Spire Wellesley Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Spire Wellesley Hospital is part of Spire Healthcare Limited. Spire Wellesley Hospital offers comprehensive private hospital care to patients from Southend-on-Sea and the rest of Essex.

This includes patients with private medical insurance, those who self-pay and patients referred through NHS contracts. Hospital facilities include an outpatient service, diagnostic imaging service, a 30 bed inpatient ward, eight day case beds and three extended recovery unit beds. Theatre provision includes four theatres, two with laminar flow and a sterile services department. From January 2015 to December 2015 there were 7525 visits to theatre. Spire Wellesley Hospital also provides elective routine surgery for children aged three years to 18 years with consultation appointments within the outpatient and diagnostic imaging departments.

The hospital had a comprehensive inspection in November 2014 following an increased number of never event incidences in the previous year. The hospital was not rated following this inspection as it was conducted as part of our piloting of the independent sector methodology.

We inspected this hospital as part of our independent hospital inspection programme. This was the second comprehensive inspection of Spire Wellesley Hospital. The inspection followed the Care Quality Commission's comprehensive inspection methodology. It was a routine planned inspection.

We carried out an announced inspection of Spire Wellesley Hospital on 16 and 17 May 2016. Following this inspection we also undertook an unannounced inspection on 31 May 2016, to follow up on some additional information.

The inspection team inspected the following core services:

• Medical care

• Surgery

• Services for children & young people

• Outpatients and diagnostic imaging

We rated Spire Wellesley hospital as requires improvement overall, with all services rated as requires improvement except medical care which was rated good overall.

Children's and young people's services were rated as inadequate for safety following significant concerns. Subsequent to the inspection we served the provider a warning notice on 30 June 2016 under Regulation 13 (Safeguarding service users from abuse and improvement) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and told the provider they must make improvements. We will follow this up and report on our findings.

Our key findings were as follows:

Are services safe at this hospital:

- Incidents were not reported as required within the children's service or diagnostic imaging service.
- The resuscitation equipment for children was not standardised across the hospital.
- There were no risk assessments in place to ensure the environment and access onto the ward was secure and provided safety for children. We raised this issue with senior hospital managers who responded and took immediate action.
- Whilst there was reference to child abduction in two of the provider's policies there was not a specific child abduction policy in place, and staff were not aware of the hospital's policies and procedures in relation to child abduction, nor where they could access these.
- Compliance with level three safeguarding training was poor across all staff levels and job roles.

Summary of findings

- Where incidents were investigated, root cause analysis (RCA) reports had limited recommendations or action plans.
- There was a lack of hand hygiene practice observed in children & young people's services.
- The hospital did not achieve its target for grade two pressure ulcers, inpatient falls or incidents of venous thromboembolism events (VTE) in 2015.
- Documentation was not robust. Consultant records were not always legible and were often brief and undetailed.
- A small number of Consultants kept outpatient medical notes for patients, including the initial referral letters, off site. However, the hospital has a process in place in order to access these documents on request.
- Security of patient information was not robust, notes were unattended and computer screens left unlocked. We raised this issue with senior hospital managers who responded and took immediate action.

Are services effective at this hospital:

- Oncology services worked to recognised national guidelines. Local audits had been undertaken and improvement made as a result.
- Pain management was appropriate to ensure adequate pain relief for patients. Oncology services worked with palliative care specialists to ensure end stage pain relief requirements were met.
- Nutrition and hydration was appropriately assessed.
- Patient Reported Outcome Measures (PROMs) data from April 2014 to March 2015 was above the England average following hip replacement and knee replacement.
- There were good processes in place to obtain consent from patients in children & young people's services and medical care.
- Systems were in place to ensure safety checks and maintenance of equipment.
- One-hundred per cent of staff had received an appraisal in 2014 and 2015.
- Local service policies did not reference evidence based practice, relevant legislation and national guidance.
- Staff knowledge about the Mental Capacity Act and Deprivation of Liberty Safeguards was not consistent.
- We raised concerns during the inspection that written consent had not been undertaken in the outpatient department for a procedure involving injection into the joints. Senior staff took action following our concerns to improve practice.
- Multidisciplinary team meetings did not occur for children & young people's services.
- There were no specific audits undertaken for children & young people's service.

Are services caring at this hospital:

- Patients provided consistently positive feedback about the care that they had received.
- There were positive interactions between staff and patients in all areas.
- Friends and Family Test data (FFT) showed that 100% of patients who responded in March 2016 were likely to recommend the hospital. The hospital had consistently scored above 98% since March 2015.
- Within medical care services, each patient had a named nurse with overall responsibility for their individual care.
- Children had a dedicated registered nurse (children's branch) who oversaw their care throughout their admission.
- "ISpire" children's booklets explained information in a child friendly manner to help ensure children understood aspects of their care.

Are services responsive at this hospital:

- Patients had access to care when they required it.
- There was a resident medical officer (RMO) on site 24 hours a day, seven days a week, to provide medical care and advice.
- Provision of support services such as physiotherapy, radiography, pharmacy and theatres out of hours was via an on call system.
- In 2015 the clinical scorecard showed that 75% of patients felt prepared for discharge, which was above the Spire target of 71%.

Summary of findings

- Oncology patients were provided with unique individual patient folders and could choose an appointment time that suited them.
- Staff were aware of equality and diversity and information was available for patients from varying cultures and religious beliefs.
- Provision was available to allow relatives and parents to stay overnight when required.
- There was evidence across services that feedback received from patients had been acted on and examples of this were displayed in waiting areas through "You said we did" posters.
- The children & young people's service did not robustly capture and monitor the number of cancelled operations.
- There were no dedicated children's play areas or waiting rooms throughout the hospital and a lack of toys and entertainment for children and young people.
- The hospital had received an increase in complaints between 2014 and 2015 which was comparative to an increase in patient volumes. There was no formal system for monitoring patient satisfaction with the complaints process.

Are services well-led at this hospital:

- There was a lack of effective governance and oversight at senior management level.
- We found significant concerns with regards to children and young people's services, particularly in relation to the governance arrangements in place to ensure children and young people accessing services were safeguarded from abuse and improper treatment. Furthermore, there was a lack of medical leadership for children and young people's services, no multidisciplinary team meetings took place for the service and children and young people were not well represented at the medical advisory committee (MAC) meetings. This meant there was no platform at senior level for challenge or scrutiny into the running of children's services at this hospital.
- Policies and procedures were not reviewed regularly and there was a lack of oversight in relation to the management and development of policies and procedures. We raised this issue with senior hospital managers who responded and took immediate action.
- Risk management systems were ineffective. There were no risks on this register, or any separate register, which related to children and young people's services although during our inspection we identified many risks which required addressing.
- Root cause analysis (RCAs) and subsequent actions plans were not always completed in detail. Root causes were not always identified which meant potential additional actions were missed.
- There was a reluctance to accept the seriousness of the concerns we raised following our inspection, specifically with regard to security of records and aspects of consent. However subsequent actions were taken by the senior team to address issues.
- The medical advisory committee (MAC) regularly reviewed consultant's applicability, from a safety perspective, to continue treating patients under their practising privileges. We also saw evidence of clinical governance issues, including incidents that had been reported, being reviewed regularly at the MAC.
- Staff were aware of the vision, values and strategy for the service.
- Staff told us that they felt well supported by management, and members of the higher management were described as friendly and approachable. However, in the 2015 staff survey an average of only 64% of staff answered positively to questions about senior leadership and 58% of staff answered positively to questions about working together, although this was in line with the Spire average.
- Staff described an open culture at this service and felt able to raise concerns.
- The oncology service achieved MacMillan Cancer Support accreditation for being a good environment to be treated for cancer.

We also saw several areas of good practice which included:

- The care provided by staff to patients and their relatives was seen to be compassionate, kind and dignified.
- Feedback about the service from patients and relatives was consistently positive. The 2015 Friends and Family Test data demonstrated that between 99% and 100% of patients would recommend the hospital.

Summary of findings

- The service benefited from a committed and loyal workforce that understood the vision and strategy for the hospital.
- There was strong local leadership within the oncology service.
- Nursing documentation was clear and up to date with all necessary care plans and risk assessments having been completed.
- Patients felt their pain was managed effectively.
- There were clear and understood procedures in place to support people living with a learning disability when they accessed the service.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- The provider must ensure that a safeguarding children policy and an abduction policy are developed and implemented. These must reflect the requirements of the local children's safeguarding board and other relevant local and national guidance.
- The provider must ensure that processes are in place to ensure appropriate safeguarding risk assessments are undertaken for children and young people accessing services.
- The provider must ensure that all staff working with or responsible for children and young people are trained to the appropriate level for safeguarding children and young people.
- The provider must ensure that there is an effective governance system which yields sufficient management oversight of all the services provided at the hospital.
- The provider must ensure there are effective systems which allow it to assess, monitor and improve the quality and safety of all services
- The provider must ensure there is an effective risk management system to protect the health, safety, and welfare of service users and others who may be at risk.
- The provider must ensure that records are stored securely at all times and that consultant entries are legible and contain all relevant information

In addition, the provider should:

- The provider should consider the environment where children and young people are cared for so it meets their needs with a separate waiting area and age appropriate materials.
- The provider should consider reviewing the arrangements in place to ensure the appropriate storage of medicines and blood products.
- The provider should consider reviewing the prescription arrangements in oncology where there were two systems running.
- The provider should consider reviewing infection control arrangements in relation to effective hand hygiene practices.
- The provider should consider improving staff awareness of the needs of patients living with dementia and for patients whom may need a translation service because their first language is not English.
- The provider should consider improving the level and quality of competency checks provided to staff to ensure they remain competent in their roles.
- The provider should consider additional training for all staff to ensure understanding and practical application of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Good	We rated the medical care service as good across all five domains: safe, effective, caring, responsive, and well-led. Nursing staff knew how to report and escalate concerns and incidents. Identified lessons were shared back to staff. Nursing and medical staff were aware of their responsibilities under duty of candour. Infection control practices were in place and the environment was visibly clean. Staff adhered to 'bare below the elbow' policy and good practices of hand washing and sanitation. All equipment and medicines were stored correctly in line with the Nursing & Midwifery Council (NMC) standards for medicines management guidelines. Staffing was adequate and specialist knowledge provided by four oncology specialist nurses. They had sufficient training and were proactive in their professional development. Oncology services were effective and provided a 24-hour advice line. Staff used the UK Oncology Nursing Society (UKONS) triage tool, allowing them to work to safe and clear guidelines. Staff were innovative and used internal audits to improve patient records and communication with other departments. Pain relief was well managed and patients' nutrition and hydration needs were met. Nursing staff provided compassionate and caring support. Additional support was available via a Macmillan counsellor and palliative care consultant when required. Patients were involved in their care and could attend coffee mornings or drop in sessions to provide feedback on the service, ask advice or discuss concerns. The service was responsive to patients' needs. Patients had no concerns regarding waiting times and could pick an appointment that suited them. Staff were aware of the vision and values of the service. Staff felt that the senior management were approachable and supportive. The department engaged with patients and actively sought feedback. However:

Summary of findings

Some medical records used were inconsistent, leading to confusion and potential risk of medication mistakes.
Staff had completed training in Mental Capacity Act and Deprivation of Liberty Safeguards, However, there was limited need to reflect this in practice and staff were unable to explain the practical application of Deprivation of Liberty Safeguards. This was escalated as a concern and staff were provided additional training.

