There were plans to start clinical and safeguarding supervision with staff.
- The competency framework for nurses was updated centrally in 2018. We saw an example of one completed competency assessment for an existing nurse in the outpatient department.
- We saw that existing bank and agency staff had completed an induction package which included emergency procedures and the environment.
- Staff reported that they had access to education and training courses relevant to their area of specialism. Evidence of participation was seen in theatres, outpatients and the ward areas.
- We saw that the hospital employed a practice educator to deliver and train in mandatory subjects and scenarios; the practitioner was employed full-time but had only recently commenced employment at the time of inspection.
- Staff confirmed that all anaesthetists and surgeons with practising privileges for children had comparative NHS practice and had received training and appraisals through the local NHS trust.
- We saw that consultants operating on children had their practicing privileges reviewed appropriately.
- We saw documentation that the resident medical officers (RMO's) had received an induction to the hospital, which included orientation to resuscitation equipment and corporate and local policies.
- The majority of radiographers and physiotherapists had been trained in children's competencies. Those who had not, did not treat children.
- Outpatient staff who worked with children completed paediatric competencies in anaphylaxis, child and young people, level three safeguarding and paediatric intermediate life support (PiLs). We saw relevant staff had completed care of children and young people competencies.
- Regular scenario training for paediatric staff had taken place and included major haemorrhage, asthma and choking protocols; and scenarios included elements of human factors and communication training. These training sessions had been documented with action points and learning. At the time of inspection, the most recent session we saw documented was in October 2018.
- The paediatric steering group had a role to identify training needs which could not be met in house and to ensure these were available through external sources.
- We were told that the hospital supported qualified nursing staff in their revalidation process with the Nursing and Midwifery Council (NMC).

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, theatre staff and other healthcare professionals supported each other to provide care.**
- We saw that staff contacted external health providers as part of the discharge process. This included GPs, health visitors and school nurses.
- During our inspection, staff we spoke with reported good working relationships both in the children's area and in the wider hospital.
- We saw a good transfer of patients between the ward and theatre.

Seven-day services

Requires improvement

Services for children & young people

- **Services were available that supported care to be delivered seven days a week (if necessary).**
- At the time of inspection, the service had limited procedures to day-cases and children over three years of age.
- The hospital operated a five-day CYP service. Staff we spoke with said that in the past, surgeons had occasionally operated on a Saturday, to meet patients and carers needs.

Health promotion

- **The service encouraged patient to be as fit as possible for surgery and promoted good health.**
- Health promotion leaflets were displayed throughout the children's ward area and in the children's information folders which were kept by their beds.
- Leaflets on bed wetting, daytime wetting, bowel problems and potty training were displayed and available for parents to take away.
- We saw the hospital had delivered staff 'flu' jab drop-in sessions with the occupational health nurse.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**
- Staff we spoke with understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care, and how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care. Staff followed service policy and procedures when a patient could not give consent.
- Staff we spoke with understood about the issues around consent and young people, including Gillick and Fraser competencies. Staff could articulate the concept of parental responsibility and gave examples of where this had been problematic and how this had been addressed.
- Older children could talk to a clinician without their parent(s) present. The hospital had a policy on consent and we saw that young people were entitled to withhold consent. The treating doctor decided whether the young person had the competence to make their own decision.
- Staff understood the consent arrangements for children who are looked after by the local authority.
- We reviewed eight patient records during our inspection and saw consent had been appropriately documented.
- We were informed that tongue tie procedures carried out on infants as a minor procedure required verbal consent by parents only. Further advice from a CQC medical advisor informed us that this was adequate.
- We reviewed the children and young people's service clinical scorecard for quarter one to quarter three (January to September) of 2018 and saw completeness of consent forms was 100% compliant over the period.

Are services for children & young people caring?

Good

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

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- During our inspection, we observed the children's nurse and consultants interacted very well with two children who had attended the service for an operation. Nurses were compassionate and caring with children, young people and their relatives.

