Classic Hospitals Limited

Spire Hesslewood Clinic

Quality Report

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This report describes our judgement of the quality of care at this hospital. 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 hospital	Good
Surgery	Good
Services for children and young people	Not sufficient evidence to rate
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Hesslewood Clinic is operated by Classic Hospitals Limited as a satellite to Spire Hull and East Riding and is governed by the same management structure. Staff worked across both sites. Facilities at the clinic included two operating theatres for minor procedure day cases, outpatient and diagnostic facilities.

We inspected this clinic as part of our independent hospital inspection programme. The inspection was conducted using the Care Quality Commission's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following three core services at the hospital: surgery, children and young people and outpatient and diagnostic imaging. We carried out the inspection on the 14, 15, 16 September 2015.

Overall we rated surgical services and outpatient and diagnostic imaging services as good. We rated safe and well-led for children and young people's services, we inspected but did not rate effectiveness, caring or responsiveness because we did not have sufficient evidence and because of the small size of the services.

Are services safe at this clinic ?

The clinic was visibly clean but there were gaps in assessing and auditing of infection prevention and control procedures, specifically observational hand hygiene audits. Staff were aware of the duty of candour. Incidents were reported. Staff received mandatory training in the safeguarding of vulnerable adults and children and the nursing and medical staff we spoke to were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children. Mandatory training was in place for all employed staff with some areas below expected compliance levels. For the medical staff mandatory training records were not always completed or checked with substantive employers; there were only three out of 10 which we checked that had training evidence logged. The hospital undertook the 'five steps to safer surgery' checks. The required pregnancy test records for a specific dermatology treatment were not well-maintained, which meant there was a risk that patients may have been inappropriately prescribed medication when they were pregnant. There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.

Are services effective at this clinic ?

Patients mostly were cared for in accordance with evidence based guidelines. Policies were mostly developed nationally. On a local level when a new organisational policy was received, it was reviewed by the Medical Advisory Committee (MAC) and a gap analysis undertaken, information relevant to the site was added in; nothing was allowed to be removed from the policies. Clinical indicators were monitored and compared across the company through the publication of a quarterly clinical scorecard. Consultants working at the clinic were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital); these, with appraisals, were reviewed every year by the senior management team.

Are services caring at this clinic ?

Patients were cared for in a positive and compassionate way. Patients and relatives we spoke to all gave positive examples of caring. We observed positive interaction of staff with patients and staff appeared genuine, supportive and kind. There were high (scores above 85%) for the Friends and Family Test, however the response rate fluctuated from high levels (above 61%) to low levels (less than 30%). Patients felt they were involved with information and decisions taken about them.

Are services responsive at this clinic ?

Summary of findings

Spire had responded to demand and opened the Hesslewood Clinic in 2015 to initially provide outpatient services and also dermatology day surgery for NHS and private patients. No patients waited longer than 18 weeks for treatment. Theatre utilisation was growing as new services were being developed on site or transferred from Spire Hull and East Riding hospital. Patients' individual needs were met. There was a complaints policy and process in place.

Are services well led at this clinic ?

There was a vision and strategy in place for Spire across the two sites. However there was a lack of vision and strategy for the smaller core services and staff could not articulate verbally what the vision might be. Whilst there were governance structures in place for the provider and locally across the two sites these were not robustly implemented; there was a high element of trust and a low assurance culture. There was a shared governance structure, with a clinical governance committee, across both the Spire Hull and East Riding hospital and the Hesslewood clinic. This committee fed directly into the medical advisory committee (MAC). It also had direct links into the senior management team and hospital and national group governance arrangements. The monitoring system to ensure the doctors' safety to practice within the clinic was not robust at the time of the inspection, especially with regard to monitoring mandatory training and some disclosure and barring checks. The organisation had a governance structure with reasonable attendance at meetings. Staff described leadership and culture across the sites in a positive manner. The management team actively engaged in proactive recruitment and retention of staff including recent staff incentive packages.

However, there were also areas of poor practice where the provider must make improvements. Importantly, the clinic must:

- Take action to ensure that the appropriate checks and records as per HR policies are in place and recorded for the doctors working at the hospital including Disclosure and Barring Service (DBS) checks, mandatory training and appraisals.

In addition there were a number of areas where the provider should take action and these are listed at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Good	We rated surgical services at Spire Hesslewood clinic as good overall because: We saw appropriate staffing levels at the Hesslewood clinic. We observed good compliance with the 'five steps to safer surgery' procedures and the related World Health organisation audit. The clinic was visibly clean. Patient safety was monitored and incidents were reported via a centralised computer based system, Patients were cared for in a positive and compassionate way. Internal organisational patient surveys we reviewed showed positive responses around care received, discharge information, and privacy and dignity. Spire had recognised the growth in demand for services and had begun caring for patients from February 2015 on a 'walk in, walk out' basis, after a six month commissioning period. Patients' individual needs were met. Staff received mandatory training however, compliance rates in a number of areas were below the expected level of approximately 67% for the end of August 2015 especially in resuscitation training with below 50% attendance on life support courses. Medical personnel records we reviewed had variable levels of compliance with the HR policies. Mandatory training records and certification for medical staff from substantive employers were not always documented as checked and a full set of references were not always available. There were minimal IPC audits carried out, policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed. There had been no serious incidents reported since the clinic opened. Personnel

Summary of findings

records we reviewed had variable levels of compliance with the HR policies. DBS checks were not consistently recorded or reviewed regularly and a full set of references were not always recorded.
There was a vision in place for the development of the clinic.

Services for children and young people	**Not sufficient evidence to rate**		Due to the small size of the service we did not have sufficient, robust information to fully rate the service. The environment was visibly clean and personal protective equipment was available. However, the service was not carrying out hand hygiene observation audits. Equipment was well maintained and there had been no incidents reported which involved children and young people. There were no separate areas to wait or clinic time for children and young people. However, all patients were seen in private consulting rooms. Nurse staffing for children and young people was predominantly two part time contracted children's nurses who worked across both sites, and bank staff. Mandatory training was up to date for employed staff, this enabled staff to carry out their roles effectively and safely, training included awareness of safeguarding procedures and child protection. However, some consultants may have been treating children without having received the appropriate level 3 safeguarding training. Employed staff caring for children and young people had their competencies checked and received professional development, including an annual appraisal. Procedures were in place for assessing and responding to patient risk, including risk assessment of rooms where child assessments took place. For routine outpatient appointments, there were no separate clinics for children and young people. The required pregnancy test records for a specific dermatology

Summary of findings

treatment were not well maintained, which meant there was a risk that patients may have been inappropriately prescribed medication when they were pregnant. There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.
We spoke with two parents and one young person following our visit; they all told us the care received was supportive and the staff were kind, caring and friendly.
Senior nursing staff were unable to tell us about the vision and strategy for the children's service. Spire Hull and East Riding hospital and Hesslewood clinic did not carry out any specific audits relating to the services or patient outcomes for children and young people. Governance, risk management and quality measurement within the service were not well developed and there was no evidence of continuous quality improvement. Feedback from staff about the culture within the service, teamwork, staff support and morale was positive.

Outpatients and diagnostic imaging

Good

Incidents were reported and investigated, risk assessments were up to date, and protective measures were in place. Staff were well trained and adhered to policies and procedures. There were enough staff within the department to deliver care safely. The outpatient department offered flexible appointment systems. Clinical staff worked to evidence based guidance and participated in observational research. Patients were treated with kindness and compassion and staff were courteous and respectful. Patients felt that confidentiality was excellent and spoke very highly of the service provided by the pain clinic. Patients could be seen quickly for urgent appointments, clinics were rarely cancelled and waiting times were well within targets. Staff and managers had a vision for the future of their services and staff felt

Summary of findings

empowered to express their opinions or concerns. Patients were given opportunities to provide feedback about their experiences of the services provided.

Good

Spire Hesslewood Clinic

Detailed findings

Services we looked at
Surgery; Services for children and young people; Outpatients and diagnostic imaging;

Detailed findings

Contents

Background to Spire Hesslewood Clinic

In 2014 the parent company Classic Hospitals Limited acquired Spire Hesslewood Clinic, which is located approximately one and a half miles south of Spire Hull and East Riding Hospital and is operated as a satellite to Spire Hull and East Riding, under the same management structure.

After a six month commissioning period, Spire Hesslewood Clinic began caring for patients from February 2015 on a 'walk in, walk out' basis. There are two minor procedures theatres and outpatient consulting rooms at the clinic, which offer dermatology, botox, chronic migraine, dietetics, podiatry, orthotics, rheumatology and outpatient ophthalmology services. These services had previously been offered at Spire Hull and East Riding Hospital. Staff are 'flexed' across the two sites, which also share the same Medical Advisory Committee, Senior Management Team, a single medical records storage site, policies and procedures. The two sites also have a combined data collection process and clinical dashboard, meaning that data is not available at a site level for Spire Hesslewood Clinic. The two sites are registered separately with CQC.

The clinic primarily serves the communities of the East Riding of Yorkshire and Hull. It also accepts patient referrals outside of this catchment area.

There were no special reviews or investigations of the clinic ongoing by the CQC at any time during 2014/15. The clinic had not been inspected previously. We inspected this hospital as part of our independent hospital inspection programme. The inspection was conducted using the Care Quality Commission's new comprehensive inspection methodology. It was a routine planned inspection. For this inspection, the team inspected the following three core services at Spire Hesslewood clinic:

- Children and young people
- Outpatient and diagnostic imaging

In August 2015 the longstanding manager of five years was deregistered due to a promotion within the company. At the time of the inspection a new manager was in place and was registered with CQC in September 2015.

Our inspection team

Our inspection team was led by:

Inspection Manager: Karen Knapton, Care Quality Commission

Detailed findings

The team included CQC inspectors and a variety of specialists including consultants in surgery, anaesthetics, and a senior manager from another independent provider and nurses.

How we carried out this inspection

We carried out this announced inspection on the 14, 15, 16 September 2015. We talked with patients and members of staff, including managers, nursing staff (qualified and unqualified) medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

Prior to the announced inspection, we reviewed a range of information we had received from the hospital. We also distributed comment cards for patients to complete and return to us. Also we asked the local clinical commissioning groups to share what they knew about the hospital.

Facts and data about Spire Hesslewood Clinic

Activity (April 2014 to March 2015)

The combined figures for Spire Hull and East Hospital and Spire Hesslewood Clinic are shown below. The majority of the activity was at the Spire Hull and East hospital as the clinic only opened in February 2015.

- 9,838 Day case patients
- 12,681 Visits to the operating theatre
- 745 Injections of substance into skin
- 476 Cryotherapy (skin) procedures.

Core services offered between the two Spire locations

- Diagnostic imaging*
- End of life care
- Refractive eye surgery
- Termination of pregnancy
- Bupa Health and Well Being
- Cosmetic treatments
- Podiatry and orthotic service*
- Doctors and dentists working under rules or privileges 223
- Doctors and dentists employed 1
- Nurses: 56.6
  - Inpatient departments 28.2
  - Theatre departments 17.5
  - Outpatient departments 10.9
- Operating department practitioners (theatre) 13.0
- Care assistants: 22.9
  - Inpatient departments 12.2
  - Theatre departments 4.2
  - Outpatient departments 6.5
- Other hospital wide staff: 118.9
- Allied health professional 11.9
- Administrative and clerical staff 75.3
- Other support staff 31.7

At the time of the inspection the registered manager was the accountable officer for controlled drugs.

Services accredited by a national body:

- Bupa accredited breast cancer, bowel cancer, MRI, critical care, chemotherapy, paediatric and ophthalmology services
- Macmillan quality environment mark accreditation
- SGS Accreditation for Sterile Services Department.

Outsourced Services:

Detailed findings

- Clinical waste removal
- Cytotoxic drugs service
- Interpreting services
- Grounds Maintenance
- Laser service
- Laundry
- Maintenance of medical equipment
- Non-clinical waste removal
- Occupational health
- Pathology and histology
- Radiation protection
- RMO provision
- Staff agency
- Blood Transfusion

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Requires improvement	Not rated	Not rated	Not rated	Requires improvement	Not rated
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Notes

1. KLOE's and reflect the prompts.
2. There was not sufficient evidence and only minimal patients available to speak with at the inspection therefore we were unable to rate this domain.

Good

Are services safe?

Our findings

The clinic was visibly clean but there were gaps in assessing and auditing of infection prevention and control procedures, specifically observational hand hygiene audits. Staff were aware of the duty of candour. Incidents were reported. Staff received mandatory training in the safeguarding of vulnerable adults and children and the nursing and medical staff we spoke to were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children. Mandatory training was in place for all employed staff with some areas below expected compliance levels.The medical staff mandatory training records were not always completed or checked with substantive employers; there were only three out of 10 which we checked that had training evidence logged. The hospital undertook the 'five steps to safer surgery' checks. The required pregnancy test records for a specific dermatology treatment were not well-maintained, which meant there was a risk that patients may have been inappropriately prescribed medication when they were pregnant. There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.

Good

Are services effective?