Surgery

Good

We rated surgical services as good overall. Safe, effective, caring and responsive were rated as good with well led rated as requires improvement.
Nursing documentation was complete and nursing assessments and monitoring of patients was appropriate. National Early Warning Scores (NEWS) were used to identify and respond to a deteriorating patient. The hospital was within Spire target for surgical site infections (SSI) for knee operations and had no SSI's for hip operations during 2015.
There was an effective process in place for the servicing of equipment and all equipment checked was within its required service date.
Pain assessments were regularly undertaken and patients' pain control was monitored and responded to efficiently. The latest Patient Reported Outcome Measures (PROMs) data was positive.
Staff provided compassionate, kind and dignified care. Patients felt involved in the decision-making processes around their care needs. The latest Friends and Family Test (FFT) results for NHS patients showed that throughout 2015, the hospital scored 99% to 100%. The hospital's patient wide survey also showed that consistently over 99% of patients would recommend the hospital to friends and family.
Patients had timely access to assessments, diagnosis and urgent treatment and staff knowledge around additional support required by patients with a learning difficulty was good. The hospital had facilities to allow relatives to stay with patients to provide additional support if needed. The hospital met its target of 71% in 2015 for the way patients were prepared for discharge, scoring 75%.
The hospital had a vision and strategy in place and staff were positive about the local leadership.
However:

Summary of findings

Storage and security of patients' records, both electronic and paper based, was lacking. We raised this issue with senior hospital managers who responded and took immediate action.
Some orthopaedic surgeons did not follow infection control guidance within theatre.
Staff knowledge of safeguarding procedures, Mental Capacity Act 2005 (MCA), mental capacity assessments, and Deprivation of Liberty Safeguards was limited. We received inconsistent responses from nursing staff regarding the care needs of patients living with dementia
The annual average compliance score with pre-operative fasting guidelines had increased to 60% in the first 3 months of 2016. However this meant that some patients were at risk of having fasted for a prolonged period.
Not all senior staff were familiar with the contents of the risk register and the storage of several versions led to some confusion.
Root cause analysis (RCAs) and subsequent actions plans were not always completed in detail. Root causes were not always identified which meant potential additional actions were missed.

Services for children and young people

Inadequate

Children's and young people's services at Spire Wellesley Hospital were rated as inadequate overall. The safety and well-led domain were rated as inadequate, the effectiveness domain as requires improvement, and responsive and caring received a rating of good.
There was poor compliance with safeguarding training across the service and the safeguarding policy in place was not fit for purpose. Subsequent to this we served the provider a warning notice on 30 June 2016 under Regulation 13 (Safeguarding service users from abuse and improvement) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and told the provider they must make improvements. We will follow this up and report on our findings.
In addition, hand hygiene was poor and the service did not carry out any observational hand hygiene audits. Incidents were not reported where required and environments where children and young people were cared for were not appropriately risk assessed. Some

Summary of findings

areas of the hospital were not secure and the hospital did not have an abduction policy in place. Resuscitation equipment was not standardised across the service.

Paediatric competencies were in place for nursing staff caring for children in the ward and in theatres, however, not for nursing staff within the outpatient department. Training compliance across the service was poor and not monitored effectively. Auditing did not take place to enable monitoring compliance against best practice and patient outcomes. There were no dedicated waiting or play areas for children and young people and there was a lack of toys and entertainment available. Governance, risk management and quality measurement was not robust. Our concerns were heightened given the safety issues found and throughout the service it was evident that the provider's policy was not always followed. Furthermore, there was a lack of medical leadership for children and young people's services, no multidisciplinary team meetings took place and children and young people were not well represented at the hospital's medical advisory committee (MAC) meetings.

However:

Areas of good practice included a visibly clean and organised environment and the appropriate use of personal protective equipment. Staffing numbers were sufficient and children who were admitted were always cared for by a registered nurse, children's branch (RCN). Whilst the service did not monitor access and flow routinely due to the small number of children and young people accessing the service, we found that the patient pathway was seamless. Pain relief was effective and given in a timely way and there were suitable patient feedback systems in place. The service had not received any complaints.

Feedback received from children and their parents was positive. Parents said that staff were kind and went above and beyond to support them and their child. Parents said they felt involved in their child's care and treatment and understood the plan of care in place. The "Ispire" children's booklet, which included child friendly information about the hospital and its service, was effective to support children to be involved in, and understand, their care. There was a clear service vision and strategy in place and feedback from staff about

Summary of findings

the culture within the service was very positive. Staff worked effectively as a team, were dedicated and very passionate about children and young people's services.

Outpatients and diagnostic imaging

Good

Outpatient and diagnostic imaging services at Spire Wellesley Hospital were rated as good overall. We inspected, but did not rate, effective.

Areas of good practice included effective processes to ensure equipment was checked, serviced and ready for use and radiology and pathology reports and results were available to appropriate staff via secure electronic systems.

Data provided showed that 100% of outpatient and diagnostic staff and completed their annual appraisal for 2015

Patients were seen and treated within national guidance timeframes and were very happy with the level of care they received.

We saw that staff interactions with patients were polite, friendly, and helpful and the hospital was mindful of the needs of patients from various religions and backgrounds and translation services were available.

"You said, we did" notices were displayed in patient waiting areas, showing changes made as a result of complaints received.

However:

The procedures for monitoring medication fridge temperatures were not adhered to.

Patient records were not always fully complete or legible. The hospital did not hold a copy or summary of consultants' records held off site however this was accessible on request.

Incident reporting was minimal within the diagnostic imaging department.

Incident information was provided to heads of department regularly but this data was across the hospital and not specific to individual departments.

There was a lack of oversight in relation to the management and development of hospital policies.

Summary of findings

Contents

Requires improvement

Spire Wellesley Hospital

Services we looked at

Medical care (specifically oncology services); Surgery; Services for children and young people and Outpatients & diagnostic imaging.

Summary of this inspection

Background to Spire Wellesley Hospital

Spire Wellesley Hospital (SWH) originally opened in March 1983 as part of the HCA group and subsequently became part of the BUPA group in the 1990's. In 2007 BUPA sold its hospital group to Cinven, leading to the formation of Spire Healthcare. SWH offers comprehensive diagnostics and treatment to patients in Southend-on-Sea and the surrounding area. The hospital is a purpose built two-storey building which has benefitted from major refurbishment and investment in recent years, including the addition of CT and MRI scanners.

A major project in 2012 saw the completion of a new sterile services department which achieved accreditation in early 2013. In 2013 there was further investment in imaging with potential for interventional radiology, an increasing range of cardiac CT diagnostics as well as improvements to patient bedrooms and a patient lounge.

Spire Wellesley is a 46-bedded independent hospital based in purpose-built premises. Services offered include acute healthcare, day care, inpatient, and outpatient care.

There is a well-utilised outpatient department and the hospital provides inpatient treatment for adults and children over the age of three years.

The Registered Manager is Matthew Calver, Hospital Director, who has been in post for one year and eight months.

Our inspection team

Our inspection team was led by:

Inspection Manager: Tracey Wickington, Care Quality Commission

The team on site included four CQC inspectors, one assistant inspector and four specialist advisors: one consultant anaesthetist, a governance nurse, an oncology doctor and a theatre nurse.

How we carried out this inspection

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

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

The inspection was announced and took place on 16 and 17 of May 2016. We also undertook an unannounced inspection on 31 May 2016.

Before visiting, we reviewed a range of information including information held by us and information provided by the hospital. In addition to private healthcare services the hospital treats NHS funded patients and we contacted the main clinical commissioning groups (CCG) for their views on the hospital.

We talked with patients and staff from the ward and operating theatre areas and outpatient services. We observed how people were cared for, talked with carers and/or family members and reviewed patients' records. We also undertook a focus group at the hospital, on 16 May 2016, for a variety of staff to attend.

In addition, patient views were collected by means of comment cards in the immediate weeks running up to and immediately following the inspection.

Summary of this inspection

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Spire Wellesley Hospital.

Information about Spire Wellesley Hospital

Key Figures

- Summary of beds:

  Overnight beds: 30

  Day case beds: 8

- Staff:

  Medical doctors working under rules or privileges: 143

  Doctors and dentist employed: 1

  Nursing: 45.1 wte

  Operating department practitioners: 7.8 wte

  Care assistants: 18.7 wte

  Other: 90.1 wte

- Inpatient Activity Summary (January to December 2015):

  NHS funded: 2593

  Other funded: 3743

- Outpatient Activity Summary (January to December 2015):

  NHS funded: 19231

  Other funded: 34472

There were 7525 visits to the theatre between January and December 2015. The five most common procedures performed were:

• Injection of therapeutic substance into joint (854)

• Insertion of prosthetic replacement for lens NEC (602)

• Primary prosthetic replacement of knee (174)

• Phacoemulsification of lens with implant (172)

• Endoscopic examination of bladder (158).

There were a range of outpatient services available and these included but were not limited to; cosmetic surgery, gastroenterology, gynaecology, orthopaedics, paediatrics, pain management, rheumatology and urology.

Diagnostic imaging facilities on site include a CT scanner, mobile x-ray, ultrasound, an MRI scanner, and a plain film and fluoroscopy room.

Spire Wellesley outsources pathology services to a nearby NHS provider and the Spire Pathology Network.

Oncology services are Macmillan accredited and the sterile services department is SGS accredited.

The accountable officer for controlled drugs is Lorraine Barrs, Matron and Head of Clinical Services.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

Good

Medical care

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

Information about the service

Spire Wellesley Hospital's oncology service was established in 2014 and provided chemotherapy as well as palliative care. They provide treatment for patients with cancer including breast, gynaecological, renal, urological, head and neck, upper gastro-intestinal, colorectal, lung and haematological conditions. The hospital provided an overarching oncology consultation service to 147 patients in 2015. The service had treated 53 patients with cancer in the six months prior to the inspection.

The Macmillan Quality Environment Mark (MQEM) is a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. Spire Wellesley was awarded the MQEM accreditation in September 2015.

The chemotherapy service is provided from the Ivy oncology suite between Monday and Friday with a 24-hour telephone support line available to patients outside these hours. There were five rooms dedicated to chemotherapy treatment.

During this inspection we spoke to three clinical oncology nursing staff, one support staff, three patients and one of their relatives. We reviewed six patients' records, observed the environment and reviewed information provided by the hospital.

Summary of findings

Overall, we rated the oncology service at Spire Wellesley Hospital as good because:

- Nursing staff understood their responsibilities to report incidents. Once reported these were escalated and investigated and any lessons learnt were fed back to staff. There were no never events or serious injuries in the reporting period January 2015 to December 2015.
- Nursing and medical staff were aware of their responsibilities under duty of candour and could provide incidents where there had been honest communication with patients and apologies made.
- Infection control practices were in place to lower the risk of infection. Infection rates were low and staff undertook good practices of hand washing and sanitation.
- Medication storage was in line with the Nursing & Midwifery Council (NMC) standards for medicines management guidelines.
- Nurse staffing was adequate, provided by four oncology specialist nurses, all of which were up to date with mandatory training. These staff were proactive in their professional development to maintain competency
- Oncology services provided a 24-hour advice line. The UK Oncology Nursing Society (UKONS) triage tool was in use to ensure care was provided following safe and clear guidelines.
- Patients' pain relief was well managed and their nutrition and hydration needs were met.

Good

Medical care

- Nursing staff provided compassionate and caring support. Additional support was available via a Macmillan counsellor and palliative care consultant when required.
- Patients were involved in their care and could attend coffee mornings or drop in sessions to provide feedback on the service, ask advice, or discuss concerns.
- The service was responsive to patients' needs. Patients had no concerns regarding waiting times and could pick an appointment that suited them.
- Local leadership of the oncology services was good. Staff were aware of the vision and values of the service and felt that the senior management were approachable and supportive.
- The service encouraged patients to give feedback and used this to make changes such as improved seating, equipment and waiting areas.
- The nursing staff were innovative and used internal audits to improve patient records and communication with other departments.

However:

- Some types of medical records used were inconsistent, leading to confusion and potential risk of medication mistakes.
- Staff had completed training in Mental Capacity Act and Deprivation of Liberty Safeguards. However, there was limited need to reflect this in practice; staff were unable to explain the practical application of Deprivation of Liberty Safeguards. This was escalated as a concern, and staff were provided additional training.

Are medical care services safe?