Requires improvement

Services for children & young people

- Both families told us they were happy with the care they received from nursing and medical staff. We spoke with an additional three families by telephone and all told us their children had received good caring treatment at the hospital.
- Compassionate care in practice was an integral part of mandatory training.
- Children's and young people's questionnaires were available for completion and asked for feedback on the child or young person's stay.
- The hospital website highlighted that there was adherence to the six c's in caring which included compassion, caring, competence courage and commitment.
- CYP patient satisfaction data for the period September to December 2018 stated that 100% of patients or their carers would recommend the service to a friend. In addition, when asked about how staff welcomed them, and the way in which they were treated, 100% of respondents rated these measures as 'good' or 'great'.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff provided children with appropriate emotional support. Children could attend the hospital for pre-operative familiarisation visits; where they met nurses, clinicians and the anaesthetist. This was important in reducing their anxiety in a strange environment.
- The children's nurses played with children who were scared or upset. They had toys that helped to demonstrate procedures to be undertaken.
- The hospital had plans in place to recruit a play therapist; and senior leaders informed us that one had been appointed following our inspection.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- We spoke with two patients and their patents during our visit and we spoke with an additional three parents of children who had recently had procedures via telephone following the inspection. Patients and parents we spoke with described they were satisfied with the communication and care provided. They told us that paediatric nurses were sympathetic and offered age appropriate reassurance and advice. Parents told us they felt reassured that their child was being provided with a high level of care.
- We saw there was the use of a story, which was read to children by their parents; about a small bear who has an anaesthetic. It allowed children to ask questions and explore any worries they may have about what was going to happen during their admission. This information was from the Royal College of Anaesthetists (UK) and included a leaflet for parents.
- The patient information board identified information about staffing levels, complaints information in six languages, who to contact following discharge, photos of the children's nursing team and chaplaincy service information. The 'youth rights in healthcare' included information on consent, feedback and confidentiality.
- CYP patient satisfaction data for the period September to December 2018 showed, that when asked about the information provided, and the way in which staff listened, 100% of respondents rated these measures as 'good' or 'great'. We saw 97% of respondents thought the way their questions were answered was 'good' or 'great'.

Are services for children & young people responsive?

Good

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

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of local people.**
- The CYP service at the hospital was a paediatric 'hub' for Spire hospital's in the region; as other Spire locations in the vicinity had stopped undertaking surgery on children (from 2016 to 2017 onwards).

Requires improvement

Services for children & young people

- The paediatric unit was a child friendly environment, was decorated with pictures and had games which all children could access. Toys and electronic entertainment were available for children and young people to access. We saw that interactive toys were available.
- The unit was comprised of eight side rooms, all of which were ensuite. One room was used for pre-assessment, so that the children could become familiar with the ward they would be admitted to.
- Two toy cars were available for children in theatres, which were used for distraction.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Paediatric nurses rotated through an on-call system; so that parents could approach them post-discharge for advice. At the time of inspection, the nurse on call was the lead paediatric nurse, as remaining staff were new to their roles and required a period of induction before they were asked to undertake this role. We saw previous nurse on call rotas dated from June 2018. Staff told us that each on call nurse was on call for one week at a time.
- During our inspection, staff we spoke with said that to reduce the time inpatients stayed on the ward, children with catheters in place were discharged home and returned to the hospital approximately one week later for catheter removal. If parents had concerns they were able to call the on-call children's nurse. Parents could also access their consultant for support.
- The ward had a family focus with unrestricted visiting times and a reasonable number of family members were allowed to visit. One parent could stay overnight if required, with meals provided. Arrangements could be made for siblings to visit, if appropriate.
- Staff told us it was possible to pre-book an interpreter, when needed; and said these needs would be identified at booking and pre-assessment. Staff we spoke with were unsure if there was a corporate interpreting policy, or how they could access British Sign Language translation.
- Senior managers provided us with a flowchart, which guided staff to use a recognised national interpreting service. The hospital's CYP policy described the requirements regarding using an interpreter, including guidance to advise against use of family members, unless in an emergency. Health promotion leaflets we saw on wards and department were mostly in the English language.
- Staff we spoke with said that to reduce disruption to a child's education, every effort was made to arrange appointments and treatment around education arrangements.
- We saw diverse games and activities available at the hospital, which were appropriate for different age groups and stages of development.
- There was a vacancy within the service for a play specialist at the time of inspection.

Access and flow

- **People could access the service when they needed it.**
- People were supported to access the service. Access information was displayed in the main hospital reception area and advised patients and families what access tools were available; for example, a hearing loop and how to request the equipment.
- The 'Local Paediatric Policy for Spire Leeds Hospital' outlined criteria for admission to the CYP service. Ordinarily, the hospital accepted children over one year of age and 10 kg in weight for admission; but services were limited to children over three years of age and day-cases at the time of our inspection. Policy stipulated that every child had a clinical pre-assessment by a registered children's nurse two weeks prior to admission. If the child was unfit to go ahead with the procedure as planned, their assessment would not be repeated.
- The five families we spoke with during and following our inspection said there had been no delay from referral to procedure.
- We reviewed referral to treatment (RTT) data for the location from July 2018 to December 2018. We saw the proportion of NHS patients referred and treated within 18 weeks was 98.5% on average over this timeframe.