Our findings

Patients mostly were cared for in accordance with evidence based guidelines. Policies were mostly developed nationally. On a local level when a new organisational policy was received, it was reviewed by the Medical Advisory Committee (MAC) and a gap analysis undertaken, information relevant to the site was added in; nothing was allowed to be removed from the policies. Clinical indicators were monitored and compared across the company through the publication of a quarterly clinical scorecard. Consultants working at the clinic were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care in the hospital); these, with appraisals, were reviewed every year by the senior management team.

Good

Are services caring?

Our findings

Patients were cared for in a positive and compassionate way. Patients and relatives we spoke to all gave positive examples of caring. We observed positive interaction between staff with patients. Staff appeared genuine, supportive and kind. There were high (scores above 85%) for the Friends and Family Test, however the response rate fluctuated from high levels (above 61%) to low levels (less than 30%). Patients felt they were involved with information and decisions taken about them.

Good

Are services responsive?

Our findings

Spire had responded to demand and opened the Hesslewood Clinic in 2015 to initially provide outpatient services and also dermatology day surgery for NHS and private patients. No patients waited longer than 18 weeks for treatment. Theatre utilisation was growing as new services were being developed on site or transferred from Spire Hull and East Riding hospital. Patients' individual needs were met. There was a complaints policy and process in place.

Requires improvement

Are services well-led?

Our findings

There was a vision and strategy in place for Spire across the two sites, however, there was a lack of vision and strategy for the smaller core services.When staff were spoken to by the inspection team they could not articulate verbally what the overall vision was . Whilst there were governance structures in place for the provider and locally across the two sites these were not adhered to. There was a high element of trust and a low assurance culture. There was a shared governance structure with a clinical governance committee across both the Spire Hull and East Riding hospital and the Hesslewood clinic. This committee fed directly into the medical advisory committee (MAC). It also had direct links into the senior management team and hospital and national group governance arrangements. The monitoring system to ensure the doctors' safety to practice within the clinic was not robust at the time of the inspection, especially with regard to monitoring mandatory training and some disclosure and barring checks. The organisation had a governance structure with reasonable attendance at meetings. Staff described leadership and culture across the sites in a positive manner. The management team actively engaged in proactive recruitment and retention of staff including recent staff incentive packages.

Surgery

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

Information about the service

Spire Hesslewood Clinic was opened in 2015 and provides dermatology day surgery for NHS and private patients. Plans are in place to increase this service to include ophthalmic surgery. There are five day case beds, two operating theatres and consulting rooms available.

Spire Hesslewood clinic and Spire Hull and East Riding hospital admitted 9,838 day case patients between April 2014 and March 2015.

At the time of our inspection surgery was provided for both adults and children. There was a policy outlining the inclusion/exclusion criteria for patients wanting to access the service. Medical and nursing staff rotated from the inpatient area and day case area between the two Spire locations: Hull and East Riding hospital and the Hesslewood clinic.

As part of our inspection, we visited the day case unit and the theatre suite. We spoke with eight members of staff with varying roles and grades and the senior management team. We observed care and treatment and spoke with two patients and looked at patient's medical records.

Summary of findings

We rated surgical services at Spire Hesslewood clinic as good overall because:

We saw appropriate staffing levels at the Hesslewood clinic. We observed good compliance with the 'five steps to safer surgery' procedures and the related World health organisation audit. The clinic was visibly clean. Patient safety was monitored and incidents were reported via a centralised computer based system,

Patients were cared for in a positive and compassionate way. Internal organisational patient surveys we reviewed showed positive responses around care received, discharge information, and privacy and dignity.

Spire had recognised the growth in demand for services and had begun caring for patients from February 2015 on a 'walk in, walk out' basis, after a six month commissioning period. Patients' individual needs were met.

Staff received mandatory training .At the end of month eight it would be expected that approximately 67% of staff would have completed mandatory training in line with the calendar year training programme. For some aspects of training it was behind trajectory to achieve Spire's expected level of 95% by the end of the year, for example resuscitation training with below 50% attendance on life support courses. Medical personnel records we reviewed had variable levels of compliance

with the HR policies. Mandatory training records and certification for medical staff from substantive employers were not always documented as checked and a full set of references were not always available.

There were minimal IPC audits carried out, policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed. There had been no serious incidents reported since the clinic opened. Personnel records we reviewed had variable levels of compliance with the HR policies. DBS checks were not consistently recorded or reviewed regularly and a full set of references were not always recorded.

There was a vision in place for the development of the clinic.

Are surgery services safe?

Good

We have rated surgical services at Spire Hesselwood Clinic as good because:

The clinic was clean and tidy and we witnessed cleaning and the relevant checklists being completed.

Patient safety was monitored and incidents were reported via a centralised computer based system.

Pre- operative assessment was noted to be thorough and comprehensive and the clinic undertook the 'five steps to safer surgery' procedures and the World Health Organisation audit tool.

Staff received mandatory training. At the end of month eight it would be expected that approximately 67% of staff would have completed mandatory training, in line with the calendar year training programme. Some aspects of training were behind trajectory to achieve Spire's expected level of 95% by the end of the year, for example resuscitation training with below 50% attendance on life support courses. Medical personnel records we reviewed had variable levels of compliance with the HR policies. Mandatory training records and certification for medical staff from substantive employers were not always documented as checked and a full set of references were not always available.

There were minimal IPC audits carried out, policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed. Sharing of learning from incidents across the two sites was variable. However, there had been no serious incidents reported since the clinic opened.

Incidents

- Incidents are reported and investigated using a centralised national computer system. Senior nursing staff reviewed the incidents reported and analysed the data to identify any trends. Staff told us that learning from incidents was shared internally through displays on walls, staff meetings and on the computer system.

- Serious Incidents (SI) are incidents that require further investigation and reporting. Spire Hesslewood clinic had no serious incidents reported since its opening.
- Learning from incidents was shared via governance and clinical effectiveness meetings. Staff worked across both sites and attended relevant meetings at Spire Hull and East Riding hospital. We reviewed three sets of minutes from the ward and pre-assessment team meetings and noted that complaints and incident themes were discussed. Theatre team meetings had variable attendance and incidents or complaints themes were not discussed.
- Overall the two Spire sites reported 364 clinical incidents during the reporting period April 2014 to March 2015.The number of clinical incidents reported each month has been consistent, and the overall rate of clinical incidents (per 100 inpatient discharges) over the period has remained consistent at around three per 100 discharges. This is low reporting when compared with other services inspected recently. Reporting has increased in recent months with 497 incident reports completed to July 2015.
- Nursing and medical staff we spoke to were all aware of the centralised incident system. All incidents were initially reviewed by the ward manager and then disseminated to senior nursing staff for investigation. Nursing staff were aware of their roles in relation to incidents and there need to report, or provide evidence, take action, triage or investigate as required. Senior staff recognised the need to close down investigations in a more timely fashion.
- The clinic had reported no incidents requiring root cause analysis review since opening. The senior management told us that RCA training had recently been introduced for all senior staff carrying out RCAs to improve the process, timescales and clinician involvement. RCA data was rated as amber on the Spire corporate scorecard due to timeliness of the RCA process.

Duty of Candour

- All staff we spoke to were aware of the duty of candour.
- Staff were able to describe what was required regrading informing patients if an incident or mistake had occurred and to be open and honest with patients.
- Staff were able to provide us with specific examples about its use.

Safety thermometer

- The NHS Safety thermometer is a nationally developed improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It looks at risks such as falls, pressure ulcers, blood clots, and catheter and urinary tract infections. Spire Hesslewood together Spire Hull and East Riding hospital submitted data on a monthly basis. All (100%) audited had been rated as harm free care this is better than the England average of 93%.

Cleanliness, infection control and hygiene

- The clinic was clean and tidy and we witnessed cleaning and the relevant checklists being completed.
- We saw no evidence of a formal IPC qualification for the IPC lead. Minimal IPC audits were carried out, policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were was not performed.
- Nationally Spire healthcare had a service level agreement with a consultant microbiologist to provide advice and support.
- The IPC lead for the clinic was also the governance manager. In addition we were told that this person supported 13 other Spire IPC leads/ sites within the group for Infection prevention specialist advice.
- We reviewed minutes of the IPC committee. Attendance was good, and medical input was noted to some meetings via the organisational microbiologist, however no on-site clinician attendance was noted.
- The provider reported no cases of methicillin resistant staphylococcus aureus (MRSA), Clostridium difficile (C.difficile) or methicillin sensitive staphylococcus aureus (MSSA) infections April 2014 to March 2015. MRSA and MSSA pre-operative screening was undertaken and a policy for NHS patients and non NHS patients was available.
- Surgical site infection (SSI) data was reviewed. Performance targets were in place to benchmark SSI with other Spire hospitals. SSIs were reported through incident reports and discussed internally in the IPC committee. Information provided by the clinic showed that no SSIs had been recorded at the clinic since opening.
- The environment was clean and tidy, and all bed spaces, once clean, had a leaflet placed on them to provide assurance of cleanliness, which was named and dated.

- Spire did measure product (hand gel) usage data and compared this against other hospitals/clinics in the group.
- Alcohol gel was available in all rooms we visited and in communal areas.
- IPC training was delivered both face to face and via e-learning. This training was delivered by a member of staff with no formal IPC qualification. Compliance rates were reviewed and were noted to be 75.6% for e-learning and 44.6% for face to face training by August 2015 against an expected compliance rate of approximately 67%, in line with the calendar year training programme.

Environment and equipment

- The inpatient environment was observed to be in excellent condition and very clean and tidy.
- Resuscitation equipment was routinely checked and found to be in good working order.
- Staff told us that they had all the equipment they required to carry out their role.
- All equipment used was maintained by a national company and maintenance records were available to show servicing records.

Medicines

- Access to pharmacy services was available at the Spire Hull and East Riding site.
- Medicine cupboards we reviewed were found to be secure, organised, clean, tidy and with good stock rotation.
- Controlled drugs were stored appropriately according to legal requirements. Controlled drug books were reviewed and found to be legible, complete and appropriately recorded.
- Medication errors were audited internally.

Records

- The clinic used a paper patient records system for nursing and medical documentation. Records were stored in a locked office when not in use..
- Pre-operative assessment documentation was clear and processes appeared thorough.Policies used were based on NICE guidance.
- Patient records had risk assessments for VTE, pressure care and nutrition although these were completed in pre-assessment.
- All patients attending the clinic have a full set of medical records stored on site for a maximum of a four month period, and all clinics were arranged 24- 48 hours in advance which ensured patients should never attend clinic without medical records being available.
- Information governance training rates for the hospital were in line with the hospitals expected levels at 41% for July 2015 with a deadline of March 2016 for 95% compliance..

Safeguarding

- Staff received mandatory training in the safeguarding of vulnerable adults and children as part of their induction followed by yearly safeguarding refresher training. Compliance data showed that across both sites 63% of theatre staff and 56% nursing staff had completed safeguarding refresher training during 2015. The deadline for remaining staff was the end of December 2015. Specific numbers for medical staff training was not held.
- Data supplied by the provider showed that no safeguarding concerns were recorded in the last 12 months.
- The nursing and medical staff we spoke to were aware of their responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children, including escalation to the relevant safeguarding team as appropriate.
- Safeguarding flow posters were displayed highlighting key actions and key individuals to contact were displayed in the ward office.
- Spire policy is for staff to have a DBS review every 10 years, however our review of personnel records found that this did not always occur.

Mandatory training

- As part of induction, staff received training in appropriate training for their role such as fire, IPC, manual handling. Staff also completed refresher training every year. Mandatory training was delivered as a mixture of face to face and e-learning training. Staff we spoke to all said they had undertaken mandatory training required for their role.
- Compliance rates were reviewed and we noted variable compliance with training. At the end of month eight it would be expected that approximately 67% of staff would have completed mandatory training, in line with the calendar year training programme. Some aspects of

training it was behind trajectory to achieve Spire's expected level of 95% by the end of the year. Examples include level 2 blood transfusion training and resuscitation training was 38%; basic life support was 51%; basic life support level 2, and Immediate Life Support (ILS – a course for first responders) was 30%, following the inspection the hospital informed us that the 2014 full year training results showed above 95% compliance with mandatory training modules.

- For clinicians that were employed by other organisations (usually in the NHS) and had practising privileges (the right to practice in a hospital) with Spire Hull and East Riding hospital and Hesslewood clinic, we were told that mandatory training was usually undertaken by the substantive employer and monitored by Spire. However during our review of the personnel documents we had little assurance that monitoring of this was effective .