Good

We rated safe as good because:

- Staff understood how to report and escalate incidents, and the importance of duty of candour.
- There had been no never events in the reporting period of January 2015 to December 2015.
- Incidents were reported, investigated and improvements were discussed at monthly meetings.
- Nursing staff were up-to-date with mandatory training.
- Infection control practices were in place to lower the risk of infection.
- Ten items of consumables were checked, all were stored correctly, in sterile packaging and within expiry dates.
- Medications, including chemotherapy drugs, were stored appropriately and at the correct temperatures.
- Patient records were well organised and legible. Appropriate patient specific risk assessments were recorded to ensure patient safety.
- Oncology nurses were aware of safeguarding escalation procedures and were up to date with safeguarding training.

However:

- There was inconsistency in the types of medicine records used, leading to confusion and potential risk of medication mistakes.

Incidents

- Nursing staff were able to explain how incidents were escalated and reported using the electronic reporting system.
- The ward manager provided an example of an incident that had been reported, investigated, lesson learned and shared with the staff involved.
- There were no never events relating to the oncology service in the reporting period January 2015 to December 2015. Never events are serious incidents that have the potential to cause serious patient harm or death.
- Staff understood the principles of duty of candour. Under duty of candour a hospital should inform and apologise to patients when mistakes in their care have

led to significant harm. Staff explained the importance of investigating incidents, having honest communication with patients and apologising when mistakes have occurred.
- Staff described one incident where duty of candour was undertaken. A patient developed a venous thromboembolism (VTE). The consultant met with the patient and discussed the incident with them.
- Incidents were discussed at monthly meetings which enabled discussion of incidents and sharing of learning. We reviewed a set of meeting minutes that corroborated this.

Safety thermometer

- Although not oncology specific, hospital outcomes were audited against a fixed set of criteria using the Spire clinical scorecard to support the safe running of the service. This contained a number of measures including VTE, critical care transfers, readmission and pressure ulcers. The clinical scorecard benchmarked these measures across the network of 38 Spire hospitals.
- The scorecard for July to December 2015 showed 92% of cancer patients had evidence of multidisciplinary team meetings; this exceeded both their target of 65%, and the Spire average of 75%.

Cleanliness, infection control and hygiene

- There were no reported incidences of MRSA or Clostridium difficile (C.difficile) in 2015 for oncology services.
- All four oncology nurses were up to date with mandatory training which included infection prevention.
- Staff adhered to the 'bare below the elbow' policy. Hand hygiene foam dispensers were available at the entrance to and throughout the ward. Staff were observed using these at appropriate times. A hand hygiene sanitiser audit was conducted quarterly. At the time of inspection there were no oncology patients receiving treatment. However, staff stated they would wear gloves and change them between patients. This followed infection control guidance from the National Institute for Health and Care Excellence, and reduced the risk of cross infection.
- Personal protective equipment such as gloves and aprons were readily available.
- The ward area was visibly clean and tidy. Domestic staff confirmed the ward was cleaned daily.
- Sharps bins were available in each room for the safe disposal of sharps. Each of the four bins checked were labelled, dated and not overfilled. This reduced the risk of infection from sharps injuries.

Environment and equipment

- Five beds within the hospital were available for the oncology service and the administration of chemotherapy. Each patient room had seating and an en-suite shower room.
- The hospital had been awarded the Macmillan Quality Environment Mark in September 2015. The design and use of space, the patient's journey through treatment, staff interactions and patients' involvement in care decisions are measured to gain the award.
- Fire alarms were tested quarterly and extinguishers were checked monthly by engineers and yearly by contractors.
- Contracted engineers maintained equipment. Full portable appliance tests (PAT) were undertaken yearly. All equipment seen was within date for safety checks.
- There was a resuscitation trolley on the ward. This was checked daily and documented in a logbook; entries confirmed this daily check took place. This ensured the equipment was safe and ready to use when required.
- We checked 10 items of consumable stock; each one was sealed in a sterile pack and within its expiry date.

Medicines

- Medicines storage was secure with access to the room controlled by a keypad access code. The medicine cupboard and fridge were locked and keys were carried by the oncology nurse in charge. This ensured the medication was accessible and stored securely.
- Certain medications require storage at specific temperatures to maintain efficacy. There was a process and record in place to check both fridge and ambient room temperatures where medications were stored. These were checked daily and within the recommended range.
- Cytotoxic drugs are used during chemotherapy treatment. These medicines contain chemicals which are toxic to living cells. Cytotoxic drugs and waste were disposed of correctly in purple-lidded sharps bins and purple waste bags. This was in accordance with recognised legislation.

- Ten boxes of medication were checked, they were stored in the correct location and within their expiry date.
- Oncology did not store controlled drugs. They were ordered and collected from the pharmacy department when required.
- Intravenous chemotherapy was ordered electronically. Staff felt this was a safe method as an error message appeared on the screen if the wrong dosage was entered.
- There had been one recorded medicines incident in the week leading up to the inspection. The required dosage of a chemotherapy drug was not stipulated on the prescription. The error was identified before the drug was administered and an electronic incident form was completed. There were plans in place to investigate the incident, identify cause and lessons learnt from this and possible improvements to the procedure.
- There was inconsistency in the type of prescription charts used, with a variety in use. Some were Spire healthcare based, whilst some consultants used their own. Although there had been no specific incidents, staff sometimes found this confusing. There were plans in place to use one type, on an electronic tablet, to reduce the risk of errors. Staff were not aware of dates when this would take place.

Records

- Six sets of chemotherapy notes and six sets of patient care pathways were reviewed. Notes identified the named consultant for the patient and were well organised, legible, signed and dated. An internal audit in 2015 showed 97% of entries into notes were fully signed and dated by consultants. This was higher than both the service's target and the Spire average of 95%.
- All risk assessments were current and up to date. This meant that people were assessed for clinical risks such as venous thromboembolism (VTE), falls and pressure ulcers so that where necessary care intervention could take place.
- Each care pathway booklet contained completed treatment checks and observations. This ensured the patient's safety and comfort was regularly monitored.
- Improvements were made following internal audits. Ticks and crosses are now used in the patient's records and pathways, rather than just leaving negatives blank. This allowed staff to confirm the assessments had taken place.

Safeguarding

- The lead oncology specialist nurse stated that all four of the nursing staff had completed level two safeguarding as part of their mandatory training. Evidence provided by the hospital did not break this down, but showed compliance at ward level of 47.7%.
- Nursing staff were able to explain the process of raising a safeguarding concern, and the types of concerns they would escalate. This helped to protect vulnerable patients.
- The hospital had a designated lead in safeguarding for both adults and children.

Mandatory training

- Mandatory training included fire safety, infection control, safeguarding adults and children, manual handling, compassion in practice, equality and diversity and information governance.
- All four nursing staff were up to date on their mandatory training, and completed annual competencies in oncology. We looked at the nurse's individual training files that corroborated this.
- Data provided by the hospital showed that 85.7% had training in advanced life support. We confirmed that one member of staff had received this additional training in advanced life support. Three had training in intermediate life support.
- Staff felt the hospital focused on the importance of training. Nursing staff were booked on to additional training, such as courses on neutropenic sepsis and care of central lines.

Assessing and responding to patient risk

- The UK Oncology Nursing Service (UKONS) 24 hour triage rapid assessment and access toolkit was in use. This toolkit was designed to ensure that patients received robust and reliable assessment. Staff felt competent in utilising the toolkit and it was also carried on an advice card by the on call nurse.
- A National Early Warning Score (NEWS) was noted on patients observation charts. This was taken into account when assessing deteriorating health of patients. All NEWS scores reviewed were recorded appropriately. Staff were able to explain escalation procedures should it be required.

Nursing staffing

Good

Medical care

- There were four whole time equivalent (WTE) nursing staff to cover the oncology service. This consisted of a lead specialist nurse, deputy specialist nurse, a breast cancer care nurse and a chemotherapy nurse.
- Staffing levels were sufficient to cover the needs of the service and there was no need for agency staff between January 2015 and December 2015.
- Staff rotas were completed by the lead nurse a week in advance. Staff were flexible and covered shifts at short notice when required.
- Handover meetings took place at the start of each shift change. Each patient was reviewed with updates and concerns discussed at each handover to ensure continuity of care.

Medical staffing

- Consultants were on call for the duration of the patient's stay. There was always a resident medical officer (RMO) present in the hospital for immediate medical advice should it be required.
- Nursing staff were aware of how to contact the palliative consultant if required. The hospital recognised that they required a second palliative care consultant.

Are medical care services effective?

Good

We rated effective as good because:

- Staff were up to date with the latest advances in oncology and national guidelines.
- There were procedures for pain relief. Patients felt their pain was well managed.
- All staff appraisals were completed annually; staff felt they had easy access to training.
- There was good communication with both internal departments and external services.
- Staff had completed training in the Mental Capacity Act and could explain its principles.

However:

- Staff were unable to fully explain the principles of Deprivation of Liberty Safeguards.
- There was limited evidence to demonstrate patient outcomes were being monitored following chemotherapy treatment.

Evidence-based care and treatment

- Nursing staff were aware of the policies, protocols and procedures for prescribing, administering and disposal of chemotherapy.
- Staff subscribed to national nursing journals. This allowed staff access to the latest advances and updates in oncology and National Institute for Health and Care Excellence (NICE) guidelines.
- Staff obtained up to date drug information on the electronic Medicines Compendium website.
- Staff used a triage tool from the UK Oncology Nursing Society (UKONS) and received email oncology updates from UKONS.
- Staff felt up to date equipment enhanced the treatment for their patients. For example, the service had access to equipment for scalp cooling, which some evidence suggests reduces hair loss.
- Staff also identified an increase in sepsis post chemotherapy one month. An audit was completed in response to this. There were no trends identified, so no changes were made.

Pain relief

- Pain relief was prescribed by the consultant oncologist or haematologist.
- When required, patients would be referred to the palliative care consultant, who could also prescribe pain relief. Nursing staff spoke highly of the palliative care team. We were told that when prescribing pain relief, the consultant would ensure the patient understood the risks and benefits of medication and were comfortable.
- One patient said they had never felt any pain and staff were attentive to their needs.
- Ninety-two per cent of patients felt the hospital did all they could to control the pain.

Nutrition and hydration

- A menu was available in each patient's room.
- Patients felt their nutrition and hydration needs were met and complimented the food quality and choice.
- In the April 2016 patient survey 91% of patients were satisfied with the quality of the food.
- A nutritionist and a dietician were available for both telephone advice and patient visits.

Patient outcomes

- The Spire oncology lead attended the hospital every six months to discuss the hospital's standards and discuss how they compare to other similar trusts. This allowed the hospital to benchmark against other providers.
- However, there was limited evidence to demonstrate patient outcomes were being monitored following chemotherapy treatment.

Competent staff

- All four oncology nursing staff had received an appraisal in the last 12 months. This was completed by the lead clinical nurse. Appraisals included a meeting half way through the year to discuss areas of achievement and development. The department had an open assessment approach and any areas of poor performance were addressed immediately. This ensured learning needs of staff were identified.
- All four oncology nurses had received specialist training to deliver and administer chemotherapy. They attended a refresher course every six months. Three members had received additional training in breast cancer treatments and one in mentorship.
- Staff felt they had received sufficient training to perform their duties competently, and that the hospital understood the importance of training. Requests for extra training were always agreed.

Multidisciplinary working

- Multidisciplinary team (MDT) meetings took place at the local NHS hospital. The notes from these meetings were made available to oncology nurses, and they felt they could attend if they felt it necessary.
- Oncology staff had set up education sessions for other wards and departments, these included subjects like chemotherapy safety. This allowed staff to work across departments and plan ongoing care and treatment.
- The department had approached other providers to gain insight on how they could improve. As a result multidisciplinary team meeting minutes are now recorded in the patient's notes.
- The 2015 annual governance report had found an increase in the percentage of cancer patients with evidence of a MDT meeting. The report found this was due to improved communication with the secretaries at the trust, nurses prompting consultants to provide reports, the appointment of a breast care nurse to attend the MDT meeting, and the appointment of administrative staff to ensure it was filed in the notes.
- We noted form the clinical scorecard that in quarter one (January to March) of 2016, 100% of patients had documented evidence of MDT meetings in their records.