Requires improvement

Services for children & young people

- Staff told us that older children were admitted to the adult ambulatory care unit for minor operations as outpatients. Discussion with staff identified that when children attended this area, paediatric staff from the ward or outpatient department cared for those children. Resuscitation equipment was brought to the ward by the paediatric nurse. Staff told us this resuscitation equipment was taken from the theatre recovery area.
- In outpatient's, children's clinics were predominately ear, nose and throat (ENT) clinics. Two clinics took place weekly run by paediatric ENT surgeons. Children were not seen first, staff said the reason for this was dictated by patient choice; which meant children may be seen later in the clinic. Therefore, clinics included adult and children. A weekly urology paediatric clinic also took place. We saw that the paediatric nurse was present at these clinics.
- A Friday allergy clinic and immunology clinics were undertaken by paediatricians.
- We reviewed theatre lists and saw that where possible, children and young people were treated first on the lists, and then in age order from the youngest to the oldest; to help ensure an adequate post-operative recovery time on the ward.
- During our inspection, we saw that all relevant staff we spoke with had completed paediatric intermediate life support (PiLs) and level three safeguarding training sessions. The provider had paediatric competency tools in place for non-paediatric staff supporting the service. Staff said they were well supported by the paediatric nursing staff.
- Data for January to December of 2018 showed the rate of avoidable cancellations on the day of surgery was 0.16; this was better than the peer group average of 0.50.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously and investigated them.**
- There was a complaints policy available on the hospital intranet and staff we spoke with knew how to access this.
- Staff we spoke with were clear about what they would do should a concern or complaint be raised by a patient, or their parent/guardian.
- 'Please talk to us' Spire Leeds Hospital leaflets were available for children and families to access. They offered advice about the complaints process and stages of complaints review.
- During our inspection we were informed complaints information could be accessed in a variety of languages on request.
- Information provided by senior managers following our inspection showed there had been five formal complaints about the CYP service from November 2017 to October 2018; and 80% of these had been closed within the designated timeframe; against a target of 75%.
- Senior staff advised us that there were no current complaints in CYP services at the time of inspection.

Are services for children & young people well-led?

Inadequate

Our rating of well-led went down. We rated it as **inadequate.**

For more detailed information, please see the well-led section of the surgery report.

Leadership

- **Key leaders in the service did not have the right skills and abilities to run a service providing high-quality sustainable care.**
- The service was led by a hospital director, who was supported by a senior management team comprised of a matron / head of clinical services, business development manager, operations manager and finance manager.
- Day-to-day running of the service was managed by a paediatric lead, with matron having overall responsibility for the service.
- The CYP service leadership was challenged by the significant turnover of nursing staff, both substantive and bank, in the 12 months before our inspection.

Documents submitted to the CQC highlighted that there had been significant difficulties within the team dynamics and lack of cohesive team work during this period.

- At the time of our inspection, there was in effect a new nursing team in place. We spoke to current staff who told us they felt well supported.
- Post-inspection, senior managers said that an additional full-time children's nurse/play specialist, and a full-time deputy team leader had been recruited.
- However, we had significant concerns about the abilities of the leadership team to promote and maintain a positive culture, ensure good governance of the service and to adequately manage risks, issues and performance in the service (please see relevant sections below, and the well-led section of the surgery report).

Vision and strategy

- **The hospital had a strategy for what it wanted to achieve and workable plans to turn it into action; however, there was no CYP specific mission statement or vision.**
- There was no children's and young people service mission, statement or vision in place at the service. However, we saw the Royal College of Nursing Paediatric Philosophy of Care was in place; which encouraged the active participation of the child and their family in their care.
- Following our recent inspection, senior managers provided us with a hospital-wide 2018 strategic priorities document, which detailed six main aims. These included, to be outstanding, develop staff and enhance behaviours, and deliver high levels of customer experience. The remaining strategic aims related to sub speciality development, financial growth, and maintenance of operating margins.
- The ethos of the hospital-wide strategy was to "promote teamwork, excellent communication and celebrate our success together".