Assessing and responding to patient risk

- An emergency call system was available in the recovery area which was audible in two other areas, to summon help. An emergency trolley with medications was available that was, checked on a daily basis, paediatric equipment was also available.
- An algorithm was available on the wall detailing cover arrangements in an emergency or procedures to be carried out if a patient became unwell. Staff we spoke with were aware of the procedures, however, confirmed they had never had to use them.
- The service undertook the five steps to safer surgery procedures and audit, including the use of the World Health Organisation WHO checklist. Internal audits we reviewed showed 100% compliance during retrospective audit of 10 sets of medical records. During the inspection we observed good compliance with the procedures.
- Prior to undergoing surgery there was a preoperative risk assessment to identify patients with underlying medical conditions or those deemed at risk of complications after surgery.
- Venous thromboembolism (VTE) screening rates were noted as being much better than expected with 100% of all patients requiring VTE screening being screened in all quarters April 2014 to March 2015. No incidence of hospital acquired VTE or pulmonary embolism (PE) was noted in the reporting period April 2014 to March 2015. We have assessed this rate to be 'better than expected'.
- The provider has a service level agreement for 24 hour cover with the local NHS hospital for pathology, transfusion, pharmacy and transfer of deteriorating patients.

Nursing staffing

- During the inspection staffing at the clinic was appropriate to meet the needs of patients.
- Nursing staff rotated between the two sites; overall the provider employed 22.2 qualified nurses. We reviewed current vacancy rates which were monitored across both sites; there were 6.8 WTE posts vacant. Senior staff told us that they were actively recruiting to these posts.
- In the theatre department 34.7 WTE staff were employed. We reviewed current vacancy rates and noted that five vacancies were outstanding as of July 2015.
- We reviewed six sets of nursing staff personnel records and found mixed compliance with regard to reference checking and DBS (police checks) checks. In one set of records we checked a member of staff had not had a police check for over 15 years. Following the inspection we were told that professional PIN number checks are recorded on Spire HR system.

Surgical staffing

- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in hospital).
- During the inspection we were provided with different numbers of consultants who worked at the sites varying from 223 to 248 to 272. Following the inspection we were told these figures varied as in some instances they included support specialists such as nutritionists.
- Prior to the inspection Spire reported 100% bi-annual review of practice privileges at the two sites. Evidence from June and August MAC minutes noted that the figure was 97%. Staff told us that the grace period was three months for receiving the correct information to allow practice privileges to continue, and after this time practising privileges were stopped. There was no grace period for GMC registration.
- Medical cover on the day unit was provided by the consultants in charge of the patient's care.
- We reviewed 10 sets of medical personnel records and noted variable levels of compliance with the HR policy.

DBS checks were not performed regularly, mandatory training records were not always completed or checked with substantive employers, and two references were not available for all medical staff.

Major incident awareness and training

- There was a business continuity plan in place.
- The plan had been implemented on the Spire Hull and East Riding hospital site, due to an electrical problem, which was resolved during the inspection. Senior staff said the plan had been implemented successfully.
- Five resuscitation scenarios had been carried out involving staff who worked on both sites and including two specific paediatric scenarios.

Are surgery services effective?

Good

We rated surgical services at Spire Hesselwood Clinic as good for effective because:

Patients were cared for in accordance with evidence based guidelines. Staff training compliance rates for Mental Capacity Act training were noted to be good.

Patients we spoke to were happy with the pain relief medication they had been offered post-operatively, and we saw good examples of staff offering pain relief.

There was no specific outcome data for the Hesslewood clinic as Spire did not collect data and evidence separately for the locations Spire Hull and East Riding hospital and Spire Hesslewood clinic.he locations shared the same governance structure, meetings and quality dashboards. Comparable patient outcomes by consultant were not audited, however the senior management team told us these were monitored via complaints and incidents data.

Competence records were used by staff; all records we reviewed had been self-signed. Post inspection, the senior management team provided evidence that this process had changed. Appraisal rates were good but there were some discrepancies with the percentage for medical staff appraisal rates.

Evidence-based care and treatment

- Patients care was carried out according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and guidance from the Royal Colleges. We witnessed very recently released guidance for skin cancers in use.
- The majority of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the site was added in.Nothing was allowed to be removed from the policies. Policies were available in hard paper format on the unit and in electronic format on the intranet.

Pain relief

- Staff we spoke to said that they used a pain assessment score of 0-4 to assess the comfort of patients both as part of their routine observations and at regular intervals following surgery. Staff could detail the correct action to be taken if a patient was in pain. We saw the pain score being used during surgical procedures to measure patients' pain levels.
- Patients' records we looked at recorded that patients that required pain relief were treated in a way that met their needs and reduced discomfort. Patients we talked to said that during their stay their pain had been well controlled and extra pain relief has been offered post-operatively.
- Staff we spoke to told us that they asked whether the patient was in pain, had any nausea and observed their wound, if present.

Nutrition and hydration

- Patients were offered a selection of drinks. As surgery was only scheduled for short admission periods, food was not routinely available. Biscuits were provided and sandwiches were available on request.
- Patients' records we looked at contained an assessment of patients' nutritional requirements. Malnutrition universal screening tool (MUST) assessments were completed during pre-assessments.

Patient outcomes

- Patient outcomes were audited through various means including pre & post-operative patient satisfaction surveys and patient complaints.
- Comparable clinician outcomes were not audited locally or against other organisations so outcomes could not be measured or practice benchmarked per clinician. Surgical staff told us it was difficult to benchmark private practice with colleagues as no formal feedback mechanism existed even when similar types of surgery were carried out. The senior management team told us that outcomes were reviewed on an individual basis if incident or complaints information highlighted trends. We noted on the senior management team minutes for that complaints themes were identified by "consultants and outcomes of surgery".
- Clinical indicators were monitored and compared across the company through the publication of a quarterly clinical scorecard. This document was RAG rated which allowed the two Spire sites to compare their combined outcomes with other Spire sites. It included VTE risk assessment, patient falls, surgical site infections, hospital acquired infections, return to theatre, and pressure ulcer incidents.
- Patient satisfaction audits for caring, pain control, experience and discharge arrangements which we reviewed showed a good level of satisfaction. However there was a low response rate with an average of 17.4%.
- Local audits set by the corporate audit plan were carried out at the location and local audits could be added onto the plan if required.

Competent staff

- Newly appointed staff underwent an induction process. Staff we spoke to told us that they had a four week supernumerary period at the start of employment. During this time staff worked with an induction buddy to complete an induction record bookwhich detailed competency and skills required for the role.
- We reviewed five competency books (in total across both sites) and all five were found to be self-assessed and not signed off by senior staff. We raised this at inspection and following the inspection we were supplied with a document which indicated that this process had been reviewed and processes for sign off changed.
- Staff told us that bank staff had a longer induction and used the same competency books.Agency staff had an agency staff induction checklist delivered by the senior nurse on duty. Several different agencies were used to fill vacant roles.
- High staff appraisal rates were noted for inpatient and other staff groups. The senior management team reported 100% appraisal rate in theatres for both nurses and ODPs. Nursing staff told us that they had all received appraisals on a yearly basis.
- Consultants worked at the clinic under practising privileges (authority granted to a physician or dentist by a governing board to provide patient care). Practising privileges were reviewed every year by the senior management team. Documents reviewed showed that there were approximately 270 consultants utilised at the two Spire sites under practising privileges and that 95% of consultants had a recorded appraisal. Of the 5% that had no recorded appraisal, 1% were inside the clinic's "grace period" and 4% outside the "grace period". There were 24 consultants who had no indemnity cover seen and all were outside the grace period. Post the inspection we were supplied with a document which shows 100% compliance.
- A policy to support nurse revalidation had been launched by the organisation and a working party was due to be commenced.

Multidisciplinary working

- There was good communication between multidisciplinary teams within the clinic. Staff told us they had a positive working relationship with the consultants and a member of medical staff told us they had a "fantastic nursing team".
- Due to the types of surgery carried out within the clinic there was little requirement for direct access to physiotherapy, imaging services and pharmacy provision. However, if required, it was available from the Spire Hull and East Riding hospital site seven days a week and occupational therapy was available six days a week.
- Medical staff told us that all patients diagnosed with skin cancer were discussed at the local NHS hospital multidisciplinary meeting; specialist nurse input on site was not available.

Seven-day services

- The theatres were available for admissions from 07:30 to 20:00 hours, Monday to Friday (07:30 to 16:00 hours on Saturdays). However, theatre time was not fully utilised as the services were still in development.
- Should they be required, on-call rotas and procedures were available for key staff, such as pharmacist, physiotherapy, radiology, senior nurse and senior management team.
- Patients had access to the consultant in charge of their care 24 hours a day. Should a surgeon be on leave arrangements were locally agreed with another consultant with practising privileges to cover the leave.

Access to information

- Staff had access to the Spire computer system. This included booking information and pathology reporting systems.
- Paper based patient records were available on site for patients seen in the last four months with access to other patient records via an external storage centre.
- Password access was supplied to staff as required on an individual basis.
- Staff could access information such as policies and procedures on the Spire intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was gained both verbally and in written form.
- The staff we spoke with were aware of how to seek verbal and written consent before providing care or treatment. Staff we spoke with had the appropriate skills and knowledge to seek consent from patients or their representatives.
- Consultant medical staff sought consent from patients prior to starting surgery/ procedure. Where patients lacked capacity to make their own decisions, staff told us they sought consent from an appropriate persons , that could legally make those decisions (for health and welfare) in the patients best interest.
- Staff we spoke to were able to describe their responsibilities in relation to the legal requirements of the Mental Capacity Act 2005 (MCA). We reviewed MCA training compliance rates and noted 77% compliance for nursing staff and 90% for theatre staff. However overall training rates for the two Spire sites up to July 2015 was 68%.

Are surgery services caring?

Good

We rated surgical services at Spire Hesslewood Clinic as good for caring because:

Patients were cared for in a positive and compassionate way. Patients we spoke to all gave positive examples of a caring approach. We observed positive interaction of staff with patients.Staff appeared genuine, supportive and kind.

Low response rates were noted in the friends and family test results however, respondents were highly likely to recommend the service to others. Internal organisational patient surveys showed positive responses around care received, discharge information, and privacy and dignity.

Patient records we reviewed took into account patient preferences and patients felt they were involved with information and decisions taken about them.

Compassionate care

- We spoke with two patients who both gave positive comments about the care and treatment they received.
- When we observed staff going about their work we saw positive patient/ staff interaction with staff who were thorough, genuine and knowledgeable. Staff took time to make the patient at ease by explaining all aspects of procedures being undertaken.
- Patient dignity was maintained by covering the patient in the corridor with gowns/dressing gowns.
- Bed curtains were used around the bed space to maintain dignity.
- The NHS Friends and Family Test (FFT) is a satisfaction survey that measures patients' satisfaction with the healthcare they have received. For NHS day cases in July 2015, there were 45 responses (across both sites) with 76% extremely likely to recommend the service to others.
- An internal organisational patient survey was carried out for April to July 2015, around care, discharge information, decisions, and privacy and dignity. This showed that approximately 80 to 90% of patients received excellent care and attention from nursing staff. Approximately 78% of patients had an excellent admissions process and discharge process.

Surgery

Understanding and involvement of patients and those close to them

- Patient records we looked at included pre-admission and pre-operative assessments that took into account individual patient preferences.
- Patients told us they were fully informed of their plan of care, right from their first visit into the pre-op clinic and consultant appointments and also said they felt they were involved in decisions about their care and treatment plans.
- We saw evidence of patients being able to ask questions of the medical and nursing staff pre and post-operatively.
- Patients were offered a choice of appointment times, and were able to choose the one they required. Patients known to the consultant team were able to receive rapid access via a system of contact with the medical secretary.
- Discharge planning was considered pre-operatively and discussed with patients and relatives to ensure appropriate post-operative caring arrangements were in place.

Emotional support

- We saw evidence of emotional support offered to patients during pre-operative explanations of procedures to patients and during the operative phase of the procedure.

Are surgery services responsive?

Good

We rated surgical services at Spire Hesselwood Clinic as good for responsive because:

Spire understood the needs of the local population and had responded to demand and opened the Hesslewood Clinic in 2015 to initially provide dermatology day surgery for NHS and private patients.

Across the two sites patients waited no longer than 18 weeks for treatment.

Patient's individual needs were met. Complaints were recorded, reviewed and actions monitored.

Service planning and delivery to meet the needs of local people

- Spire had responded to demand and opened the Hesslewood Clinic in 2015 to initially provide dermatology day surgery for NHS and private patients.
- A further growth in service was anticipated and plans were in place to open ophthalmology clinics to improve the patient experience.
- The service had a policy which outlined the inclusion and exclusion criteria for surgical patients.

Access and flow

- Patients were referred to the clinic by their GP, self-referral or NHS referral.
- There were five day case beds available.
- Data showed that across the two sites patients waited no longer than 18 weeks for treatment. The provider met the target of 92% of patients with an incomplete pathway beginning treatment within 18 weeks of referral each month in the reporting period April 2014 to March 2015.
- Access to theatres was in development as the clinic had only opened in 2015.
- Patient records we looked at showed staff completed appropriate discharge summaries and these were communicated to GPs in a timely manner.