Seven-day Services

- Chemotherapy treatments were generally administered between the hours of 9am and 5pm Tuesday to Friday. The on call oncology nurse would attend the ward outside of these hours if required.

Access to information

- Staff had access to patients' records maintained by Spire Healthcare ltd. These were securely stored in a cabinet in the nurses' office.
- There were three copies of care summaries. One went in patients' notes, and two went with patients when discharged. Patients then passed one of these to their GP. Doctors who prescribed medications would also send a report to the patients' GP. This ensured communication and continuity of care.
- An oncology referral form had been produced in order to improve communication and handover to other providers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was gained prior to undertaking interventions. This was signed and recorded in the patient's records.
- Staff had received training on the Mental Capacity Act (MCA). However, at the time of our inspection staff could only recall one patient that required a MCA assessment to be carried out. This meant we could not test the practical application of these requirements. The staff stated that the patient lacked capacity to consent due to Alzheimer's disease and a best interests decision had been made.
- Staff had limited exposure in practice to caring for patients that required a Deprivation of Liberty Safeguard to be applied and were unable to fully explain what this was. At the time of the unannounced inspection on 31 May 2016, staff had received training and felt they now had a better understanding. Staff stated that if they felt a Deprivation of Liberty Safeguard application was required they would seek advice from the matron or hospital director.

Are medical care services caring?

Good

Medical care

Good

We rated caring as good because:

- Patients stated that staff were caring, considerate and always helpful. Staff were polite, respectful and had calming interactions with patients and relatives.
- Staff were proactive in giving support to patients, with coffee mornings, advice lines and social media groups.
- Patients had easy and timely access to advice and support.

Compassionate care

- The hospital collected patient views on a monthly basis, although not specific to oncology. Ninety-nine per cent of patients asked in December 2015 were likely to recommend the hospital.
- All chemotherapy patients complimented the care they received. One patient could not think of anything negative to say.
- Staff interacted well with patients; they explained what was happening at each stage of their treatment in a polite and calm manner.
- Each patient had a named nurse with overall responsibility for their individual care. However, staff introduced patients to all members of the team, as someone else may attend to them. One patient's feedback stated he was treated like a friend.

Understanding and involvement of patients and those close to them

- Every three months the oncology team would organise coffee mornings. This was an opportunity for current and past patients to chat and share experiences. Staff also took this as an opportunity to get patient feedback.
- The oncology nurses felt that the hospital considered individual patients' circumstances. They provided an example where funding options had been explored for a patient that had recently relocated to this country to enable care to be provided.
- Staff actively collected feedback from patients. Compliments were shared with any staff individually identified and added to their personal files.
- One patient had their family with them at the time of inspection, they were also pleased with the care their relative had received and felt they were involved and had all their questions answered.
- The April 2016 Friends and Family Test showed that 99% of patients would recommend their friends and family to use Spire Wellesley for a similar treatment.

Emotional support

- The palliative care consultant could provide additional emotional support to patients when required. Nursing staff accompanied the consultant which meant they were present to provide additional support, were aware of decisions to ensure continuity of care and helped to form good relationships with patients.
- An oncology trained MacMillan counsellor was available to give support when required. Staff were aware how to contact them, enabling patients to have easy access to further information about their care and treatment.
- Patients felt supported throughout their treatment. Nursing staff stated they were in the process of sourcing additional training on emotional support.

Are medical care services responsive?

Good

We rated responsive as good because:

- Patients were provided information folders unique to their needs.
- Patients could choose an appointment time that suited them.
- Staff had awareness of equality and diversity. Information was available for the needs of different religions and cultures.
- There had been no complaints specific to oncology in the reporting period of January 2015 to December 2015.

However:

- Staff told us they utilised relatives to interpret for patients whose first language was not English. This was not good practice because it did not promote patient confidentiality.

Service planning and delivery to meet the needs of local people

Good

Medical care

- An additional member of nursing and administrative staff had recently been recruited to meet the growing needs and future development of the department.
- The lead specialist nurse has attended a meeting with the local NHS hospital to deliver smooth transfer of patients.

Access and flow

- The chemotherapy unit was open for appointments between the hours of 9am and 5pm Tuesdays to Fridays. Mondays were reserved for preparation, blood tests and medication ordering, although patients were able to drop in for support.
- A 24-hour telephone advice line was provided to patients. A member of the oncology nursing team carried a mobile phone. Three calls were received during the inspection. In one call the patient was advised to visit the hospital for an examination and when they arrived they were seen promptly.
- Between January 2015 and December 2015, 147 patients received oncology care.
- Patients could choose their appointment at a time that suited them. One example seen was a patient that had requested their appointment on the same day as their blood test.
- Oncology nurses developed a handover sheet to ensure smooth transfer of patients to other departments.
- Patients had no concerns with waiting times and stated they were always seen within 10 minutes of arrival.

Meeting people's individual needs

- The waiting area for oncology had magazines, patient information leaflets, hot and cold drink making facilities and seating.
- On admission, each patient was given a purple folder with information specific to his or her care. This contained contact details, leaflets of information for medication, leaflets of expectations and a diary.
- There was an end of life folder on the suite that staff could access, containing information and last office procedures. This provided a range of procedures to meet different religious and cultural needs.
- Staff had set up a social media page to provide information, links to external resources, available courses and relaxation evenings. This enabled patients to have contacts and links with the community.
- All nursing staff had received training in equality and diversity; this meant that staff were equipped to deliver the service in a way that took account of the needs of different people.
- If a patient did not have English as a first language staff had access to a telephone translation service. However, staff told us they often utilised relatives to interpret. This was not good practice because it did not promote patient confidentiality.
- Each patient room and clinic area had a call bell; this was linked directly to a pager, carried by the nurses on the ward. This enabled patients to contact staff if required. Patients confirmed staff responded in a timely manner.

Learning from complaints and concerns

- There was information available for patients using the service which informed them of how to raise any concerns, complaints or compliments about their care.
- There were no oncology related complaints between January and December 2015. All patients felt they had no reason to complain, but felt confident to do so if it were necessary.
- Staff stated that any oncology complaints would be discussed at the departmental meeting. The department manager would discuss any new processes implemented. Staff could not recall when they last had a complaint regarding oncology.
- Two areas of concern were noted on patient feedback. The hospital had responded by making improvements within the department. One was regarding uncomfortable chairs. The hospital has now introduced all reclining chairs throughout oncology. The second was to introduce magazines in the waiting rooms, rather than just information leaflets.

Are medical care services well-led?

Good

We rated well-led as good because:

- Oncology staff were proud of and involved in the hospital's vision and strategy.
- Staff were aware of the oncology governance structure and understood their specific roles.

- Oncology had monthly meetings, attended senior clinical meetings, and felt hospital management were supportive and approachable.
- The department engaged with patients and actively sought feedback.
- Staff were innovative and made improvements from internal audits and governance recommendations.

Vision and strategy for this this core service

- The hospital had a vision to be recognised as "a world class healthcare business".
- The six values for Spire Wellesley were displayed on posters throughout the hospital.
- Staff were aware of this vision and strategy, stating they felt they were realistic, and they felt proud to work at a hospital with these values.
- The lead oncology nurse was in the process of writing departmental values, leading to a departmental strategy, although they had no planned date of completion.

Governance, risk management and quality measurement for this core service

- The lead specialist nurse and her deputy led oncology. They were reportable to the ward manager.
- The medical advisory committee (MAC) discussed the oncology service when appropriate. We saw evidence of this in the meeting minutes following an expected death. Oncology was represented by a haematologist.
- There were monthly service meetings within oncology for staff to raise concerns and discuss recent reports and actions to be taken. We saw meeting minutes that corroborated this.
- The hospital had heads of department monthly meetings, oncology was represented by the ward manager. The department was not discussed in these meeting minutes between December 2015 and March 2016. Nursing staff felt this was due to the service having few issues, rather than an oversight.
- The lead specialist nurse attended a weekly senior clinical meeting where incidents were reviewed and actions agreed.
- Oncology was flagged on the 2015 risk register by clinical review as non-compliant with Spire cancer standards in some areas, such as staffing levels. This has since been mitigated by recruiting additional staff, to keep pace with the growth of the service.

Leadership and culture of service

- The four oncology nurses felt they were supported by the ward manager and matron, and trusted the decisions they made. They felt they were friendly and approachable.
- There was an open culture amongst staff working within the service.
- Staff were friendly, welcoming and proud of the service they provided.
- Nursing staff encouraged and mentored each other throughout their training.

Public and staff engagement

- The service encouraged patients to give feedback on their experience; there were feedback cards in the department corridors and in reception areas, Staff informed us they would use occasions like coffee mornings to discuss improvements with patients.
- During feedback from these sessions, some patients felt uneasy asking for the chemotherapy department. Patients had recently took part in a survey and chose the name Ivy Suite.
- There was a staff awards system in place. Staff could nominate each other for an outstanding practice award. Two of the four oncology nurses had been awarded this. Awards were held quarterly and recipients were given a gift voucher along with a meal prepared by the kitchen.

Innovation, improvement and sustainability

- A clinical review in June 2015 highlighted a number of issues in the oncology service which required immediate action. An oncology action plan was set up in 2015, listing improvements to be made and actions to be taken. We saw evidence of nominated individuals to complete tasks. The nursing team believed there had been positive changes and actions had been completed. For example the use of the UKONS tool.
- The Macmillan Quality Environment Mark (MQEM) is a quality framework used for assessing whether cancer care environments meet the standards required by people living with cancer. Spire Wellesley was awarded the MQEM accreditation in September 2015.

Good

Surgery

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

Information about the service

Spire Wellesley Hospital has one inpatient ward consisting of one day care unit and four operating theatres. A further three extended recovery beds, located within a separate three-bedded area, were available in the main inpatient ward.

The hospital had 1,698 overnight patient stays and 4,519 day case patients and a total of 7,525 visits to theatre throughout 2015; this was inclusive of all patients including children. The hospital does a variety of surgical procedures, including orthopaedic, gynaecological, urological, vascular, bariatric and endoscopic procedures. The three commonest procedures done in 2015 were injections into joints, replacement of eye lens and knee joint replacement.

We spoke with 27 staff including consultants, the resident medical officer, nursing staff, operating department practitioners, care assistants and senior managers. We spoke with five patients, three relatives and reviewed eight patient records.

We reviewed policies, procedures and compliance with national guidance and legislation in all areas of the hospital.

Summary of findings

We rated this service as good overall because:

- The hospital used National Early Warning Scores to assess patients and met its target for completion in 2015. Patients' pain was assessed regularly and pain relief administered as required and prescribed.
- The hospital's surgical site infection rates for hip and knee operations in 2015 were within Spire targets, with no surgical site infections reported in knee operations.
- The latest Patient Reported Outcome Measures data for Spire Wellesley was positive.
- Nurses completed documentation in detail and nursing documentation was accurate and up to date.
- All equipment checked across the hospital was within its service date, stored appropriately and visibly clean. The engineers kept detailed and accurate records of all equipment and knew when equipment required servicing.
- 87% of staff completed their mandatory training in 2015. The hospital had made good progress in 2016 and at the time of inspection were exceeding targets for mandatory training.
- Staff provided kind, compassionate and dignified care. Patients told us they felt happy with the care received and involved in decisions about their care.
- The latest Friends and Family Test results for NHS patients showed that throughout 2015, the hospital scored 99% to 100%. The hospital's patient wide survey also showed that consistently over 99% of patients would recommend the hospital to friends and family.

Good

Surgery

- Staff knowledge around additional support required by patients with a learning difficulty was good. The hospital had facilities to allow relatives to stay with patients to provide additional support if needed.
- The hospital met its target of 71% in 2015 for the way patients were prepared for being at home, scoring 75%.
- Staff spoke positively about local leadership. Staff told us that an open door policy was embedded across the hospital and felt confident to approach their management team for advice or to raise a concern.