Culture

- **Senior managers had not promoted and maintained a positive culture that supported and valued staff and created a sense of common purpose based on shared values.**
- At the time of inspection, the nursing team was relatively new. Staff told us they felt supported by managers and were being mentored.
- However, we saw that in the 12 to 18 months prior to our inspection, concerns had been raised by several staff; who had felt that their concerns had not been sufficiently addressed by the service, or by the hospital. This resulted in whistle-blowing to head office, and an investigation was undertaken that upheld or partially upheld several of their concerns. Concerns were also reported to CQC.
- When we reviewed the internal whistleblowing investigation report submitted to the CQC post inspection, we were concerned that there had been an incident rated as 'weak'; which had indirectly involved family members of one of the whistle-blowers. We saw this allegation had been upheld. Following our inspection, senior managers said that the assessment of 'weak' was in relation to the criticality of the concern as it relates to any (potential) risk to patient safety.
- At the time of our inspection, a designated freedom to speak up guardian (FTSUG) was available at the hospital for staff to access and we saw their contact details on the staff noticeboard. We saw an action plan had been developed to support the induction of the new team, which included raising awareness of the hospital's FTSUG amongst service staff; however, this was in the early stages of implementation.
- During our inspection, outpatient staff told us they thought the children's service was a 'great little service'; and that their role within the department worked well.
- Surgical consultant staff were described as approachable and responded to any questions and support required.
- Please see the associated section of the surgery report for hospital-wide staff survey results and initiatives.

Governance

- **The service did not systematically improve service quality and safeguarded high standards of care.**

- We reviewed a hospital management structure chart for December 2018, which showed a line of responsibility that went from the hospital director, through the matron / head of clinical services, to the paediatric lead.
- The hospital had a paediatric steering group which was established to manage CYP service's clinical governance and to ensure compliance and the promotion of best practice. Discussions from the paediatric steering group fed into clinical effectiveness, clinical governance, senior management team and medical advisory committee (MAC) meetings. We saw that the whistleblowing issues had been discussed at the October 2018 MAC meeting.
- Terms of reference (ToR) we reviewed described the paediatric steering group was required to meet a minimum of three times per year. The provider told us that the third meeting for December 2018 had been cancelled due to not meeting quorum. This frequency did not assure timely oversight of key performance target and safety measures.
- We saw ToR for the paediatric steering group included core membership and objectives of the group; for example, to review admission criteria to ensure a safe and effective service. Meeting minutes were seen to be adequately detailed, but we were not always assured of the robustness of data discussed.
- Senior managers reported that due to an administration error, paediatric medical record audit data (see effective section of the report) was not available for quarter two (April to June) of 2018. As such, the paediatric steering group report produced October 2018 contained associated quarter one (January to March) 2018 data. However, CYP scorecard data for quarter two of 2018 was presented. Post-inspection, we saw that quarter three (July to September) and quarter four (October to December) 2018 data was presented in the March 2019 paediatric steering group report.
- However, as described earlier (see effective section of the report), information provided post-inspection showed children's services dashboard data was not accurately presented in key reports. Different data for the same CYP service performance indicators were presented in the quarter four 2018 clinical quality report (dated April 2019), and the March 2019 paediatric steering group report. In addition, we could not always reconcile WHO five steps to safer surgery audit data to associated documentation (see safe section of the report).
- There had been a comprehensive review of children's services within the hospital in June 2018, which highlighted positive findings. This had been challenged by some staff which resulted in a further review August 2018. The outcome of the follow-up (August 2018) review concurred with the findings of the June 2018 review. However, we later saw several concerns raised by staff about the factual accuracy of the June 2018 report had been upheld or partially upheld in the later whistle-blower investigation report.
- We saw there was a consultant paediatrician and advisor to the Spire group. Their role was to advise on national policy, process and legislation; and significant incidents at local level, if required.