Meeting people's individual needs

- Information leaflets about the services provided were available in areas visited. Written information leaflets including the complaints leaflet could be made available in several different languages if required.
- Patients whose first language was not English could access an interpreter. Staff could describe to us how to access interpreting services. They spoke about times when they have cared for patients in rooms with an interpreter present.
- The access criteria for the services meant that staff did not routinely care for patients with confusion, severe dementia and/or complex needs.
- Locally Spire had developed dementia awareness champions.
- Staff were not sure if they had had appropriate training for nursing patients with dementia, learning disability or for patients with complex needs. There was no specific training for all staff to raise awareness of dementia and

how to care for people with it. Post the inspection we were told that the clinic used a module from the NHS compassion in practice which covered some aspects of dementia. This module was mandatory for all staff.
- We reviewed patient led assessment of the care environment (PLACE) results and noted that the dementia care was scored at 91.42% vs. a national average of 74.51%.

Learning from complaints and concerns

- Complaints were recorded, reviewed and actions monitored.
- Information on how to raise complaints was documented on the patient satisfaction leaflet provided to all patients.
- Patients we spoke with had no complaints or concerns about their care.
- Staff we spoke to were clear about the complaints process for receiving, handling and investigating complaints.
- All complaints were investigated by a senior manager who was supported by their head of department. This information was recorded onto a centralised incident reporting system.
- Complaint acknowledgement letters were sent within 48 hours of the complaint. The full response was routinely sent to the patient within 20 working days of receipt.
- There had been no complaints about this service since it opened.

Are surgery services well-led?

Requires improvement

We rated surgical services at Spire Hesselwood Clinic as requires improvement for well led because:

The strategy and governance arrangements for the service were not as yet well embedded as the service had only been in operation since February 2015. Staff were aware of the Spire vision and strategy and the values of the organisation. There was a shared governance structure with Spire Hull and East Riding hospital and this included the monitoring system to ensure the doctors' safety to practice within the clinic and this was not effective at the time of the inspection. Systems to ensure compliance with IPC standards required improvement.

Staff described leadership and culture of the service in a positive manner.

Vision, strategy, innovation and sustainability for this core service

- The Spire vision for the two sites was to 'be a world class healthcare provider'.
- Staff appraisals and performance objectives were linked to the vision and values.
- The vision and values were displayed and had been shared with staff. Staff we spoke to showed understanding of the vision and values.
- There was no documented vision and strategy for surgical services. Staff were unable to describe a specific vision or strategy for surgical services. Staff were aware of the planned move of ophthalmology services from Spire Hull and East Riding hospital to Hesslewood clinic.

Governance, risk management and quality measurement for this core service

- The service shared a governance structure and clinical governance committee with Spire Hull and East Riding hospital. This committee took reports from the clinical, audit and effectiveness committee, infection prevention and control committee. This committee fed directly into the medical advisory committee (MAC). It also had direct links into the senior management team, and the local and Spire group governance arrangements.
- Senior staff told us that they had 100% attendance at the MAC. However during review of the minutes we noted that attendance was lower, about 50%, with apologies being noted from medical staff at all three of the meetings reviewed.
- Medical staff we spoke to spoke about the MAC working well and having assurance in the system. They spoke about specific changes they had seen as a result of discussion at the MAC, for example, changes in pain relief for inpatients.
- We reviewed four sets of clinical governance minutes and noted attendance was good. Detailed documentation of the discussions held were clear and included complaints, incidents and performance.
- The Spire local senior management team met weekly with the heads of department and discussed risk, finance, incidents and current operational issues.
- We reviewed three team meetings minutes from the ward and pre assessment team and noted average attendance. These were well documented meetings

with complaints and incident themes discussed. Theatre team meetings had variable attendance. One meeting was good, and one planned meeting had no attendance. Key issues for the department were discussed however incident or complaints themes were not documented as discussed.

- Spire locations had performance dashboards which showed performance against key organisational performance targets and were used during contract monitoring with the local commissioner. There was a shared dashboard for Spire Hull and East Riding hospital and Spire Hesslewood clinic.
- We reviewed the risk register and the risk analysis register which covered both locations. Open risks were noted with the oldest of the risks being documented in 2010 relating to Spire Hull and East Riding hospital.
- The monitoring system to ensure the doctors' safety to practice within the clinic was not robust at the time of the inspection. We reviewed 10 sets of medical personnel records and noted variable levels of compliance with the HR policies. DBS checks were not performed regularly; four were recorded as out of date according to Spire's policy. Mandatory training records were not always completed or checked with substantive employers and there were only three records with training evidence logged.
- Systems to ensure compliance with IPC standards required improvement. There were minimal IPC audits, policy implementation and policy into practice audits did not occur, and observational hand hygiene compliance or technique data audits were not performed.

Leadership/culture of service related to this core service

- The clinic was led by the senior management team. The day case unit was led by a senior member of nursing staff for both inpatient areas and theatre department. This role was supported by a team of four nursing sisters. Staff we spoke to told us they understood the reporting structure clearly. All staff we spoke with commented positively about local leadership.
- Staff we spoke to all described the culture within the service as friendly with a cohesive group of colleagues, and spoke positively about their colleagues being "fantastic and supportive" and they gave positive examples of support after illness and bereavement.
- Staff we spoke to said they felt able to raise concerns. We also saw evidence of a "speak out" campaign, encouraging staff to speak out if they had any concerns. The senior manager had developed an "Ask Maria" initiative which allowed staff to speak to her directly with specific concerns or questions.
- Staff turnover was fairly static.Several staff we spoke with had been in the role for many years.
- Staff we spoke to expressed that their biggest worry was staffing levels and recruitment.
- Senior staff recognised that improving staff and consultant feedback was an area requiring improvement and discussions had started on how to address this.

Public and staff engagement

- The latest staff survey was for 2014 and therefore prior to Spire Hesslewood opening.
- The local Spire management team used regular team briefs, which included recognition and thanks to individuals from their colleagues.
- Public engagement activities included asking patients from feedback as to how services could be improved on the patient satisfaction survey.

Innovation, improvement and sustainability

- In 2014 the parent company Classic Hospitals Limited recognised the potential for further development of health care services in the geographical area and acquired Spire Hesslewood Clinic is operated as a satellite to Spire Hull and East Riding and is under the same management structure.
- There is further potential to develop the site and plans were shared with us regarding expanding ophthalmology services on the site.

Services for children and young people

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Not sufficient evidence to rate
Responsive	Not sufficient evidence to rate
Well-led	Requires improvement
Overall	Not sufficient evidence to rate

Information about the service

Spire Hesslewood Clinic is a satellite of Spire Hull and East Riding Hospital. Staff in outpatient clinics at Hesslewood treated children and young people. Children and young people were admitted for day case surgery using local anaesthetic.

Services offered to children and young people at the two Spire sites included diagnostic imaging, endoscopy, podiatry and orthotics, pharmacy and physiotherapy.

We visited all of the clinical areas where children and young people were admitted or which they attended on an outpatient basis. This comprised the outpatients (OP) department (OPD) and theatres. During the inspection we spoke with the OP sister and the OP manager. After the inspection we spoke with two relatives and one young person (a patient). We reviewed nine sets of medical/ nursing records and management and quality documents related to the service.

Staff employed by Spire worked across the two sites. The sites also shared the same medical advisory committee (MAC), senior management team, a single medical records storage site and policies and procedures. The two sites had combined data collection process and clinical dashboards, this meant data was not available at site level for the Spire Hesslewood Clinic.

Activity from April 2014 to March 2015 for children and young people (for both sites) were as follows;

- 17 inpatients overnight aged 3 to 15 years
- 14 inpatients overnight aged 16 to 17 years
- 80 day cases aged 3 to 15 years
- 44 day cases aged 16 to 17 years

- 12 outpatient first attendances aged 0 to 2 years
- 250 outpatient attendances aged 3 to 15 years
- 136 outpatient attendances aged 16 to 17 years.
- 358 outpatient follow ups aged 3 to 15 years
- 163 outpatient follow up aged 16 to 17 years.

Services for children and young people

Summary of findings

Due to the small size of the service we did not have sufficient, robust information to fully rate the service.

The environment was visibly clean and personal protective equipment was available. However, the service was not carrying out hand hygiene observation audits or general environmental audits. Equipment was well maintained and there had been no incidents reported which involved children and young people. There were no separate areas to wait or clinic time for children and young people. However, all patients were seen in private consulting rooms.

Nurse staffing for children and young people was predominantly two part time contracted children's nurses who worked across both sites and bank staff. Mandatory training was up to date for employed staff.This enabled staff to carry out their roles effectively and safely.Training included awareness of safeguarding procedures and child protection. However, some consultants may have been treating children without having received the appropriate level 3 safeguarding training. Employed staff caring for children and young people had their competencies checked and received professional development, including an annual appraisal.

Procedures were in place for assessing and responding to patient risk, including risk assessment of rooms where child assessments took place, however,for routine outpatient appointments there was no separate clinic. The required pregnancy test records for a specific dermatology treatment were not well-maintained which meant there was a risk that patients may have been inappropriately prescribed medication when they were pregnant. There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.

We spoke with two parents and one young person following our visit they all told us the care received was supportive and the staff were kind, caring and friendly.

Senior nursing staff were unable to tell us about the vision and strategy for the children's service. Spire Hull and East Riding hospital and Hesslewood clinic did not carry out any specific audits relating to the services or patient outcomes for children and young people. Governance, risk management and quality measurement within the service were not well developed and there was no evidence of continuous quality improvement. Feedback from staff about the culture within the service, teamwork, staff support and morale was positive.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We rated children's' services at Spire Hesslewood Clinic as requires improvement for safe because:

The required pregnancy test records for a specific dermatology treatment were not well-maintained, which meant there was a risk that patients may have been inappropriately prescribed medication when they were pregnant. There were no separate areas to wait or clinic time for children and young people. However, all patients were seen in private consulting rooms. Staff we spoke with told us this was not a problem as low numbers of children and young people attended outpatients. The provider was unable to demonstrate that all consultants who treated children had received the appropriate level 3 safeguarding training.

Staff told us children's nurses would come to the Hesslewood clinic if a child or young person was having a surgical procedure. Nurse staffing for children and young people having procedures was predominantly two part time contracted children's nurses and bank children's nurses. The service planned elective surgical cases according to availability of appropriately trained staff. Senior staff told us they planned to recruit more children's nurses.

The environment and equipment were well maintained and mandatory training for employed staff was up to date, this enabled staff to carry out their roles effectively and safely, training included awareness of safeguarding procedures and child protection. The environment was visibly clean and personal protective equipment was available. No incidents had been reported which involved children and young people.

Incidents

- We looked at the clinic's incident reports and found no incidents had been reported which involved children and young people.
- When we asked the paediatrician and children's nurses about this; they confirmed there had been no incidents at the clinic involving children or young people. They explained children and young people treated at the clinic were generally low-risk, healthy and without any co-morbidities.
- The children's nurses told us they knew how to report incidents.
- The lack of incidents reported involving children and young people meant we were unable to judge whether there was learning from incidents for this core service.

Cleanliness, infection control and hygiene

- All of the areas we visited were visibly clean, including the communal areas and toilets. We saw personal protective equipment (PPE), such as aprons and gloves, was readily available for staff to use.
- We saw there was hand sanitizer and hand wash next to every wash hand basin and there were alcohol gel dispensers available throughout the building. Cleaning schedules were in use and these were completed correctly and up to date.
- The provider had reported no cases of methicillin resistant staphylococcus aureus (MRSA), clostridium difficile (C.difficile) or methicillin sensitive staphylococcus aureus (MSSA) infections in the reporting period Apr 14 to March 15 at either Spire Hull and East Riding hospital or Spire Hesslewood clinic. There had been no cases of MRSA, MSSA or C.difficile in the children's service.
- Records showed that 75.9% of staff had completed infection control training at the time of the inspection and were on target to complete this training by the end of 2015.
- The service was not carrying out hand hygiene observation audits or general environmental audits. This meant there was a lack of assurance to show the clinic was providing and maintaining a clean and appropriate environment that facilitated the prevention and control of infections.
- We saw infection control and prevention notices on display in the waiting area at Hesslewood clinic, these included information about MRSA and C.difficile and monthly figures for infection rates.

Environment and equipment

- Spire Hesslewood clinic occupied the ground floor of the building it was situated in.

- The clinic's OPD had six consulting rooms, a laser room and a treatment room. Staff told us three of the consulting rooms were used exclusively for ophthalmology.
- The two theatres did not have laminar flow.There was an admission / discharge area with five bays.
- All of the areas of the clinic where children and young people were cared for were well maintained and appropriate. However, there were no separate waiting areas for children in the outpatient department. All patients were seen in private consulting rooms. Staff we spoke with told us this was not a problem as low numbers of children and young people attended outpatients.
- The carpeted outpatient area had leather chairs, two televisions and magazines.
- There were two toilets available and a disabled toilet.
- The two parents and the patient we spoke with after the inspection told us they were happy with the environment and facilities at the clinic.
- The equipment for dermatology procedures was stored in the theatre area.
- We saw resuscitation equipment for adults and children was readily available and regularly checked. The resuscitation trolleys were locked.
- The paediatric trolley had a paediatric resuscitator, a defibrillator for the use with infants or children and printed paediatric guidelines. Paediatric resuscitation packs were available with equipment designed to accommodate children of different weights and heights.