However:

- Storage and security of patient records was lacking. Computers were left logged on with patient details visible. Staff left patient records in empty rooms for long periods. Senior staff took action following our concerns to improve practice.
- Some orthopaedic surgeons did not follow infection control guidance within theatre.
- Staff had limited knowledge about safeguarding processes and procedures. Staff could not give examples of practical applications of safeguarding or what was involved in safeguarding patients.
- Staff had limited knowledge of the Mental Capacity Act, mental capacity assessments and Deprivation of Liberty Safeguards. Staff could not provide examples of practical application of the Mental Capacity Act or when it may be applied. Staff could not describe the principles of Deprivation of Liberty Safeguards.
- The blood fridge was not checked on a regular basis and not all staff were aware of the process. The inconsistencies in checking the blood fridge were raised to the ward manager during the inspection. The fridge had an alarm that would trigger if temperature parameters were breached which partially mitigated the risk.
- We witnessed two patients being weighed in a corridor near other patients, visitors and staff and this did not promote the patients' dignity. Following inspection the scales were moved and practice changed.
- The annual average compliance score with pre-operative fasting guidelines for 2015 was 58%, and this had increased to 60% in the first 3 months of 2016. However this meant that some patients were at risk of having fasted for a prolonged period.
- There were inconsistencies amongst staff knowledge in relation to accessing translation services The number of complaints received by the hospital had increased year on year from 28 complaints in 2013 to 52 complaints in 2015 which was comparative to an increase in patient volumes.
- The risk register was limited in detail. Root cause analysis (RCAs) and subsequent actions plans were not always completed in detail.

Good

Surgery

Are surgery services safe?

Good

We rated safe as good because:

- The hospital had positive surgical site infection results for both hip and knee arthroplasty surgery.
- National Early Warning Score compliance rates were on average 98% throughout 2015.
- Documentation and review by nursing staff was good. Evidence of reassessment of Waterlow and Malnutrition Universal Screening Tool scores were seen. Appropriate interventions were made where patients showed an increased risk of developing pressure damage.
- All equipment checked had been serviced as per manufacturer guidance.
- The engineering department kept contemporaneous documentation of equipment and the hospital building and structure.
- The hospital achieved an overall mandatory training compliance rate of 87%.

However:

- Orthopaedic surgeons were observed in theatre not using appropriate personal protective equipment, namely visors and hoods, when performing joint surgery.
- Staff had limited knowledge of safeguarding procedures, what would constitute a concern and were unable to relate to practice.
- The blood storage fridge was not checked for temperature compliance on a daily basis. We found 16 dates between January 2016 and May 2016 that had not been checked. The fridge had an alarm that would trigger if temperature parameters were breached which partially mitigated the risk.
- When theatre lists were updated, old lists were not destroyed, leading to a risk of the wrong patients being taken to theatre. We raised this issue with senior hospital managers who responded and took immediate action.

Incidents

- There was an electronic incident reporting system in place and staff were aware of how to use this.
- From January 2015 to December 2015, the hospital reported eight serious incidents, one unexpected death and three expected deaths. Spire Wellesley reported two serious injuries between January 2016 and the inspection in May 2016.
- The hospital recorded no never events in 2015. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- From January 2015 to December 2015, the hospital recorded 221 incidents. The medical advisory committee reviewed clinical incidents quarterly.
- The Spire clinical scorecard target was 75% for incidents closed within 45 calendar days of the initial report. Spire Wellesley achieved the average score of 68% for 2015 however there was an improving picture with Q3 and Q4 results being 93% and 92% respectively. This continued into Q1 2016 with 99% achieved which meant incidents were being investigated in a timely manner.
- The medical advisory committee meeting minutes showed learning from incidents. In May 2015 it was documented that following an incident within theatres, processes around the use of a particular pain relief had been changed.
- Staff demonstrated an understanding of duty of candour and were aware of the principles.
- From our review of the hospitals 2015 annual governance report we saw that the hospital had regard to Duty of Candour. Patients were contacted when things went wrong and provided with appropriate information and support. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Safety thermometer

- Patient outcomes were measured against a fixed set of criteria using the Spire clinical scorecard. Spire hospitals compared outcomes nationally on a quarterly basis. Spire Wellesley also benchmarked against NHS key performance indicators and Commissioning for Quality and Innovation (CQINS), submitting data quarterly for all NHS patients treated.
- In 2015, the hospital did not meet its target for inpatient falls, scoring an average of 2.53 against a target of two per 1000 bed days.

- Venous thromboembolism (VTE) data showed that the hospital exceeded its target of 95% for VTE risk assessment completion in 2015, scoring 96% on average, and exceeded all targets for effective prescribing of chemical prophylaxis in line with NICE Guidelines to prevent such incidents. However incidents of VTE in hip and knee arthroplasty patients were above the Spire target, scoring 1.28 against a target of 0.5 per 1000 bed days.
- For surgical site infections (SSI) in hip arthroplasty operations, Spire Wellesley scored 0.47% against a target of 0.6%. The hospital recorded no SSI following hip arthroplasty in Q1 2016. The hospital recorded no SSI's following knee arthroplasty operations in 2015 or in Q1 2016.
- In 2015, the hospital recorded 14 surgical site infections across all surgical procedures. This represented a rate of 0.18% of surgical cases performed.

Mandatory training

- Staff were aware of their responsibility to undertake and complete mandatory training. Mandatory training was delivered via the Spire electronic system.
- The Spire annual target for mandatory training compliance is 95%. In 2015, Spire Wellesley achieved 87%.
- From January 2016 to March 2016, 47% of mandatory training had been completed against a national target of 25% for the period.

Safeguarding

- From January 2015 to April 2016, no adult safeguarding concerns had been raised.
- Staff had limited knowledge of safeguarding procedures, what would constitute a concern and were unable to relate to practice. We asked three ward staff what they understood constituted to a safeguarding concern. One member of staff could not differentiate between mental capacity and safeguarding. Another two members of staff told us that they undertook training in safeguarding but were unable to explain what safeguarding a patient involved or how to apply this to their day-to-day work.
- Spire Healthcare introduced new safeguarding modules in January 2016. From January 2016 to March 2016, 18% of ward staff had completed their adult safeguarding mandatory training and 16% had completed their level two child safeguarding training. Within theatres, 52% had completed the adult safeguarding training and 41% had completed level two child safeguarding training.
- Spire Healthcare had a national Safeguarding Vulnerable Adults Policy in place. Spire Wellesley submitted their Safeguarding Vulnerable Adults Policy as part of CQCs request for information. Spire Wellesley had not personalised the national Spire policy for local use. Local procedures for contacting multiagency safeguarding teams were not completed. Contact details for escalating safeguarding concerns for NHS funded patients were also missing. We were not assured that safeguarding procedures were reviewed on a regular basis and updated to reflect local practices.

Cleanliness, infection control and hygiene

- Housekeeping staff undertook domestic cleaning. Patient rooms, corridors, ward areas, waiting areas and en-suite facilities were all visibly clean.
- The Department of Health: Health Building Note 00-09: Infection control in the built environment 3.115 states that, "Carpets should not be used in clinical areas. This includes all areas where frequent spillage is anticipated. Spillages can occur in all clinical areas, corridors and entrances."
- Ten of the 43 bedrooms were carpeted which was in contradiction to the Department of Health: Health Building Note 00-09. Whilst there is no requirement for independent healthcare providers to comply with the Department of Health building notes, it is advised that independent healthcare providers consider the guidance when planning services and undertaking building maintenance and risk assessments. The hospital had a rolling refurbishment plan that would see replacement of the remaining carpeted bedrooms with hardwood flooring by the end of Q1 2017. There was a risk assessment undertaken and regular cleaning programme in place to ensure infection risks were minimised.
- Patient bathrooms, treatment rooms and sluice room had laminate flooring in place. This was in line with Department of Health: Health Building Note 00-09.
- Hand wash facilities within the general clinical areas were not compliant with Health Building Note 00:09. Sinks were not free from overflow and plug and they did not have mixer elbow operated taps. This increased the

potential risk of cross infection. However it is also recognised within Health Building Note 00:09 that single bed rooms with en-suite sanitary facilities are optimum environment for infection prevention.

- Staff used hand sanitiser before and after patient contact and followed a 'bare below the elbows' policy.
- Hand hygiene audits were undertaken in 2015 using the light box method to establish the correct hand washing technique. Forty-two staff were assessed from across the hospital, including catering, nursing and administrative staff. Of the 42, 25 were fully compliant with all aspects of the assessment.
- Staff completed annual infection control training in electronic format as part of the hospital's mandatory training program. In 2015, 96% of staff across the hospital completed this training. From January 2016 to March 2016, 57% of staff had completed their infection control training update for 2016, against a quarterly target of 25%.
- Ward staff were aware of when and how to use appropriate personal protective equipment (PPE) such as gloves and aprons and ward staff were observed to use PPE appropriately.
- During 2015, the hospital identified no MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA) or Clostridium difficile cases.
- Theatre staff used appropriate hand decontamination processes before commencing surgical procedures. Scrubs were worn within the theatre environment and were laundered by an external company on a daily basis.
- Orthopaedic surgeons were observed not using visors, eye protection or hoods during joint replacements. The use of visors and hoods is considered good practice in reducing the risk of cross infection and injury.
- The central sterile services department (CSSD) cleaned, packed and sterilised surgical instruments on site.
- One of the two washers within CSSD was not working. There was no separate corridor within CSSD to segregate clean and dirty items. A risk assessment had been undertaken and dirty instruments were transported in a closed trolley.
- Five of nine gynaecology trays were past their sterilisation date, as they have a shelf life of one year. CQC raised concerns with staff at the time and the items were removed from use.
- A bed space had not been cleaned within the extended recovery unit following patient discharge for over 14 hours. The bed space contained used linen and medical equipment from the previous patient. Staff stated the patient was discharged the evening before but nursing staff do not clean bed spaces and this is left to the housekeeping staff.
- In the latest Patient-Led Assessment of the Care Environment results, the hospital scored 100% for cleanliness.

Environment and equipment

- Waste management was compliant with the Department of Health Safe Management of Waste 2011 guidance. An external contractor undertook the removal of waste.
- All equipment checked across the hospital was within its service date and clearly labelled with the next date of service. The engineering department held contemporaneous records detailing the service history of all equipment, when equipment was next due for service and by which contractor.
- Resuscitation equipment was available on the ward and within theatres. The hospital treats patients from the age of three within the ward and theatre areas. The resuscitation trolleys contained full adult and paediatric advanced life support equipment. All resuscitation equipment checked was in date, with intact packaging where needed and stored appropriately. Daily checks were carried out on the resuscitation trolley and records of these kept.
- The extended recovery unit (ERU) was equipped with portable monitoring equipment and patient transfer bag. The transfer bag contained equipment required to transfer a deteriorating patient between ERU and theatres or to a waiting ambulance for transfer to a hospital intensive care unit.
- The hospital had four operating theatres on site.
- There was a difficult intubation trolley within theatres, located near the anaesthetic rooms.
- The most recent Patient-Led Assessment of the Care Environment scores for the hospital were published on 11 August 2015. The hospital scored 94.2% for the condition, appearance and maintenance part of the assessment, which was better than the national average of 74.5%.