Managing risks, issues and performance

- **The service had not sufficiently applied the systems available to identify risks and implement plans to eliminate or reduce them consistently well.**
- We were not assured that the task specific risk assessment for nursing children in adult areas had been implemented in a timely manner. We were also concerned that patients aged under 16 years of age had been nursed in adult areas without sufficient risk assessment taking place (see safe, assessing and responding to risk section).
- We were not assured that the severity of reported incidents had been correctly classified. We reviewed RCA reports which were of sufficient quality overall. However, we were also not assured the sign-off procedure was robust; as recommendations and action plan information was sometimes ambiguous, and evidence of actions being followed through and closed out was not always available (see safe, incidents section).
- We saw there was an up to date service level agreement (SLA) in place for transfer of deteriorating children to other hospital sites. However, the SLA for the critical care transfer of paediatric patients from the hospital to another (NHS trust) hospital centre had lapsed in

February 2018 and had not been renewed as of January 2019. We saw evidence that showed attempts had been made by service leads during 2018 to renew the agreement with the provider. However, when asked to provide assurance of meeting surgical standards for children, should the service resume procedures for children aged three years and younger, and for more complex procedures (the former of which had occurred in February 2019), senior managers described the agreement as offering an element of assurance. As of May 2019, we have seen no evidence that the agreement has been renewed.

- We could not be assured that the CYP risk-register presented an accurate reflection of risks facing the service or was being appropriately managed. Before our inspection we were provided with a paediatric risk register dated to 23 November 2018. We saw there were 13 risk entries and risk-rating scores varied from nine to one; with two entries risk-rated as nine and one entry risk-rated as eight. The register included 11 risks which were relevant to the CYP service, but which were managed at a hospital level. For example, we saw that two risks had been added to the register on 22 October 2018 (regarding allergy bracelets (risk-rated as four), owned by 'wards', and equipment failure (risk-rated as three) owned by 'theatres'). Within these risks, we identified one risk register entry showed the 'target' risk rating as higher than the 'current' risk rating, and three risk register entries showed the 'target' risk ratings were the same as 'current' risk ratings. There were only two CYP specific risks owned by the paediatric department; risk that prescription errors may lead to patient harm (added 27 September 2018 and rated nine) and risk to patient care quality if staffing levels are not adequate (added 26 June 2018 and rated six).

Managing information

- **The service had systems to manage information. However, appropriate and accurate information was not always effectively processed, challenged and acted upon.**
- The service maintained a clinical scorecard to monitor key performance and patient outcome indicators. Scores were RAG-rated (red, amber, green rated) according to target measures or whether incident rates were a statistical outlier when compared to other hospitals in the group.
- However, the service did not always ensure that the information used to monitor, manage and report on quality and performance was accurate, valid, reliable, timely and relevant. For example, we saw that paediatric medical record audit data (see effective section of the report) was not available for quarter two (April to June) of 2018. Post-inspection, we also saw different data for the same CYP service performance indicators presented in the quarter four 2018 clinical quality report (dated April 2019), and the March 2019 paediatric steering group report. In addition, we could not always reconcile WHO five steps to safer surgery audit data to associated documentation (see safe section of the report).
- Information provided by senior managers following our inspection showed that 100% of hospital staff had completed information governance training.
- Computers were available on wards. During the inspection, all computers were locked securely when not in use.
- Guidance on 'How to transport confidential data' was displayed in the ward office.
- Electronic rostering had been introduced in the CYP service.

Engagement

- **The service engaged with patients, staff, and local organisations to plan and manage services.**
- During our inspection, staff we spoke with said that staff meetings took place quarterly and were documented. However, due to staffing difficulties during 2018, there were several months when these had not been held.
- 'Tops and Pants' patient feedback was displayed on the ward. The 'Tops and Pants' tool gives children and their families the opportunity to provide feedback by writing comments and hanging them on a washing line displayed on the wall. Things they like about are written on 'tops' and any areas which the service could do better are displayed on 'pants'. We saw 'tops' feedback included the nurses, chicken nuggets, toys and support received in the theatre room. We saw 'pants' feedback included pain, a hurting hand, waiting to go home, and feeling sick.
- We saw that a local general practitioner (GP) was an honorary member of the medical advisory committee

(MAC) to provide insight on local information. This GP did not practice at the hospital. Post-inspection, senior managers said that this added independent insight into clinical issues explored by the MAC.

- Please refer to the surgery report for details of hospital-wide engagement activities.