Medicines

- There was no on-site pharmacy at the clinic.
- Staff sent prescriptions to the pharmacy at the Hull and East Riding hospital when required and patients were requested to collect their prescriptions from there.
- Consultants dispensed eye drops to patients.

Records

- Staff at the Spire Hull and East Riding hospital prepared medical records for patients to be seen at the Hesslewood site. The hospital had its own transport (van) which was used to transport records; there were three van runs a day between the two sites.
- We reviewed nine paper based treatment records for patients seen at the Hesslewood clinic during the inspection; these were for young people who had attended the dermatology outpatients clinic and been prescribed roaccutane for acne. Six of the nine patient records were for female patients prescribed roaccutane. We found three out of these six patient records included the patients' pregnancy test results and three did not. One patient had been prescribed roaccutane eight times between 11 Nov 2014 and 5 August 2015; there were no records for pregnancy tests in this patient's care records.
- In two of the three care records where the pregnancy test result was present, we found there were several missing entries on the form. For example, in both records, there was no date to show when the test was performed, no date of the patient's last menstrual period and no record of the batch number of the pregnancy test used.
- A pregnancy test is a diagnostic test and the result is used to inform clinical decisions. The lack of information in the care records to show whether patients had been tested for pregnancy prior to roaccutane being prescribed meant we were unable to establish whether the procedures required prior to treatment with roaccutane had been followed correctly. There was a risk that patients may have been inappropriately prescribed roaccutane when they were pregnant.

Safeguarding

- No safeguarding concerns had been reported to CQC since the clinic opened. The matron confirmed there had been no incidents involving children and young people that had required reporting.
- The safeguarding lead was the Spire Hull and East Riding hospital's director and the responsible person was the matron / head of clinical services.
- The matron told us that in the event of a safeguarding incident, this would be managed locally, and discussed and overseen by the group medical director. They said the service actively participated in the local safeguarding board and would escalate any concerns to the relevant council safeguarding lead.
- Records showed that for staff across both sites, between 1 April and 31 August 2015, 282 (68.9%) had completed safeguarding refresher training and 372 staff (91%) had undertaken child protection training.
- We were told that all the consultants on the paediatric register had been written to by Spire, asking them for evidence of their recent training and that they had to be up to date with safeguarding and paediatric

resuscitation. Senior staff told us that Spire locally was planning to "put on training" in level 3 safeguarding and paediatric basic life support (BLS), to help ensure they were up to date with current requirements. However, we requested but were not shown any evidence by the service to confirm this.

- The children's nurses, including the bank children's nurses, had been trained to safeguarding level 3. Staff told us one of the substantive children's nurses had safeguarding level 4 and was a train the trainer in safeguarding. However, we did not see any records to confirm this.

Mandatory training

- Staff and managers told us mandatory training was all up to date and records submitted by the service confirmed this. For example, 80.9% of staff had completed fire safety training, and 90.5% of staff had completed equality and diversity training.
- Mandatory training records for staff were not broken down by site.

Assessing and responding to patient risk

- Children and young people treated at the clinic were generally low-risk, healthy and without any co-morbidities.
- Staff told us the clinic did not administer any general anaesthetics, only local anaesthesia was used. They said the day care unit carried out procedures for dermatology patients and that patients were, "In and out in 45 to 60 minutes."
- We saw there were relevant health and safety notices on display in the five bay day case area; these included first aid notices and a notice about what to do in the event of a needle stick injury.
- We reviewed the intensive care transfer policy and saw it stated that patients who require critical care treatment should be referred and transferred as early as possible. The policy also stated that paediatric stabilisation beds were located at the local NHS Trust. Staff we spoke with on the Spire Hull and East Riding hospital site confirmed this was the procedure to follow if a child or young person required critical care.
- There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.
- The dermatology service saw a number of young people for roaccutane treatment for acne. Female patients for this treatment were required to have a pregnancy test prior to the prescription being written, this is because roaccutane has side effects if the patient is pregnant.

Nursing staffing

- Staff employed by Spire worked across the two sites.
- The clinic used two part time qualified children's nurses and two bank children's nurses to care for children and young people. We found one of the contracted part time nurses, employed on a 7.5 hours a week contract, was leaving at the end of the inspection week. They told us they were going to join the Spire bank when they left.
- Staff at Hesslewood told us trained children's nurses were always on site if children or young people were undergoing a surgical procedure.
- However for routine outpatient appointments there were no separate clinics for children and young people in addition children were not routinely cared for by qualified children's nurses.
- Patients were booked in for elective day surgery according to the availability of qualified children's nurses and theatre staff with appropriate paediatric training and skills.
- There were low numbers of children and young people receiving care and treatment at the clinic; this meant staffing for each surgical procedure was considered on an individual basis.
- The two parents and one patient we spoke with after the visit all told us there were enough staff on duty to meet their individual needs.

Medical staffing

- Staff employed by Spire worked across the two sites.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were mainly employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice with Spire at this site). Documentation received from Spire prior to the inspection indicated that there were 223 doctors and dentists working under practice privileges with Spire Hull and East Riding and Hesslewood Clinic.
- A paediatrician represented children on the local Spire medical advisory committee (MAC).

Major incident awareness and training

Services for children and young people

- During our inspection visit, no specific evidence was identified which related to major incident awareness and training for staff working with children and young people at this site.
- The clinic was not a major incidentreceiving centre. We found that Spire locally had a business continuity plan, which had been used effectively at the Spire Hull and East Riding site on the weekend prior to our visit.

Are services for children and young people effective?

Not sufficient evidence to rate

Due to the small size of the service and the lack of sufficient evidence we did not rate the effectiveness of this service.

The clinic did not carry out any audits relating to services for children and young people and there was no evidence to show the service monitored patient outcomes. There was no standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests were not performed.

Staff caring for children and young people had their competencies checked and received professional development, including an annual appraisal.

Evidence-based care and treatment

- The majority of the operational policies were developed by Spire group nationally. Those we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the site was added in; nothing was allowed to be removed from the policies. Policies were available in hard paper format on the unit and in electronic format on the intranet.
- The dermatology service saw a number of young people for roaccutane treatment for acne. Female patients for this treatment were required to have a pregnancy test prior to the medication being prescribedThis is because roaccutane has side effects if the patient is pregnant. We discussed the pregnancy testing procedures with the clinical staff and received inconsistent answers which indicated that the procedures for dealing with samples were not well understood by staff.
- We asked for the standard operating procedure (SOP) for pregnancy tests, and audits of pregnancy tests performed. There was no SOP for pregnancy tests. Staff told us they followed the instruction in the pregnancy test kits. We received pack inserts showing which pregnancy tests were used at the two Spire sites but no audit information.
- There was no audit record of pregnancy test results performed and no audits of patient care records

Pain relief

- During our inspection visit, no specific evidence was identified related to pain relief for children and young people at this site.

Nutrition and hydration

- In the outpatient waiting area, we saw a tea and coffee machine and a water dispenser were available for patients to use.

Patient outcomes

- There was no evidence to show patient outcomes for children and young people's services at the clinic were monitored.
- There was no evidence to show that the children and young people's service participated in any relevant national or provider based clinical audits.

Competent staff

- The children's and young people's service cared for low numbers of patients and had low numbers of nursing staff; these staff maintained competencies in their roles within other organisations, usually within the NHS, which also employed them.
- The outpatient's sister told us that all nursing staff who worked at the Hesslewood site were trained in paediatric intermediate life support (PILS).
- Consultants and anaesthetists caring for children and young people at the clinic had undertaken paediatric care as part of their substantive role within their NHS practice.
- Consultants working at the hospital were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care). Practising privileges were reviewed every year by the senior management team. Checks were also made for doctors' indemnity cover.

Services for children and young people

- Spire provided consultants with an annual appraisal report when requested to support their NHS annual appraisal. This detailed information such as their practice profile, clinical indicators, serious adverse events and complaints.
- The Medical Advisory Committee (MAC) meetings discussed any serious issues.

Multidisciplinary working (in relation to this core service)

- Staff told us teams and services worked together well to deliver effective care and treatment for children and young people using the service.
- We observed positive interactions between different disciplines of staff.

Seven-day services

- The theatres were available for admissions from 07:30 to 20:00 hours, Monday to Friday (07:30 to 16:00 hours on Saturdays). However, theatre time was not fully utilised as the services were still in development.
- Local anaesthetic cases were performed in these theatres, such as minor procedures and minor plastics.
- The clinic did not have an on-site pharmacy or radiology service; however, both services were provided at the Spire Hull and East Riding Hospital site. Pathology samples were sent either to laboratories at the local trust or to the laboratories at Spire Manchester.
- Staff told us the outpatients department at Hesslewood clinic currently opened five days a week and clinic times varied from week to week

Access to information

- Staff had access to the hospital computer system. This contained booking information and pathology reporting systems.
- Paper based patient records were available on site for patients seen in the last four months, with access to other patient records via an external storage centre.
- Password access was supplied to staff as required on an individual basis.
- Staff could access information such as policies and procedures on the hospital intranet.

Consent

- Staff told us the consultants completed the consent documentation for female patients prior to prescribing roaccutane treatment. Staff we spoke with could not provide any more information about the consent process followed by the consultants.
- Six of the nine dermatology patient records reviewed were for female patients. Two of these six records contained correctly completed and signed consent forms for roaccutane treatment; there was no consent documentation in the other four female patients' records.
- We did not speak to any parents or patients who had required pregnancy tests prior to treatment in dermatology outpatients at the Hesslewood clinic. The two parents we spoke with both had male children and the female patient we spoke with had not needed a pregnancy test for her treatment. This meant we were unable to ask any parents or patients whether consent procedures were followed correctly.
- We reviewed the service's 'Consent for children' policy, which described the process to follow for gaining consent from children and young adults for examination or treatment.
- We saw the policy described how to obtain consent and how to test whether the child had sufficient understanding and intelligence to enable them to understand fully what was proposed. This is known as Gillick or Fraser competence and is a legal requirement.

Are services for children and young people caring?

Not sufficient evidence to rate

We were unable to rate caring because we did not have sufficient evidence.

There were no patients at the clinic during our inspection. We spoke with two parents and one patient following our visit, they all told us the care received was supportive and the staff were kind, caring and friendly. They also told us they were happy with their involvement in their child's care and treatment.

Compassionate care

Services for children and young people

- During our visit, staff generally were observed to be interacting with patients and their families in a caring and friendly manner.
- We saw a positive caring interaction between a dermatology consultant and a young child.
- One parent we spoke with after the visit said, "The staff have been very helpful every time we've been."
- The patient we spoke with after the visit said, "There was nothing that could have been improved."

Understanding and involvement of patients and those close to them

- The two parents and patient we spoke with after the inspection told us they had been involved in their care and treatment.
- One parent said, "We were kept well-informed." However, the other parent said, "The consultant was a bit vague and hadn't looked at the history. My son had been on treatment for quite a few months. I'm not sure all the options were discussed."
- The patient we spoke with said, "I got mixed messages from my consultant about whether I could take my medication. I voiced my concerns and they told me it was fine. They didn't check; I work in healthcare and knew that it wasn't fine."

Emotional support

- We had no evidence to comment on this area.

Are services for children and young people responsive?

Not sufficient evidence to rate

We were unable to rate responsiveness because we did not have sufficient evidence.

Qualified children's nurses were available for children and young people undergoing day case procedures and the service was responsive to the individual needs of the children and young people who used it.

The service had not received any complaints; however, this meant we could not judge whether complaints were responded to appropriately.

There were no separate areas to wait or clinic time for children and young people. However, all patients were seen in private consulting rooms.

Service planning and delivery to meet the needs of local people

- Senior nursing staff told us the service planned to accommodate a mixture of NHS and private patients.

Access and flow

- There was no specific data relating to children's waiting times and access to treatment
- It was mainly young people who attended the Spire Hesslewood clinic for procedures in theatres and appointments in the OPD, with very few younger children.
- Young people mainly accessed the dermatology clinic for treatment of acne.
- One parent said, "We seemed to be in and out very quickly. The first appointment we went straight in and the second time we had to wait about half an hour."
- The patient we spoke with said, "It was really good actually; I was called in very fast."

Meeting people's individual needs

- The access criteria in place for the service meant that on the whole children and young people who accessed the services did not have complex needs.
- All staff working at Hesslewood clinic wore name badges, which included their job role. In the clinic's waiting area, we saw photographs showing the names and grades of the staff who worked at Spire Hesslewood on display.
- There were notices on display in the waiting areas which stated; 'Colouring books and crayons are available for children, please ask.'
- In the outpatients waiting room there were notices on display advising patients about the use of chaperones during consultations.
- In the outpatients waiting area leaflets were available about interpretation and translation services. The text contained in these leaflets was in nine different languages.
- British sign language interpreters were also available on request.
- There were no separate areas to wait or clinic time for children and young people. However, all patients were seen in private consulting rooms.

Services for children and young people

Learning from complaints and concerns

- In the clinic's waiting area, there was a notice about 'What to do if you have a complaint'.
- We were told there had been no complaints or concerns raised about services for children and young people at the Hesslewood clinic. We were therefore unable to judge whether the service was responsive to complaints and concerns received.
- When we asked staff about responding to concerns, they told us they did not record all issues raised as the staff were responsive and sorted any issues out straight away.