Medicines

- Of the eight sets of patient notes reviewed, all had appropriately completed medication charts. Medication was prescribed in accordance with the British National Formulary, was clear and legible, and patient allergies were documented.
- Controlled drugs (CD) were appropriately managed. CD registers were accurate and correlated with the stock within theatre and the ward. No patient own CDs were available at the time of inspection. However, evidence of the completion of the patient own CD register was seen. Two registered nurses checked CDs daily and recorded within the CD register.
- Treatment rooms were locked using numerical key pads to restrict access by any unauthorised person. All medication was stored appropriately in locked cupboards or fridges, in accordance with manufacturer guidance. A registered nurse holding the keys on their person at all times controlled access to medication.
- However, senior nursing staff were unaware of who knew the code to the treatment rooms. There was no process for changing the key codes on a regular basis. This could potentially lead to unauthorised staff having access to the treatment room. CQC raised concerns to the ward manager during the inspection. However, no actions were taken at the time.
- Intravenous fluids were stored appropriately within treatment rooms and theatres.
- Medication fridge temperatures were checked on a daily basis and evidence of recording was seen with monitoring of temperatures to ensure medications were stored appropriately.
- The blood fridge was not checked on a regular basis. The blood fridge was not checked on 16 days from January 2016 to May 2016. The checklist had been signed to state it had been checked on 30 February 2016, a date that does not exist.
- The inconsistencies in checking the blood fridge were raised to the ward manager during the inspection. The ward manager assured us staff would be reminded and a review into the process of checking the blood fridge would be undertaken. The process at the time of inspection was for an engineer to check the blood fridge temperatures Monday to Friday and nursing staff to check the blood fridge on a Saturday and Sunday. There was inconsistent knowledge amongst staff in the checking process of the blood fridge. The ward manager was not aware of the process when initially asked. The fridge had an alarm that would trigger if temperature parameters were breached which partially mitigated the risk.

Records

- We reviewed eight patient records during the inspection. Staff found records quickly. Nursing records, including risk assessments, were completed in full.
- One set of notes had conflicting times documented on the pre-operative notes. The documented time for the induction of the patient and for the start of surgery time was the same. No time was documented for undertaking the safety checklist.
- Theatre lists were printed at the start of each day on plain white paper. If changes were made, the lists were reprinted on plain green paper. Following any further changes, theatre lists were printed on plain yellow paper. Previous lists were not removed and destroyed, leading to confusion amongst theatre staff as to the current list being worked to. We were not assured that all theatre staff were aware of patient movement and changes in surgical lists. We raised this issue with senior hospital managers who responded and took immediate action.
- Ward staff were leaving patients' records in patients' allocated side rooms prior to the patient arriving. Patient records were left unsupervised for up to an hour prior to the patient arriving. Staff were seen to leave computer screens on and unsupervised with patient details on display. Patient notes were also left unsecured around the nurses' station on the ward and on top of filing cabinets. We were not assured that patient information was kept secure and concerns were raised to the hospital management team during the inspection.
- Following the inspection, the hospital implemented a number of actions to reduce the risks highlighted during the inspection. These actions included not leaving patient notes in rooms prior to their arrival, safeguarding information on computers by having a 'time out' function to automatically lock computers and updating all staff on the importance of information governance.
- A patient label (containing the patient's name, address and date of birth) was left tied to the end of a bed in ERU 14 hours after the patient was discharged. Staff stated

that they would remove it and dispose of the information. The information had not been removed after an hour and the ward manager was informed who stated it would be removed immediately.
- The theatre department undertook intra-operative documentation audits in February 2016 and April 2016. The audits looked at six aspects of intra-operative documentation including temperature recording, final swab count and medication documentation. In February 2016, the theatre department was 89% compliant. In April 2016, the theatre department was 97% compliant, which shows a good improvement.
- Surgical safety checklist audits were undertaken in March 2016 which showed a compliance of 96% with documentation and 100% for observing staff involvement within the checklist procedure.

Assessing and responding to patient risk

- Spire Wellesley submitted their Admission and Discharge Policy. This was the same as the Spire Healthcare national policy. The policy contained a clear pre-admission assessment process which highlighted patients at greatest risk. Patients were reviewed by an anaesthetist where concerns were raised pre-operatively.
- The World Health Organisation Safer Surgery Checklist was in use at the hospital. The five steps to safer surgery incorporate a briefing before surgery commences at the beginning of the list and debrief at the end. Huddles were taking place before each list and with each change of consultant to ensure safety and a coordinated approach to the surgery. Evidence of huddle lists was seen.
- In the event of a patient cardiac arrest, there was a dedicated telephone number for staff to ring. The cardiac arrest team was made up of the resident medical officer (RMO), theatre staff and senior nursing staff. Emergency call bells were available in each patient bedroom and consulting rooms.
- The hospital used the National Early Warning Score (NEWS) to assess patients. NEWS is a nationally recognised scoring system to establish the stability and deterioration of a patient based on predetermined parameters for observations such as pulse, temperature, pain and blood pressure.
- NEWS were completed appropriately in accordance with hospital guidance. Escalation plans accompanied the NEWS assessments and were appropriately implemented. Compliance with National Early Warning Score (NEWS) completion was above 98% in 2015, which is better than the hospital's target of 95% or above.
- National Institute for Health and Care Excellence QS81 Pressure Ulcers guidance states that a pressure ulcer risk assessment should be undertaken within six hours of a patient being admitted into a hospital. The use of the Waterlow score system is a common assessment tool used in hospitals. A Waterlow score provides a risk based score against a set of predetermined standards to establish the likelihood of pressure damage occurring.
- Patients were assessed using the Waterlow score at pre-admission and were reassessed throughout their inpatient stay. We found two patients that had been assessed as high risk of pressure damage at pre-assessment with continuing assessments and interventions.
- The environment and equipment within the extended recovery unit (ERU) was sufficient and appropriate to care for a level one patient requiring additional monitoring and closer observation.
- Criteria was in place for escalation of deteriorating patients, including transfer to the nearest NHS hospital for level two or level three critical care. Wellesley Hospital has submitted their Admission and Discharge Policy which sets out the process for emergency transfer to another hospital and to level two and level three facilities. The hospital had a local transfer policy in place to support the national policy.
- Prior to the inspection, the hospital stated there had been 8 unplanned transfers of care to another hospital during 2015, providing a breakdown of the data into each quarter of the year. The hospital changed the data stating there had been two unplanned transfers of care in 2015. However, when asked, the management team was unable to provide a breakdown of the data to support the change in data.
- During the inspection we asked to speak to a patient after reviewing their notes. The reception staff stated the patient had been discharged and this was reflected on the computer system. We found the patient was still an inpatient with a plan to remain in hospital for several more days. Staff were unaware that the plan of care had changed and that the patient had not been discharged. Therefore, we were not assured that staff were fully aware of patients that were currently within the ward area.

Good

Surgery

Nursing staffing

- There were 20 whole time equivalent (WTE) registered nurses and 6.3 WTE care assistants within the ward areas. In theatres, there were 10.8 WTE registered nurses, 6 WTE nurse managers, 7.8 WTE operating department practitioners (ODP) and 4.6 WTE care assistants.
- The number of staff on each shift was dependant on the expected number and acuity of patients. Acuity was monitored on a daily basis by senior nursing staff and additional staff brought in when required. However, senior nursing staff stated no specific acuity tool was in use at the hospital.
- The use of agency staff reduced during 2015, with agency use between 10% and 12% of total staffing in quarter one (January to March) of 2015. This reduced to less than 3% in quarter four (September to December) of 2015.
- The hospital scorecard had shown agency spend as a percentage of total staff costs to be worse than the Spire target of less than 3%,with an average spend of 13.1% in 2015.

Surgical staffing

- There was a resident medical officer (RMO) at the hospital 24 hours a day, seven days a week. The RMO worked seven 24-hour shifts in a row, with facilities on site for them to sleep over night. The RMOs handed over at midday on a Monday.
- There was no internal auditing of how many times the RMO was woken during the night. CQC raised concerns over the ability for the RMO to work the following day if they had been awake for long periods during the night. The hospital had a process to contact the agency and request cover for the RMO should it be required, for example during sickness or to cover additional sleep time. We were informed that replacement cover could be provided within two hours or earlier if possible.
- Individual consultants remain responsible for patients during their inpatient stay for advice and guidance. The consultants should be contactable 24 hours a day. The RMO was aware of how to contact consultants and was happy to do this when necessary.

Major incident awareness and training

- The hospital had procedures in place in the event of an incident occurring on site. The engineering manager explained the process for power failure. Backup generators were in place to provide power. Essential equipment, for example within theatres and imaging department, ran from separate circuits. Emergency lighting would come on in the event of a power failure.

Are surgery services effective?

Good

We rated effective as good because:

- Pain relief was readily prescribed post theatre and to take home as required. We saw the appropriate use of a patient controlled analgesia pump.
- Pain assessments were regularly carried out and acted on.
- Food and drink was readily available for patients throughout their admission.
- The latest Patient Reported Outcome Measures data suggests good outcomes from the patients' perspective.
- Specialist staff, including consultants, pharmacists and engineers, were contactable 24 hours a day, seven days a week and staff felt confident to contact them out of hours if required.
- Nursing staff were gaining consent prior to undertaken any intervention for patients in ward areas.

However:

- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards knowledge amongst nursing staff was limited. Staff could only provide basic examples of the practical application of the MCA or of Deprivation of Liberty Safeguards; and there was a lack of understanding in how the MCA should be applied within Spire Wellesley Hospital.
- Local audit plans were limited and lacked detail.

Evidence-based care and treatment

- Staff knowledge of policies and procedures was inconsistent. Two of three staff asked were unaware of the safeguarding policy. However, the use of Waterlow and the Malnutrition Universal Screening Tool scores were embedded and used appropriately to guide care planning.

- Hospital policies were appropriately referenced and signposted to the evidence base. For example, the Vulnerable Adults Policy referenced the Department of Health, Care Act 2014, and the Equality Act 2010.
- The hospital's admission and discharge process was compliant with National Institute for Health and Care Excellence (NICE) guidance.
- Staff were seen following NICE guidance QS66 administration of intravenous medication.
- Within theatres, staff were aware of the World Health Organisation (WHO) safer surgery checklist. The WHO checklist was observed being used within theatre and was embedded into the routine of the patient's pathway.

Nutrition and hydration

- Pre-operatively patients were advised regarding fasting guidelines. For general anaesthetics this was six hours prior to surgery for solid food and two hours for clear fluids. Information on fasting was given or sent to patients during the pre-operative assessment or consultation.
- Patients had a daily menu to choose meals from and food was prepared fresh by the onsite catering staff. Patients had access to food between meal times as required. Water was available to all patients throughout the day.
- Patients with special dietary requirements were highlighted at pre-assessment and their needs were catered for throughout their stay.

Pain relief

- Spire Wellesley was not meeting standards as set out in the Faculty of Pain Management core standards for pain management services in the UK guidance, published 2015. The hospital did not provide a specialist pain management team or pain management multidisciplinary review of patients. There was a pharmacist on site Monday to Friday 9am to 5pm to dispense and provide advice and support.
- Patients felt their pain was managed appropriately. We saw the appropriate use of a patient controlled analgesia pump for a patient post operatively. The patient stated that nursing staff have always changed the syringe prior to it ending and that pain control was very good on the ward.
- Patients' pain assessments were being undertaken and documented as part of the NEWS.
- 'As required' pain relief was prescribed within theatre. Ward staff told us the resident medical officers were supportive and willing to review pain relief if requested by nursing staff.
- We reviewed eight inpatient prescriptions for pain medication and found all were completed in full, legible and appropriate doses prescribed. Evidence of regular and appropriate administration of medication was seen in line with the prescription.
- We reviewed six 'to take out' prescriptions and found good evidence of pain relief being prescribed for patients on discharge. All prescriptions were in line with the British National Formulary prescribing guidance.
- Patients' pain scores were recorded in 100% of cases on the clinical scorecard in 2015. The hospital's target for recording pain was 95% or above.

Patient outcomes

- The hospital was auditing 34 areas using the national Spire scorecard. These included patient fall rates, VTE compliance, cancer care standards and hand hygiene compliance.
- A further three national audits (national comparative blood transfusion, Patient-Led Assessment of the Care Environment and sharps awareness) were listed on the 2016 audit plan. These audits were scheduled but were yet to have a date assigned to them.
- The latest Patient Reported Outcome Measures (PROMs) data provided covered April 2014 to March 2015. Of the 113 patients who had knee replacements, 95.6% reported an improvement in generic health issues following knee replacement surgery.
- Of the 93 patient who had hip replacement, 96.7% reported an improvement in generic health issues following hip replacement surgery. The hospital's PROMs outcomes are around the national average for all aspects. The national average compares both independent health care providers and NHS providers.
- For groin hernia repairs, between 36% and 45% of patients reported an improvement in their health following surgery.