Learning, continuous improvement and innovation

- **We saw limited evidence that the service was committed to consistently improving services by learning from when things went wrong. However, we did see evidence of the service promoting training.**
- We found limited evidence of discussions about learning from incidents and complaints in meeting minutes we reviewed. Following our inspection, the senior managers said that learning from local incidents was also shared during daily huddles and in staff newsletters. They also said learning posters had been introduced to share learning in a timely manner, and these were displayed on staff notice boards in all key areas.
- CYP service RCA reports we reviewed were of sufficient quality overall; however, we were not always assured that actions had been implemented where identified. In addition, we were not assured that the service categorised, investigated and managed patient safety incidents consistently well (see safe, incidents section).
- Since October 2018, the CYP service had suspended surgical procedures for children aged under three years of age and limited services to day-case only paediatric patients; this was due to significant staffing issues, whistle-blower allegations, and the subsequent induction of new staff to the service. We were initially told that services would re-commence January 2019; we also saw references to this in different hospital meeting minutes. Following our inspection, we requested information about how the service planned to gain assurance that the service will meet surgical standards for children; and associated information was provided. In February 2019, senior managers informed us that day case surgeries for children under three years of age (weighing at least 10kg) had recommenced, and this had been risk-assessed. At that time, we requested details of associated risk-assessments and evidence of assurance processes undertaken. We saw that surgeries were limited to lower risk procedures that followed established pathways; and that more complex procedures, and those requiring overnight stays, remained voluntarily suspended.
- Post-inspection, senior managers provided a 2018 training plan for the CYP service. This included mandatory and competency training activities. It also detailed additional safeguarding training and multidisciplinary activities undertaken by the CYP lead (see safe, safeguarding section).

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The service must ensure they identify, correctly classify, and investigate incidents consistently well.

The service must ensure that they notify external agencies of incidents, where applicable; and do so in a timely manner.

The service must ensure there is sufficient learning from incidents, discussion of lessons learned are adequately documented in key committee and group meeting minutes, lessons learned are shared with staff, and the implementation and sign-off of actions is robustly monitored.

The service must ensure that risk registers are appropriately managed, key risks facing services are reflected on risk registers, and risks and targets are accurately scored and suitably reviewed.

The service must ensure it always fulfils its Duty of candour (DoC) obligations, and the specific requirements of the regulation; which include informing people about care and treatment incidents in a timely manner, providing reasonable support, and providing truthful information.

The service must ensure theatre ventilation systems are compliant; and continue to monitor hip replacement surgical site infection rates.

The service must ensure World Health Organisation (WHO) surgical safety checklist and national early warning score (NEWS) tool documentation (especially in relation to temperature monitoring) are completed consistently well.

The service must ensure that patients are not fasted for excessive periods prior to surgery.

The service must ensure they appropriately risk-assess the nursing and treatment of paediatric patients in adult areas consistently well.

The service must ensure that they follow best practice when prescribing, giving, recording and storing medicines.

The service must ensure they have an in-date service level agreement (SLA) for the transfer of critically ill children in place.

Action the provider SHOULD take to improve

The service should ensure substances hazardous to health are always stored securely.

The service should ensure emergency equipment checks are completed and documented consistently well.

The service should ensure that patients are reviewed daily and prior to discharge by a consultant, and consultants complete sufficiently detailed (and daily) medical records.

The service should ensure that committees meet frequently, and in line with their terms of reference; and key performance and audit data is available for review.

The service should ensure venous thromboembolism (VTE) risk assessments are consistently completed, actions required for patients identified as being high risk are documented; and where eligible, prophylaxis is administered within recommended timescales.

The service should ensure that there is learning from concerns, claims, and complaints; learning is shared with staff, and evidence of learning is documented in relevant meeting minutes.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure that patients are not fasted for excessive periods of time before surgery. The service must ensure theatre ventilation systems are compliant. The service must ensure they appropriately risk-assess the nursing and treatment of paediatric patients in adult areas consistently well. The service must ensure World Health Organisation (WHO) surgical safety checklist and national early warning score (NEWS) tool documentation (especially in relation to temperature monitoring) are completed consistently well. The service must ensure that they follow best practice when prescribing, giving, recording and storing medicines.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service must ensure they identify, correctly classify, and investigate incidents consistently well. The service must ensure that they notify external agencies of incidents, where applicable; and do so in a timely manner. The service must ensure there is sufficient learning from incidents, discussion of lessons learned are adequately

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Requirement notices

documented in key committee and group meeting minutes, lessons learned are shared with staff, and the implementation and sign-off of actions is robustly monitored.

The service must ensure that risk registers are appropriately managed, key risks facing services are reflected on risk registers, and risks and targets are accurately scored and suitably reviewed.

The service must ensure they have an in-date service level agreement (SLA) for the transfer of critically ill children in place.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour The service must ensure it always fulfils its Duty of candour (DoC) obligations, and the specific requirements of the regulation; which include acting in an open and transparent way, informing people about care and treatment incidents in a timely manner, and providing truthful information.