Are services for children and young people well-led?

Requires improvement

We rated children's' services at Spire Hesslewood clinic as requires improvement for well led because:

Senior nursing staff were unable to tell us about the vision and strategy for the children's service.

Governance, risk management and quality measurement within the service were not well developed and there was no evidence of continuous quality improvement.

Feedback from staff about the culture within the service, teamwork, staff support and morale was positive. Feedback from parents about the care and treatment received was also positive.

Vision, strategy, innovation and sustainability and strategy for this core service

- We were told Spire Healthcare had recently produced a clinical policy, 'Guidelines for the care of children in Spire Healthcare.' This was a recent development, which the hospital would be adopting. Following our inspection we requested a copy of this document, however this was not received.
- Staff were unable to describe a vision or strategy for children's services within the clinic or across the two sites.

Governance, risk management and quality measurement for this core service

- We did not find any evidence of specific audits, or quality assurance for children and young people's services across the two sites. For example, there was no audit record of pregnancy test results performed and no audits of patient care records. We did see some risk assessments carried out by the paediatric leads in each area where children were seen.
- When we asked about medication audits and audits of patient records, senior nursing staff and the children's nurses told us these were not done. They said the service was; "going to audit patient records."
- The matron told us paediatric services were discussed at the quarterly clinical governance meetings and there were links to the MAC, hospital and group governance arrangements. When we reviewed the June 2015 MAC minutes we saw that a Paediatric Policy was due to being released 'in the next few months' and the recommendations following the report "Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile" were also being reviewed. The August 2015 MAC minutes documented that the Paediatric Policy had been released and that consultants would have to undergo training in order to operate on children in the independent sector. The hospital would keep a paediatric register of consultants with appropriate paediatric training and the matron would organise paediatric basic life support training for consultant staff. This confirmed what the matron had told us.
- We were told that there would be a local governance review for paediatric services in December 2015.
- The matron explained that there was a national Spire paediatric steering group and the paediatrician who worked at the hospital would be contributing to this.
- Spire services had an internal annual clinical review; five people from Spire nationally had reviewed the Spire Hull and East Riding hospital and this would include Spire Hesslewood in the future. As required action plans were developed following the review and monitored nationally.
- We looked at the hospital's 'annual governance report for 2014' and saw that paediatric services were mentioned in relation to services provided (medicine and surgery). There was one action related to paediatric services this was to do a gap analysis on the 2015 national report "Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile".

Services for children and young people

Leadership/culture of service

- Spire Hesslewood Clinic shared the same overarching management structure, organisational structure and committee structure as the Spire Hull and East Riding hospital.
- Staff told us there was no specific leadership structure in place for paediatric services.
- The ward manager on the general ward managed the children's nurses, for HR issues and work schedules.
- The paediatrician told us they had taken on the lead for children's and young people's service recently, after the previous post-holder left,as a result, they had only started attending the MAC in the summer of 2015 and had been to one meeting so far. They explained that the service had been without a consultant paediatrician for five months before that.

Culture within the service

- The children's nurses working with children and young people were, "very committed and want the best for the service".
- Staff we spoke with told us they loved working at Spire, they told us it was a welcoming, supportive culture and morale was good. They said the service had a 'learning culture' with good investment in training and education.
- The lead paediatrician told us staff working at the service were, "flexible and accommodating."

Public and staff engagement

- Information regarding developments were shared and cascaded down.in addition staff could find information on the intranet, via emails and in the staff newsletter. One person told us they felt there was a "proactive approach."
- Staff told us they gave out feedback forms to children, young people and their families on discharge. Feedback all referred to one of the children's nurses and was universally positive.
- We reviewed the feedback received from 12 parents, between May and September 2015 and saw six of these twelve comments had been placed in the monthly newsletter.
- We did not see any feedback specific to the Hesslewood clinic site.

Innovation, improvement and sustainability

- When we asked the children's nurses, ward manager and paediatrician about innovation, improvement and sustainability no one gave any examples. The matron told us about an updated corporate policy which would improve services. To sustain the service senior staff told us they planned to recruit more children's nurses.

Outpatients and diagnostic imaging

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

Information about the service

Spire Hesslewood clinic was a new development, opening in February 2015, which was a satellite of Spire Hull and East Riding hospital. The clinic provided five consulting rooms and two dedicated minor procedures theatres. Consultations, diagnostic tests and treatments were offered for dermatology, migraine, eyes, rheumatology, psychiatry and podiatry. Blood tests were also performed at the Hesslewood clinic. Pathology and laboratory services were mainly provided by a local NHS trust through a service level agreement.

As the clinic was a satellite location of the Spire Hull and East Riding hospital staff worked across both sites and much of the data was aggregated. Between 1 September 2014 and 31 August 2015, the Spire Hull and East Riding and Hesslewood outpatients' service saw 73,361 patients.

During the inspection of Spire Hesslewood clinic, we spoke with four patients and six members of staff. We also received feedback from 111 patients across both locations via comments cards. Staff we spoke with included managers, nurses, doctors, healthcare assistants, and administrative staff. We observed the outpatient environment, checked equipment and looked at patient information. We also reviewed performance information from, and about, the hospital and clinic.

Summary of findings

We found that the care and treatment received by patients in the outpatient departments within the Spire Hesslewood clinic was safe, caring, responsive and well led. The service was inspected for effectiveness but not rated.

Incidents were reported, investigated and lessons learned were shared across the hospital and clinic locations. Staff adhered to policies and procedures and there were sufficient well-trained and competent nursing, allied health professional (AHP) and medical staff within the department to deliver care safely. Clinical staff adhered to evidence based practice and participated in ongoing observational research studies.

Patients told us they were treated with kindness and compassion and that staff were courteous and respectful. Receptionists were reported as excellent and chaperones were offered. Patients felt that confidentiality was excellent. The outpatient department offered appointments weekdays, evenings and Saturday mornings. Patients were able to be seen quickly for urgent appointments if required and departments offered flexibility around clinic times. Clinics were rarely cancelled at short notice and waiting times for appointments were well within target timescales.

Staff and managers had a vision for the future of their services and staff felt empowered to express their opinions or concerns. Staff were engaged with the

Outpatients and diagnostic imaging

organisation's mission to deliver the highest quality patient care and patients were given opportunities to provide feedback about their experiences of the services provided.

Are outpatients and diagnostic imaging services safe?

Good

We rated outpatients & diagnostic imaging services as good for safe because:

Incidents were reported, investigated and lessons learned were shared across the clinic. The cleanliness and hygiene in the department was of a good standard and sufficient personal protective equipment was available to protect patients and staff from cross-infection and contamination. Clean and well-maintained equipment ensured that the interventions patients received were safely carried out.

Risk assessments were up to date and protective measures were put in place where necessary.

Medical records were always available for outpatient clinics, staff were aware of policies and procedures to protect vulnerable adults or those with additional support needs and there were sufficient well-trained and competent nursing, allied health professional (AHP) and medical staff within the department.

Incidents

- Between the 1 April and 22 September 2015 there were 36 incidents logged relating to outpatient areas and diagnostic imaging services across both locations. Themes included; patients' procedures cancelled due to no longer being required; cancellations and delays due to equipment failure; three incidents were information security breaches; two incidents related to late clinic starts; two falls; and two incidents were related to pathology specimens missing or not labelled. All incidents were low risk or no harm.
- Staff were able to explain how to report incidents using the electronic incident reporting system and when to escalate incidents to their line manager.
- Outpatient staff, including medical staff reported that any incidents were discussed at departmental meetings and described an open and honest culture.
- Incident reports were reviewed by the Medical advisory committee, who were responsible for identifying any over-arching patterns and learning points.

Duty of Candour

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- Staff had knowledge of duty of candour and described how they had informed patients if an incident or mistake had occurred. They were clear of the requirement to be open and honest with patients when incidents occurred.
- We observed that information was available in the staff room regarding duty of candour and that this had been one of the topics in a recent staff briefing.
- There had been no incidents in the last 12 months that had triggered a formal duty of candour response.

Cleanliness, infection control and hygiene

- The departments we visited were visibly clean and we saw evidence that waiting areas, clinic rooms, and equipment were cleaned regularly. Rooms used for eye examinations and laser treatments were decontaminated and cleaned after use.
- Patients we spoke with felt the departments were clean, tidy and safe.
- We observed staff complying with "bare below the elbow" policy in clinical areas and hand hygiene policy. Soap dispensers and hand gel were readily available for staff, patients, visitors and the public to use. Dispensers were clean and well stocked. We observed staff using good infection control practices and they told us there were sufficient supplies of personal protective equipment (PPE).
- We observed staff using the correct handwashing technique.
- An undated hand hygiene environmental audit of outpatients and the angiography laboratory showed 100% compliance. The audit included questioning five members of staff regarding hand hygiene, using a list of standard questions. There was no observation of hand washing noted.
- Appropriate containers for segregating and disposing of clinical waste were available and in use across the departments and we saw that PPE, used linen and waste was disposed of correctly.
- Outpatients were discouraged from attending appointments if they were suffering from infectious diseases such as diarrhoea and vomiting or had flu like symptoms.
- Patients told us they had observed staff washing their hands and using hand gel before their treatment.
- Sharps audits showed compliance at 99% for the outpatient department . However, we noted that there was no temporary closure of the boxes containing sharp items.
- There was an infection control link nurse network in operation across the sites and environmental spot checks had been introduced in June 2015.

Environment and equipment

- A patient-led assessment of the care environment (PLACE) audit showed scores above the national averages. Scores for cleanliness, food, privacy, dignity and wellbeing and condition appearance and maintenance were 100%, 96.1%, 88.2% and 97.7% respectively. These scores were better than national averages of 97.6%, 88.5%, 86% and 90%.
- There was sufficient seating available in waiting areas.
- There was an emergency resuscitation trolley shared between the outpatient and theatre areas. The trolley was checked every day to ensure it was in good working order. We looked at resuscitation trolley checklists and found them to be checked and signed on a daily basis. Drawer locks were in place. The trolleys were clean and tidy and all consumables were within the use by date. The oxygen cylinder was also checked and within date.
- Equipment in outpatients was visibly clean and stickers were in place to show that cleaning had been carried out and that the equipment was ready for use.
- Curtain changes were recorded and consumable items were in date.
- Not all equipment was labelled to show when it was last serviced or maintained; however there was a systematic process in place, which ensured all equipment was serviced in line with its individual requirements.
- There were contracts and a centralised system in place to ensure regular service and maintenance of all equipment across both sites. We saw records that indicated that services and maintenance were up to date and there was an IT system in place to track and schedule routine maintenance and servicing as it became due. There were contracts in place with specialist companies to undertake emergency repairs of equipment and maintenance support could be contacted and brought in 24 hours per day, seven days a week if needed.

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- There was a system in place to decontaminate instruments after use and to ensure traceability. Traceability stickers were entered into patients' notes following procedures.
- Patients reported that they were happy with the standard of cleanliness and that the waiting areas were spacious and comfortable with plenty of refreshments on offer.
- The departments were well signposted.
- There was clear and appropriate signage regarding hazards of laser equipment.

Medicines

- We checked drug cupboards and found that all drugs were in date. We found some artificial tears had recently gone out of date and these were disposed of appropriately when we drew this to a nurse's attention.
- Prescription pads were locked in the drug cupboard and nursing staff provided these to consultants on an individual patient basis.
- There was no onsite pharmacy at Hesslewood; if patients required a prescription then they needed to go to the Spire Hull and East Riding Hospital to pick it up.
- There was a stock of eye drops kept onsite for dispensing post eye examination.
- Other drugs kept at the clinic included local anaesthesia, stocks of dressings, limited lotions for dermatology, and Botox injections for the migraine clinic.
- A register was kept regarding the use of Botox (patient's name, consultant, prescription number and expiry date) which was monitored by the Spire pharmacist on a regular basis.
- Prescription charges were covered as part of the packages of care commissioned for NHS outpatients.
- Prescription charges, for private outpatients, were added to or included in consultation fees depending on the treatment plan purchased.
- We checked records of drug fridge temperatures and found these were monitored daily, records were up to date with no gaps and fridges had been maintained within the recommended temperature range.

Records

- Records used in the outpatient department were a mixture of paper based and electronic information that included test results, reports and images. Medical notes and referral letters were not held electronically.
- All patients attending the clinic had a full set of medical records stored at the Hull and East Riding Hospital site for a maximum of a four-month period after this they were transferred to an off-site storage facility.
- All clinics were arranged 24 to 48 hours in advance, which meant patients should never have attended clinic without medical records being available. Records were transported to Hesslewood on the day of the clinic and returned following use. There were transport runs three times a day and urgent deliveries could be requested if needed in between planned trips.
- Staff reported that records were usually available in a timely manner for clinic appointments and the department estimated that records were unavailable less than 1% of the time. However, this was not routinely monitored.
- In the event of a late booking, and records being unavailable for a patient's appointment, a temporary set of records was created. Records were requested from the archive at the time of booking and temporary records were amalgamated as soon as the original was received.
- Medical records were transported securely and stored securely when not in use. This included the use of sealed boxes to transport records between Spire Hull and East Riding and the Hesslewood clinic.
- Any loss of medical records was reported to the matron. However, patients were not routinely notified by the medical records team if this occurred. It was not clear whether the loss was reported to the patient by another department.
- The Spire policy was that consultants did not take medical records off the site. Spire required that all consultants were registered with the information commissioner and were personally accountable for the protection of information.
- All electronic patient records including images held on discs were encrypted and password protected.
- None of the patients we spoke with had experienced any problems with availability of their care records.
- Records were stored securely away from waiting patients.
- We looked at four sets of records in the outpatient department at Hesslewood and found them to be complete with both NHS and Spire records attached, all had referral letter present and all had consultant letters following initial consultation. Records and letters were all signed.