Competent staff

- Staff joining the hospital received both corporate and local inductions. Agency staff were given a local

induction to the clinical area covering the ward layout, procedures in the event of an emergency and the location of emergency equipment, for example the resuscitation trolley.
- Data provided showed that 100% of clinical staff working in inpatient areas had completed their annual appraisal for 2015, barring staff on long-term sickness.
- The hospital's matron, before commencement of employment, assessed all resident medical officer qualifications and suitability.
- The medical advisory committee (MAC) within the hospital reviewed practicing privileges of consultants. Evidence of suspension of consultants practicing privileges was seen within MAC meeting minutes where consultants failed to produce evidence on competence.
- The engineering staff had yearly competency assessments carried out by the engineering manager. Evidence was seen that all engineering staff were up to date with their competency assessments.

Multidisciplinary working

- Staff of all disciplines, for example consultants, nursing and physiotherapists, worked alongside each other throughout the hospital. Physiotherapists were requested to review patients as required. Nursing staff felt confident to ask for assistance from the RMO.
- Documentation was seen from physiotherapists following the assessment of patients with reduced mobility post theatre.

Seven-day services

- The onsite pharmacy was open Monday to Friday between 9am and 5pm. Outside these hours, a member of pharmacy staff, either a technician or pharmacist, was available via the on call system to provide pharmaceutical advice and support to the staff.
- Theatres were staffed and used Monday to Saturday 8am to 7pm. There was an on call team for theatres outside of these hours, which meant that emergency provision could be provided should a patient need to return to theatre.
- There was an RMO onsite 24 hours a day. The RMO had access to consultants throughout the period of admission, or a nominated consultant in their absence. The RMO said they were happy to contact the consultants out of hours when required.
- There was an engineer available between Monday to Saturday 8am to 4pm. An out of hours on call system operated outside of these hours for emergencies.

Access to information

- All nursing and medical documentation, including risk assessments, care plans and theatre documentation, was in paper form.
- Test results were held electronically, including x-rays. The consultants and RMO had access to these as required.
- Discharge summaries were sent electronically to GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing staff were observed gaining consent from patients prior to undertaking interventions, for example taking patient observations.
- Spire provides an online e-learning package for Mental Capacity Act (MCA) that incorporates Deprivation of Liberty Safeguards.
- Nursing staff had limited knowledge of the Mental Capacity Act (MCA), mental capacity assessments or Deprivation of Liberty Safeguards. Two staff could not provide appropriate examples of when a Deprivation of Liberty Safeguards application may be needed and there was confusion between safeguarding requirements and that of the MCA. We were not assured that staff had the knowledge to deal with best interest decisions or support patients with capacity decisions.
- One care assistant described MCA as safeguarding vulnerable adults and was unable to provide any further explanation. However, a staff nurse we spoke with stated that MCA was concerned with patients trying to leave the ward and this would be discussed with the resident medical officer, and a senior nurse stated that MCA was concerned with consent and the patient making his or her own choices which demonstrated some understanding of the MCA.
- At the time of our unannounced inspection, two training sessions had been provided to staff to support them with understanding and applying the principles of the MCA.
- The hospital made no Deprivation of Liberty Safeguards applications to the local authority between January 2015 and April 2016.

Good

Surgery

Are surgery services caring?

Good

We rated caring as good because:

- We observed staff providing compassionate and kind care to patients and relatives.
- The latest Friends and Family Test results (July 2015 to December 2015) were consistently 99% to 100%.
- Both patients and relatives were positive about the nursing care provided and the care given by consultants.
- Patients and relatives felt involved and listened to throughout the treatment process.
- Patients' dignity was maintained by theatre staff throughout their theatre journey, from transfer to theatre through to recovery.
- Staff provided reassurance and emotional support to patients and relatives before and after procedures.
- Staff could access chaplaincy services for patients throughout their stay at the hospital. However, staff were unsure how to access the service.

Compassionate care

- Staff were seen to provide compassionate, kind and considerate care to patients. Staff from all professions interacted with patients and relatives in a professional but thoughtful manner. We saw staff escort patients to their rooms on arrival.
- However, we witnessed two patients being weighed in the corridor in sight of other patients, staff and visitors. This did not promote the patients' privacy or dignity, as the patients were both wearing hospital gowns. One patient's gown was not fastened appropriately behind them to maintain dignity. Following inspection the scales were moved and practice changed.
- Staff explained procedures to patients and requested consent prior to undertaking interventions.
- One patient described staff as "kind and caring" and another patient described nursing staff as "friendly and helpful". A third patient also stated that their care was very good and had no concerns over the treatment they had received.
- Patients and their relatives knew the name of the consultant in charge of their care and how to contact them. This complies with the National Institute of Health and Care Excellence QS15 patient experience in adult services guidance.
- Theatre staff, throughout the patient's journey, considered their dignity and privacy. Patients were covered throughout transfer from the ward areas to theatres. Patients were only uncovered once in the operating theatre.
- Patients within recovery were kept covered and spoken to with kindness and respect following their procedure. Nursing staff supported and comforted patients showing symptoms of post anaesthetic agitation within recovery.
- The most recent Patient-Led Assessment of the Care Environment score for the hospital was published in August 2015. The hospital scored 91% for privacy, dignity and wellbeing, which is above the national average of 86%.
- From July 2015 to December 2015, the hospital's Friends and Family Test (FFT) results were above 99%. The FFT is available to NHS patients only; however, this correlates with the hospital's score card which shows 99% of patients responded "extremely likely" or "likely" to recommend Spire Wellesley to friends and family in 2015.
- The hospital's clinical scorecard results for 2015 showed that the target was met for percentage of patients responding excellent to the overall care and attention provided by nursing staff, scoring an average of 88% in 2015, against a target of 85%. The hospital also met its target of 85% for care and attention provided by consultants, scoring an average of 89% in 2015.

Understanding and involvement of patients and those close to them

- Staff involved patients throughout their pathway of care. Staff explained procedures to patients in a calm, non-rushed way that allowed time for conversations about uncertainties or worries on the part of the patient.
- One patient stated that they had received "really good" information about the procedure before admission, and following their operation. The patient also stated that their partner was informed throughout the process and supported with any concerns they raised.

- Another patient stated that their questions and concerns were answered throughout the process by the consultant. The patient stated that if nursing staff were unsure of the answer they would seek advice from the consultant.
- A third patient stated they had regular contact with their consultant, who answered any questions they had. The patient also stated that their partner was involved in all discussions and will answer any questions that they may also have.
- The inclusion of relatives at the patient's request is in line with NICE QS15 guidance relating to patients' preferences for sharing information.

Emotional support

- Clinical and non-clinical staff checked on patients' well-being regularly and spent time with patients to discuss concerns and provide support and reassurance prior to their procedure.
- A chaplaincy service was available to patients and relatives to access throughout their stay. However, staff were unsure how to contact the chaplaincy service.
- Depending on the patient's needs the hospital offers counselling and emotional support from its oncology team, specialist cosmetic nurse advisor and an on-site psychologist.

Are surgery services responsive?

Good

We rated responsive as good because:

- Staff knowledge around the additional support required for patients with learning disabilities was good, and examples given of effective changes to care delivery.
- The clinical score card results for 2015 showed that 75% of patients felt prepared on discharge, against a target of 71%.
- Provisions were available to allow relatives to stay overnight with patients when needed.
- The hospitals average compliance score with pre-operative fasting was above the Spire clinical scorecard target at 60% in the first 3 months of 2016. Whilst this meant that 40% of patients were at risk of extended period of fasting prior to surgery, actions had been taken and an improving picture was evident.

However:

- There were inconsistencies amongst staff knowledge in relation to accessing translation services.

Service planning and delivery to meet the needs of local people

- From January 2015 to December 2015, the hospital had admitted 1711 inpatients, 6587 day case patients and 7525 patients through theatre.
- From January 2015 to December 2015, there had been eight unplanned transfers of a patient to another hospital.
- The hospital operated an open visiting culture, allowing relatives to visit patients as they wanted.

Meeting people's individual needs

- Patient information leaflets were available throughout the hospital and in multiple languages. The hospital could access information in additional languages.
- Staff had access to translation services for patients who did not speak English or were hearing impaired. There were inconsistencies in staff knowledge of how to access the service. Two nurses stated that they would access the translation service on offer for patients whose first language was not English whilst another member of staff stated they would ask relatives to translate. This was not good practice because it did not promote patient confidentiality.
- We received inconsistent responses from nursing staff regarding the care needs of patients living with dementia. One member of staff stated they would seek advice from a senior nurse and was unsure what additional support patients may require. A staff nurse stated that dementia was the same as post-operative confusion when asked what support was available for patients with dementia. However, another staff nurse stated that patients with dementia would try to be allocated a room near to the nurses' station but was unable to provide any further expansion on additional support that may be needed.
- Staff had a good understanding of the needs of patients with a learning difficulty. One member of staff stated it was important to speak with the patient and their relatives to ensure inclusion. A staff nurse stated that the ward would be told prior to admission of a patient with a learning difficulty.

Good

Surgery

- The hospital was compliant with mixed sex accommodation requirements. The inpatient and day case wards were both individual patient rooms with individual bathrooms. Within recovery, both male and female patients were present. However, the use of curtains enhanced the patient's privacy within these areas.
- Each single room had a television, access to the internet and a nurse call button. Patients who were unable to move post-operatively had the nurse call button within reach to allow them to access help when required.
- Staff were able to accommodate patients' individual dietary requirements. Staff informed the catering on admission of any dietary requirements, for example vegetarian or coeliac disease.
- Patients chose their menu choices in the morning for lunchtime service and again in the afternoon for evening meal service.
- The Spire clinical scorecard 2015 target for compliance with the pre-operative fasting guidelines was 55%. The hospital's clinical scorecard for 2015 showed that on average, 58% of patients were fasted within guidance, which was above the Spire target.
- To improve patient preoperative fasting compliance; actions had been taken to redesign of admission letters with fasting times identified and results in Quarter 1 2016 showed a further improvement to 60%. However this meant that 40% of patients were at risk of extended period of fasting prior to surgery

Access and flow

- Patients had timely access to assessments, diagnosis and urgent treatment. There were no delays in accessing treatment once a diagnosis had been made.
- The hospital met its target of 90% of NHS patients on an 18 week referral to treatment time (RTT) pathway from January 2015 to May 2015, scoring 98% and above. However, the 18 week RTT target of 90% was discontinued in June 2015 although the hospital is still measuring data. From June 2015 to December 2015, the number of patients meeting the 18 week RTT fell from 98% to 88%.
- Surgery was predominantly elective with 11 unplanned returns to theatre between January 2015 and December 2015. Staff reported unplanned returns to theatre through the hospital incident reporting system.
- The hospital met its target for unplanned returns to theatre in 2015, averaging 0.15 against a target of 0.2. However, this was slightly above the Spire national average of 0.1.
- In 2015, the hospital met its target for inpatient readmissions within 31 days of discharge, averaging 0.29 against a target of 0.3 per 1000 bed days. However, this was above the Spire national average for 2015 of 0.18. Theatre utilisation data for March 2016 showed theatre usage for theatres one, two and three between 29% and 59%. Theatre four (endoscopy theatre) had a 10% utilisation rate in March 2016. As theatre utilisation was below 60% for all theatres, access to theatre space was not restricted. This meant consultants could access theatre time in a timely manner, reducing any delays to patients.
- From January 2016 to April 2016, Spire Wellesley cancelled 17 operations on the day of surgery, with 11 cancelled due to a clinical reason. Senior staff reported and investigated all cancelled operations.
- On discharge GPs were sent a copy of the patient discharge letter, detailing treatments received and any follow up required. This promotes a joined up approach to post-operative care.
- Data from the clinical scorecard showed the target for the percentage of patients responding with 'excellent' to the question of being prepared for discharge was achieved, with an average score of 75% in 2015, against a target of 71%. This was better than the national average of 73%

Learning from complaints and concerns

- The hospital had a complaints policy in place for staff to follow.
- Spire Wellesley had received 52 complaints in 2015. This was a rise from 2014 when 31 complaints were received, and 2013 when 28 complaints were received however was comparative to an increase in patient volume.
- The hospital did not provide data that was broken down into different clinical areas instead surgery was included as part of one central report.
- Learning points from complaints and concerns were shared with staff in staff bulletins and via email from the ward manager. Any significant concerns that were raised were also discussed at staff hand over times.
- Staff were unable to provide an example of when practice had changed following a complaint from a patient or relative.