Outpatients and diagnostic imaging

- Record audits showed 100% compliance in quarters one and two regarding standard of completion including elements such as clear dating and signing of entries.

Safeguarding

- Staff we spoke with were aware of their responsibilities to safeguard adults and children and knew whom to contact in the event of concern.
- We saw evidence of children's and adults' safeguarding policies and procedures.
- Adult and children's safeguarding was a part of mandatory training. Staff told us they were up to date with mandatory training. We were told that children's safeguarding training for all staff was at level 2.
- Staff confirmed they had completed safeguarding training and that they were expected to undertake an annual refresher.
- Data provided by Spire showed 90% and 91% compliance with adult and children's safeguarding training among outpatient staff.
- There was a range of information available in the staff room relating to; anti-terrorism "PREVENT", domestic abuse, female genital mutilation and mental capacity act and deprivation of liberty standards.
- Whistleblowing posters were visible in staff areas and staff expressed confidence that they could speak to managers regarding any concerns they had about services or other staff.
- All staff felt well supported by senior staff who were readily available if they needed to escalate any safeguarding concerns.
- A staff nurse described how she had to put her safeguarding training into practice when she had found a confused person by themselves in the clinic car park.

Mandatory training

- Data provided by Spire showed overall compliance with mandatory training across the two sites was between 70% and 91% for all modules. Data was available for January to August 2015. It was not possible to disaggregate the data for outpatients only.
- The trust mandatory training programme was composed of 12 modules covering all appropriate topics including; general health and safety, adult and children safeguarding, moving and handling, information governance and infection control.
- Training provided was a combination of e-learning and face-to-face training.
- Staff in the outpatient, imaging and physiotherapy areas told us they were up to date with mandatory training.
- Mandatory training and induction was given to all staff including bank staff.

Assessing and responding to patient risk

- There were local policies, procedures and processes in place to protect patients and staff.
- Risk assessments had been undertaken in relation to patient safety, use of laser eye equipment, the environment and staff safety. Identified risks had mitigations in place to reduce potential risks to a minimum and new assessments were undertaken when new risks were identified. Ongoing risks were reviewed annually.
- All of the nurses and healthcare assistants working in the outpatient department at Hesslewood had undertaken Paediatric Immediate Life Support (PILS) training in addition to adult ILS.
- Medical staff were focussed on patient risk and safety and assessed whether patients were suitable for interventions at the Spire Hesslewood Clinic.
- Although the majority of podiatry clinics were held at Hesslewood, the podiatrist sometimes arranged for lists to be carried out at the Spire and East Riding Hospital due to certain treatments and medications not being available on the Hesslewood site.

Nursing and allied health professional staffing

- The outpatient departments were staffed by 10.9 whole time equivalent (WTE) registered nurses and 6.5 WTE care assistants some of whom worked across both sites.
- Sickness rates were less than 10% for staff working in outpatient departments, there were no vacancies for nurses, or healthcare assistants. Turnover rates were 7% for registered nurses and 11% for healthcare assistants. 100% of staff had worked for the organisation for longer than one year.
- There was no reported use of agency staff in outpatient areas in the last 12 months.
- Within outpatients, staffing levels were based upon a number of factors including the number of patients expected to attend and number, type and complexity of clinics to be held.
- Staff and patients we spoke with, as well as our observations confirmed that there were enough staff available to meet patient's needs.

- The clinic and hospital had a bank of staff to call on when needed to cover unexpected absence.

Medical staffing

- Medical staff were employed by other organisations (usually the NHS) in substantive posts and had practising privileges (the right to practice in this service). At the time of our inspection, 223 doctors and dentists were working under practicing privileges with Spire Hull and East Riding and Hesslewood Clinic.
- Staff reported that consultant contact details were available on a spreadsheet and consultants arranged their own clinic cover when required. Suitably trained colleagues, with practising privileges, provided cover.

Major incident awareness and training

- There was a major incident policy and staff were aware of contingency plans should major incidents occur. All staff were required to have read the policy and sign to say they had done so.
- As an independent provider the Spire Hesslewood Clinic did not routinely become involved in major incidents external to the organisation.
- Business continuity plans were in place and senior managers operated an on call rota to ensure availability out of hours.
- Staff were clear how to escalate both clinical and non-clinical incidents of a serious nature.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment was evidence based and staff in the department were competent. There was evidence of multidisciplinary working both internal and external to the clinic. The outpatient department was open 9am to 9pm Monday to Friday and occasional Saturday mornings.

Clinical staff adhered to evidence based guidance and were participating in ongoing observational research studies. Staff and patients had good access to information and staff gained patient consent before care and treatment was given.

Evidence-based care and treatment

- The majority of the operational policies were developed by Spire group nationallythose we reviewed included reference to and followed nationally recognised best practice guidance.
- When a new organisational policy was received, staff and the MAC reviewed the policy and undertook a gap analysis on the policy, and information relevant to the site was added in; nothing was allowed to be removed from the policies. Policies were available in paper format stored on the unit and in electronic format on the intranet.
- We saw staff in the departments were adhering to national guidance and local policies and procedures. Staff were aware of how policies and procedures had an impact on patient care and they had easy access to policies, protocols and other clinical guidance on line. Hard copies of documents in regular use were available for staff to refer to.
- Outpatients and imaging departments used communication files and signing sheets to cascade new information regarding policies, procedures, and guidance to all staff.
- Findings of audits and inspections were discussed at team meetings so all staff were aware when any changes to practice were required.
- There was an ongoing observational research study of Botox injections for the treatment of migraine, which had been accredited by the National Institute for Clinical Effectiveness as a suitable treatment.

Pain relief

- Pain relieving medications and local anaesthetics were prescribed for and administered to patients undergoing interventional procedures.

Patient outcomes

- When patients required follow up appointments or investigations they were informed of this during their consultation and appointments were made at reception before leaving the clinic. When patients were awaiting test results, the consultant would advise how these results could be accessed.
- Patient outcomes relevant to outpatients were monitored through complaints and cancellations, which were included on a clinical scorecard. This was submitted to the local commissioners on a quarterly basis and was used to benchmark against other Spire hospitals and clinics.

Outpatients and diagnostic imaging

Competent staff

- All staff groups working within the outpatient areas had received an appraisal in the last 12 months.
- Managers encouraged staff to undertake professional development.
- Staff using laser equipment had received training from an external adviser. The department had undergone an external risk assessment in September 2015 and was certified as managing laser safety safely and effectively.
- Staff told us that induction was thorough and structured. A learning diary was in place for the first four weeks, then monthly e-learning that directed staff to what they needed to know.
- New starters, which included bank staff, were allocated a "buddy" and given time to be orientated to other departments. Staff felt this was beneficial and aided understanding of where patients would be referred to for different parts of their care and treatment.
- Staff were expected to read any new policies that were issued and there was a record sheet for staff to sign when this had been actioned. We saw that this policy record sheet was up to date with staff signatures.
- Staff had access to training over and above mandatory training. For example, one nurse in outpatients was booked on a wound care course in November 2015. Training was a mixture of e-learning and face to face.
- HCAs had received further training in suture removal and wound care which increased competences relevant to their role.
- Staff were booked to attend training regarding paediatric phlebotomy during October and November 2015.
- Members of the physiotherapy team provided training to other staff regarding moving and handling and carried out competency based assessments.
- Consultants working at the clinic were utilised under practising privileges (authority granted to a physician or dentist by a hospital governing board to provide patient care). Practising privileges were reviewed every 2 years.
- The organisation liaised with the consultants' NHS employers regarding annual appraisal and fitness to practice. Consultants were provided with a report, which included practice profile information, clinical indicators, serious adverse events and complaints to support their NHS appraisal.
- There was a process in place which provided assurance that consultants held current indemnity, GMC registration, had an annual appraisal and to confirm revalidation where necessary.
- Appraisal rates from Medical Advisory Committee (MAC) minutes March 2015 indicated that 95% of all the consultants who worked at the two sites had been appraised with a further 1% being inside the grace period.
- Indemnity results from the MAC minutes showed 87% compliance with providing indemnity documentation.
- The medical director for the Spire group was the responsible officer for overseeing Medical appraisals and could undertake appraisals for consultants who no longer worked in the NHS.

Multidisciplinary working (related to this core service)

- There were examples of internal and external multidisciplinary team working (MDT). For example, podiatrists worked closely with consultants and GPs as well as with other allied health professionals (AHPs) and nursing staff to ensure patients were provided with individualised treatment plans.
- There was an improvement plan to improve interdepartmental working as a result of the 2014 staff survey. Actions regarding this had included changes to the heads of department meeting structure and active involvement of staff from all areas. One of the key areas for the action plan was to improve communications regarding handover and transfer of patient care between departments.

Seven-day services

- Outpatient clinics were accessible at varying times of day and evening up until 9pm and Saturday mornings.

Access to information

- All staff had access to the intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as x-rays, medical records and therapy records appropriately through electronic and paper records.
- Patients were not routinely copied into correspondence between Spire consultants and the patient's GP. This was done at the request of the consultant.
- Patients were told how they would receive their test results during their consultation.

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Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff demonstrated knowledge and understanding of Safeguarding Vulnerable Adults. They had received adult safeguarding training that included Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) and some awareness of dementia and people with a learning disability.
- Staff demonstrated a good understanding of informed consent.
- Staff reported if consent could not be safely obtained and/or the patient lacked capacity to consent, they would contact the hospital safeguarding lead for advice. There was a process in place for staff to follow when patients were not able to give consent because of fluctuating capacity.
- We observed that verbal or implied consent was obtained from patients before care and treatment interventions, such as obtaining specimens, routine diagnostic tests and the checking of height, weight and other physiological signs.
- 75% of staff had accessed mental capacity act training between January and August 2015.

Are outpatients and diagnostic imaging services caring?

Good

We rated outpatients & diagnostic imaging services as good for caring because:

Patients told us they were treated with kindness and compassion and that staff were courteous and respectful. Receptionists were described as excellent and chaperones were made available when needed. Patients felt that confidentiality was excellent.

Services were in place to emotionally support patients. Patients were kept up to date with and involved in discussing and planning their treatment. They were able to make informed decisions about the treatment they received. Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions or treatment. Patients spoke very highly of the service provided by the pain clinic.

Compassionate care

- During our inspection, we saw patients being treated respectfully by all staff.
- Staff were wearing name badges and were observed to introduce themselves to patients, politely and professionally.
- Reception staff were observed to provide a warm welcome to patients as they entered the clinic and gave clear instructions and advice in a helpful, caring and compassionate manner. Patients reported that receptionists were excellent.
- We saw patient's privacy was respected and the environment in the outpatients department allowed for confidential conversations.
- Notices offering chaperoning were in evidence and staff told us this was provided whenever requested.
- Patients reported that they were treated with respect; they said that staff on the front desk were very aware of confidentiality and they were impressed with the manner in which they were treated and their confidentiality was maintained.
- Patients we spoke with were satisfied with their care and treatment and told us that the staff were excellent in caring, compassion and maintaining dignity.
- Where patients had experienced problems with treatment or if a mistake had occurred staff had apologised and explained what had happened.
- There were two comment cards received during the inspection regarding poor attitude of consultants and a further two similar comments posted on NHS choices in January and March 2015. It was not possible to determine which site they applied to.

Understanding and involvement of patients and those close to them

- We observed staff spending time explaining procedures to patients using both verbal and written information.
- Patients were given time to ask questions and these were answered in a way they could understand.
- Patients and their representatives told us they were involved in decision making where appropriate.
- Patients were satisfied with the information they received about their appointment, what to expect and requirements regarding tests and procedures.

Emotional support

Outpatients and diagnostic imaging

- One patient gave feedback that they were concerned regarding emotional support, however, others were happy with the emotional and psychological support they had received.
- Chaperones were available for patients when needed and notes were stamped and signed with the chaperone's details.

Are outpatients and diagnostic imaging services responsive?

Good

We rated outpatients & diagnostic imaging services as good for responsive because:

Patients were seen quickly for urgent appointments if required and departments offered flexibility around clinic times. Clinics were only rarely cancelled at short notice and patients were given new appointments quickly if this happened. Waiting times for appointments were well within target timescales.

Mechanisms were in place to ensure the service was able to meet the individual needs of people such as those whose first language was not English. Although the clinic did not treat many patients with complex needs such as those living with dementia, a learning disability or physical disability there were mechanisms for obtaining specialist advice and support when needed and reasonable adjustments were made.

Systems were in place to capture concerns and complaints raised within the department, review these and take action to improve the experience of patients.

Service planning and delivery to meet the needs of local people

- Service planning was observed to be responsive to the needs of local people and supported delivery of services offered by the local NHS trust.
- For example, the Spire had expanded service provision in dermatology where a local NHS trust was struggling to meet demand.
- There were ongoing plans to continue to expand service provision at the Hesslewood clinic into other specialities.
- A bespoke eye examination room had been implemented to improve patient experience so that all tests and examinations could be carried out in a single space.

Access and flow

- The service accepted referrals for children and adults from a large catchment area. Private and NHS patients were referred to the Spire consultants by GPs.
- Systems of electronic referrals via "choose and book" and paper faxed referrals were in place.
- Referrals were screened and triaged by the outpatient manager and department sister as to suitability for treatment at the Spire Hesslewood Clinic. There were a number of exclusion criteria used to assess the suitability for treatment. The relevant consultants made the final decision regarding whether it was appropriate to see and treat a patient at the Spire Hesslewood Clinic.
- Most of the patients attending both Spire outpatients departments were NHS funded. Between April 2014 and March 2015, around 10,000 NHS patients were seen for first attendance. There was a further 20,000 follow up appointments during this time attended by NHS patients. Most of these were at the Spire Hull and East Riding hospital as the clinic only opened in February 2015.
- Activity for other funded patients was about 7,000 first appointments and 8,000 follow up appointments.
- A total of 44,714 appointments were attended between April 2014 and March 2015 across both sites.
- Referral to treatment (RTT) target data for the reporting period April 2014 to March 2015 showed that the provider had exceeded the target of 90% of admitted patients beginning treatment within 18 weeks every month. The data showed that 100% of patients had begun treatment within the target range for five of the reported months.
- The provider also exceeded the target of 92% of patients with an incomplete pathway beginning treatment within 18 weeks every month in the reporting period April 2014 to March 2015. The data showed that 100% of patients had begun treatment within the target range between July 2014 and March 2015.
- The provider exceeded the target of 95% of non-admitted patients beginning treatment within 18 weeks of referral. The data showed that 100% of patients had begun treatment within the target range between July 2014 and March 2015.

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- The clinic did not collect information regarding 'did not attend' (DNA) rates.
- We were told that clinics were rarely cancelled and if this did occur, it was usually due to unavailability of the consultant. Patients were contacted by telephone to tell them of the cancellation and their appointment was rescheduled as soon as possible. When a recent list was cancelled due to emergency leave, the consultant offered to provide an additional clinic if patients could not be given an appointment in a reasonable timescale.
- Consultants were flexible and available to hold extra clinics when required.
- Numbers of cancelled clinics, reasons why and timing of rescheduled appointments was not systematically monitored. If it was noted that a particular consultant was regularly cancelling clinics this would be brought to the attention of the outpatient department manager who would discuss this with the consultant concerned and escalate if further action was required.
- Waiting times within departments were not routinely collected or audited, however we were told that the average waiting time for patients was 15 to 30 minutes.
- There were notices in the reception area to inform patients that if they had been waiting 15 minutes or more for their appointment, they should speak to reception and enquire about the delay
- All patients we spoke with felt they were seen in a timely manner once they had arrived at the clinic.
- If patients needed to see more than one consultant or health professional this was arranged to take place at the same visit.

Meeting people's individual needs

- There was a clear process to identify patients who needed an interpreter. Patients requiring an interpreter were identified at booking and interpreting services were arranged in advance to ensure interpreters were present for outpatient appointments and diagnostic imaging tests.
- Written information leaflets including the complaints leaflet were available in several different languages.
- The clinic accommodated patients with a learning disability and mild dementia; the need for reasonable adjustments was determined at first outpatient appointment. There was no specific training for all staff to raise awareness of dementia and how to care for people with it.
- There was a lead for safeguarding and dementia to provide support to patients and staff when needed.
- A member of staff told us that a desk had been replaced in a treatment room with a smaller one to improve wheelchair access.
- NHS patients needed to arrange their own transport to and from appointments, or through their GP if they required the assistance of a patient transfer service or ambulance service. It was noted by a member of the clinical appointments team that they did not provide NHS patients with any information about accessing patient transport services with their appointment confirmation letter.
- Patients had access to tea and coffee and water while waiting in the outpatient and diagnostic areas.

Learning from complaints and concerns

- The hospital and clinic aimed to respond to patients complaints within 20 working days of receipt. Over the previous 18 months, 70% of complaints had been responded to within this period. Complexity of the complaint and investigation was the primary reason for responses exceeding this period. Patients were informed by letter if the time scale was likely to be longer than 20 days.
- Complaints were investigated by the matron who involved and collated information from the other members of the team involved in the patient's treatment.
- Patients we spoke with did not know how to raise a complaint or concern, but felt able to talk to staff about any issues if they arose.
- One patient we spoke with had refrained from making a complaint regarding a concern, as they did not want to reflect badly on otherwise excellent staff.
- Multi-language complaints information posters were displayed in the reception areas. The poster provided information about how to make a complaint.
- There were "Please Talk To Us" leaflets available for patients to take away which informed patients how to complain if needed.
- Complaints were discussed at the customer care committee, which included staff from all areas to facilitate shared learning. The committee identified themes and trends, developed and implemented actions and cascaded information and learning to the clinical areas.

Outpatients and diagnostic imaging

- Two of the themes identified were length of appointments and staff attitude. Complaints regarding staff attitude resulted in staff undergoing reflective exercises to improve displayed behaviours and communication skills. Complaints regarding short appointment times had resulted in longer appointments being offered in some specialities.
- The management had introduced a quarterly customer feedback update to further raise awareness among staff regarding complaints received and remedial actions undertaken.
- The outpatient manager told us that learning in the department was shared with the team in a number of ways. There was a communication folder in the department that staff could review and memos were displayed on a notice board. In addition, there were monthly team meetings, which were minuted.
- One to one discussions with staff took place to share learning, where appropriate.

Are outpatients and diagnostic imaging services well-led?

Good

We rated outpatients & diagnostic imaging services as good for well led because:

Staff and managers had a vision for the future of their service and were aware of the risks and challenges faced by the department. There were clear governance arrangements in place and staff felt empowered to express their opinions or concerns and felt they were listened to. Risk registers were in place and risk assessments were regularly reviewed.

There was an open, supportive culture and managers encouraged learning and development. Staff were engaged with the organisation's mission to deliver the highest quality patient care and patients were given opportunities to provide feedback about their experiences of the services provided. Managers made good use of opportunities to develop innovative and sustainable services.

Vision, strategy, innovation and sustainability and strategy for this this core service

- Staff were aware of the Spire vision and clearly wanted to be part of "…delivering the highest quality patient care".
- Organisational expected behaviours and competence were integral to staff performance, development and appraisal.
- Managers received information and training regarding business plans and had the support of a financial officer.
- Staff were aware of the vision and business plans to extend and improve outpatient services at Hesslewood and told us they felt positive and engaged with these developments.
- Staff told us they were encouraged to propose innovative ideas for service developments and or to improve patient experience.

Governance, risk management and quality measurement for this core service

- Staff were aware of governance arrangements and feedback from governance and management meetings was given at team meetings. All staff had access to the minutes of these meetings.
- Incidents, complaints and potential items for the risk register were discussed at Heads of Departments and operational team meetings.
- Incident and complaint data was also reported to the clinical governance committee.
- Staff were given feedback about incidents and lessons learned, comments, compliments and complaints at team meetings where audits and quality improvement were also discussed.
- The organisation had systems in place to escalate issues to its parent company "Spire Healthcare" when necessary.
- The organisation had risk registers in place for business and clinical risks and managers updated these when necessary.
- Managers were aware of the risks within their departments and were managing them appropriately.
- There were policies and processes in place to ensure competence of clinical staff and we were given examples of when these had been used to address concerns regarding consultants' practice.
- There were processes in place to both monitor and provide consultants with statistical quality information regarding their practice. This enabled any trends, concerns or areas for improvement to be identified and acted on.

- There were examples of actions taken to improve services when quality issues had arisen. For example increasing turnaround times for pathology results from the local NHS trust had led to moving some diagnostic tests to a second provider to ensure results were received in a timely manner. However, there were no formal performance targets regarding turnaround times and it was unclear how quality and timeliness of pathology results was assured.
- Registration status had been verified for 100% of staff in outpatients and diagnostic imaging.

Leadership

- We found there were clear lines of management responsibility and accountability within the outpatient's service. Staff had clear roles and responsibilities and knew what their duties would entail on each shift.
- Staff in all areas stated they were well supported by their managers who were visible and accessible. The matron and local Spire manager did weekly rounds of the hospital and clinic.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes.
- Staff told us they would be confident to raise a concern with their managers and that this would be investigated appropriately.
- Staff told us that they felt they were listened to and engaged by the organisation.
- Staff felt managers were interested in their work and encouraged them to express ideas for service development.
- Service leaders had access to leadership courses and the physiotherapy manager was undertaking this training.
- The head of outpatients was a member of the shared leadership team for both sites.
- We saw evidence that the management team and department leads were undertaking a number of improvement actions following the results of the staff's "Patient Safety Survey" 2014. Some of the actions included; increasing radiographer bank numbers to help with weekend workload, creating an admin bank, introducing communications books. Staff were being encouraged to work with other departments to improve communications and improve transfers of care. Staff told us that they were encouraged to challenge others regarding any concerns about practice or decisions. They told us managers were supportive of this and had an open door policy.
- We saw the minutes of meetings that documented discussions and updates given to staff regarding progress against this action plan.

Culture within the service

- Staff and managers told us the outpatient department had an open culture.
- Staff felt they could report concerns and incidents and felt that these would be investigated fairly.
- Posters in the staffroom advised how members of staff could raise any concerns they may have regarding the care and treatment provided at the clinic. There was access to a whistleblowing hotline outlining confidentiality and support available should a staff member have concerns.
- They told us managers were receptive to comments and suggestions for improvements from staff .Staff were encouraged to seek feedback from patients and take immediate action when issues or concerns arose.
- A positive culture was evident through low sickness levels, low turnover and length of staff service.
- The appraisal system "Enabling Excellence" was underpinned by Spire's behaviours and helped ensure that patient experience and customer service were top priorities for all staff.
- Criteria used during the recruitment process included expected behaviours as well as competence to help ensure staff were recruited who supported the organisations cultural values.
- All of the staff we spoke with were proud to work at Spire Hesslewood Clinic.

Public and staff engagement

- During the inspection, we saw good examples of public and staff engagement,for example "You said, we did" boards were visible to patients to demonstrate what actions the clinic and its staff had taken in response to their feedback. Changes made as a result of patient feedback included; improvements to the map to locate the clinic, relocation of disabled parking bays and improvements to signage.

- Other public engagement activities the organisation had been involved in included; a fundraising golf tournament; and support for national men's health awareness week, when a consultant provided online question and answer information.
- Staff felt confident that they would be involved in planning activities for service developments and managers welcomed the diversity of ideas from staff across the different disciplines.
- Staff told us that work life balance was respected and the investment in their training made them feel valued.
- The local management team used regular team briefs, which included special thanks from patients to staff and recognition of individuals' good work from other staff. Staff told us that team briefings were informative and worthwhile.
- Spire HealthCare undertook an annual staff and consultant survey and also surveyed patients from all services annually. Results were given back to the Spire hospitals and clinics to act upon the findings for their site.

Innovation, improvement and sustainability

- Staff were encouraged to suggest ways to make departments run more effectively and efficiently and we saw examples of where staff had made small changes, which made a big difference to patients as illustrated in the above section of the report.
- We saw that the management team actively engaged in talent management, proactive recruitment and promoted retention of staff. Some staff incentives included an annual wellness check-up, subsidised meals and drinks, free parking and birthday vouchers.
- It was evident in the acquisition of a number of outpatient services from the local trust and commissioning agreements that the management team actively sought opportunities to improve and sustain the services provided at Hull and East Riding Spire hospital and Hesslewood clinic.
- Business and project plans were in place regarding service developments and demonstrated good use of opportunities and facilities available.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to improve

- The provider must take action to ensure that the appropriate checks and records as per HR policies are in place and recorded primarily for the doctors working at the clinic including Disclosure and Barring Service (DBS) checks, mandatory training and appraisals.

Action the hospital SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should take action to monitor cancellation of clinics.
- The provider should ensure all disciplines fully complete and sign the patient record, especially with regard to children and young people's records.
- The provider should consider including information regarding access to patient transport services with appointments letters.
- The provider should ensure that pregnancy test records, results and standard operating procedures are in place, maintained and audited.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The providers' systems were not operated effectively to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider must take action to ensure that the appropriate checks and records, as per HR policies, are in place and recorded primarily for the doctors working at the clinic including Disclosure and Barring Service (DBS) checks, mandatory training and appraisals. Reg 17 (2)(b)