Good

Surgery

Are surgery services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The hospital's risk register was limited in detail. Not all senior staff were familiar with the contents of the risk register and the storage of several versions led to some confusion.
- CQC raised concerns to the senior management team during the inspection; certain concerns raised were met with some defensiveness, however subsequent actions were taken by the senior team to address the issues.
- Root cause analysis (RCAs) and subsequent actions plans were not always completed in detail. Root causes were not always identified which meant potential additional actions were missed.

However:

- The hospital has a clear vision and set of values in place and staff were seen to work to these.
- Staff spoke highly of the ward manager and felt there was a clear open door policy.

Vision and strategy for this this core service

- The hospital's vision and values reflected the Spire's national vision and values. The hospital's vision was to be recognised as a world class healthcare business bringing together the best people to develop the best clinical environments and deliver the highest quality care.
- The hospital's values were based around six core areas: caring is our passion, succeeding together, driving excellence, doing the right thing, delivering on our promises and keeping it simple.
- Staff were aware of and understood Spire's vision and values. Nursing staff were proud and passionate about the care they were able to provide to patients.

Governance, risk management and quality measurement for this core service

- The hospital's risk register contained 13 entries; however, the risk register was limited in detail. Three risks had no "treatment plan / comments" and one entry had "consultants requested to submit data" as the only control or plan to mitigate the risk. Not all senior staff were familiar with the contents of the risk register and the storage of several versions led to some confusion.
- CQC raised concerns to the senior management team during the inspection. However, concerns around information governance and capacity assessment and consent, were met with some defensiveness and apparent lack of understanding. However subsequent actions were taken by the senior team to address the issues.
- The hospital submitted minutes from the four MAC meetings for review. The minutes show the MAC had good oversight of issues and concerns from across the hospital. Each meeting was structured around a similar format, and included: a review of previous meeting minutes, a summary of regulatory compliance, an overview of practicing privileges and a review of all complaints that have been received by the hospital.
- There was good oversight of consultant practicing privileges by matron and the MAC. Consultants who did not provide evidence of appraisal were written to three times and then suspended from practicing at the hospital until this was produced. Matron felt that the system works. Evidence of suspensions and reinstatements were seen in MAC meeting minutes. The MAC was also aware and discussed new consultants that wanted to start practicing at the hospital.
- The hospital's clinical governance group met quarterly and minutes from the previous four meetings have been reviewed following the inspection. The minutes from September and December 2015 contained details of the incidents discussed within the body of the minutes. However in March 2016 the hospital embedded the adverse event or serious incident report into an appendix to the minutes so that it was easily identifiable which incidents had been discussed.
- The hospital had a policy for the investigation of Serious Adverse Events. The hospital submitted a sample of root cause analysis' (RCA), at the request of the CQC. Root cause analysis (RCAs) and subsequent actions plans were not always completed in detail. Root causes were not always identified which meant potential additional actions were missed.
- Most hospital policies were appropriately referenced and signposted to the evidence base. The resuscitation policy references the Resuscitation Council, and the vulnerable adults policy references the Department of

Health, Care Act 2014 and the Equality Act 2010. However, the admission and discharge policy did not contain reference or sightings of national guidance or legislation.

Leadership / culture of service

- A hospital director and a matron led the hospital. They were supported within the senior management team (SMT) by the chair of the medical advisory committee, finance and operations manager, business development manager and the theatre and endoscopy manager. The hospital management team (HMT) was made up of 11 heads of department and overseen by a member of the SMT.
- All staff we spoke to praised the local leadership within the hospital and felt there was a clear 'open door' culture at the hospital.
- Staff spoke of a team ethic across the hospital and a strong sense of a team effort in caring for patients.
- The SMT were proud of the endoscopy service at the hospital, stating that they were patient focused and nothing was too much trouble.
- The SMT praised the oncology team in its development and for the support provided by the team across the hospital. Ward staff also spoke highly of the oncology nursing team, sighting the advice and input they provided to oncology patients during inpatient episodes.

Public and staff engagement

- Patient opinion was gathered using Friends and Family Test and Patient-Led Assessment of the Care Environment, which is carried out annually.
- The hospital matron did a 'walk round' of all clinical areas three times a day to ensure oversight, highlight and rectify any concerns and be visible and accessible to all staff.
- Staff felt confident to make comments or suggestions that would improve the patient experience or staff wellbeing.

Innovation, improvement and sustainability

- Planning permission had been granted for an administration development block which would free up space for additional clinical areas within the hospital and create additional capacity to continue refurbishment.

Inadequate

Services for children and young people

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

Information about the service

Spire Wellesley provided inpatient services for children and young people aged between three and 18 years. Inpatient areas included theatres, a recovery bay, and a general ward, consisting of 40 single rooms with ensuite bathrooms. Inpatient care was predominantly day case. However, there were adaptable facilities for overnight admissions if required. Only minor elective surgical procedures were carried out on well children, without pre-existing medical existing conditions. Procedures included tonsillectomies, removal of grommets, circumcisions, and excision of lesions to skin.

Outpatient services for children and young people were also available from age new born to 18 years. Outpatient services operated from the hospital's main outpatient department (OPD) and included ear, nose and throat (ENT), orthopaedics, urology, general, plastic surgery, and general paediatric medicine. Non-invasive diagnostic imaging was also available. A paediatric consultant and nurse manager led the service. There were also three registered nurses, children's branch (RCN), including the nurse manager, who provided care and treatment to children undergoing elective surgery. There were no dedicated areas for children and young people in inpatient or outpatient areas.

Service activity between January 2015 and December 2015:

- 145 outpatient first attendances aged 0 to 2
- 95 outpatient follow up aged 0 to 2
- 608 outpatient first attendances aged 3 to 15
- 613 outpatient follow up aged 3 to 15
- 2 overnight discharges aged 3 to 15
- 89 day cases discharges aged 3 to 15
- 165 outpatient first attendances aged 16 to 17
- 201 outpatient follow up aged 16 to 17
- 6 overnight discharges aged 16 to 17
- 22 day case discharges aged 16 to 17

We visited all areas where children and young people were cared for. This included the ward, theatres, recovery, OPD, and diagnostic imaging. We spoke with two children and their parents, two children's branch RCNs, two anaesthetists, three doctors, three senior hospital managers, four registered nurses and two support staff. We also reviewed seven patient records, observed care, and analysed data that we requested from the hospital.

Inadequate

Services for children and young people

Summary of findings

We rated Children's and young people's services at Spire Wellesley Hospital as inadequate overall because:

- We were concerned about the poor compliance with safeguarding training across the service and that the safeguarding policy in place was not fit for purpose.
- Hand hygiene was poor and the service did not carry out any observational hand hygiene audits.
- Incidents were not reported where required and environments where children and young people were cared for were not appropriately risk assessed.
- Some areas of the hospital were not secure and the hospital did not have an abduction policy in place.
- Resuscitation equipment was not standardised across the service.
- There were no role specific competencies in place for staff who cared for children and young people and training compliance across the service was poor and not monitored effectively.
- Auditing did not take place, which meant that compliance against best practice, and patient outcomes could not be monitored.
- There were no dedicated waiting or play areas for children and young people and there was a lack of toys and entertainment available.
- Governance, risk management and quality measurement was not robust. Our concerns were heightened given the safety issues found and throughout the service, it was evident that the provider's policy was not always followed.
- There was a lack of medical leadership for children and young people's services with no multidisciplinary team meetings taking place.

However, areas of good practice included:

- A visibly clean and organised environment and the appropriate use of personal protective equipment.
- Staffing numbers were sufficient and children who were admitted were always cared for by a registered nurse, children's branch (RCN).
- Whilst the service did not monitor access and flow routinely due to the small number of children and young people accessing the service, we found that the patient pathway was seamless.
- Pain relief was effective and given in a timely way and there were suitable patient feedback systems in place.
- The service had not received any complaints.
- Feedback received from children and their parents was positive. Parents said that staff were kind and went above and beyond to support them and their child. Parents said they felt involved in their child's care and treatment and understood the plan of care in place.
- The "Ispire" children's booklet, which included child friendly information about the hospital and its service, was effective to support children to be involved in, and understand, their care.
- There was a clear service vision and strategy in place and feedback from staff about the culture within the service was very positive.
- Staff worked effectively as a team, were dedicated and very passionate about children and young people's services.

Subsequent to the inspection, we served the provider a warning notice on 30 June 2016 under Regulation 13 (Safeguarding service users from abuse and improvement) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and told the provider they must make improvements. We will follow this up and report on our findings.

Inadequate

Services for children and young people

Are services for children and young people safe?

Inadequate

We rated safe as inadequate because:

- Incidents were not being reported as required.
- There was a lack of hand washing observed and children's resuscitation equipment was not standardised throughout the hospital.
- Weighing scales looked dated and had not been serviced recently; these weights were used for children's medicine calculations.
- The ward was not secure and anybody could access it during the hours of 8am to 10pm.
- There had not been an environmental risk assessment for the ward area or any department where children and young people were seen.
- Whilst there was reference to child abduction in two of the provider's policies there was not a specific child abduction policy in place, and staff were not aware of the hospital's policies and procedures in relation to child abduction, nor where they could access
- Compliance with level three safeguarding training was poor across all staff levels and job roles. This included the lead safeguarding nurse.
- Whilst risk assessments of patient rooms were assessed on every admission, this assessment did not include ligature assessment; we observed cords hanging from windows in rooms where children would stay. We raised these concerns to senior managers who took action to remove these cords and implemented a more robust risk assessment

However:

- Staff knew what National Patient Safety Alerts (NPSA) were and told us that alerts were disseminated from the hospital's clinical governance lead and emailed to all staff as required.
- Documentation within patient records was clear, accurate, and legible.
- Ninety-five per cent of all staff were compliant with mandatory training in areas where children were admitted.
- There were sufficient numbers of medical and nursing staff available to meet the needs of children and young people.

Incidents

- There had been no serious incidents or never events reported which involved children and young people. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- Staff were able to describe what constituted an incident and knew how to correctly report an incident using the hospital reporting system. However, staff stated that there had not been any clinical incidents reported for the service in the past 18 months. Records confirmed this. We were concerned about the lack of incidents reported. A senior staff member told us that an incident report form should be completed in the event of an unexpected overnight admission following day case surgery. Records confirmed that in the past 18 months there had been eight children and young people who stayed overnight unexpectedly. Therefore, we were not assured that incidents were being reported appropriately.
- Staff provided an example of a recent incident within another service that had learning implications for children and young people's services. This was an incident involving a pregnancy test not being completed on a female prior to surgery. Staff knew about the subsequent changes to practice that had been implemented. This demonstrated that staff were learning from incidents.
- Staff knew what National Patient Safety Alerts (NPSA) were and told us that alerts were disseminated from the hospital's clinical governance lead and emailed to all staff as required. Staff were able to give an example of a recent NPSA, which involved the need to order new defibrillation electrodes for children.

Cleanliness, infection control and hygiene

- No cases of MRSA or Clostridium difficile (C.difficile) were reported by the hospital from January 2015 to the date of our inspection.
- All areas we visited were visibly clean and tidy.

- Notices throughout the service prompted staff to ensure good infection control. This included a notice, which encouraged staff to keep their uniform or clothing above their elbows and ensure good hand hygiene.
- Staff had access to personal protective equipment (PPE) such as gloves and aprons and alcohol hand gels. Staff were bare below the elbows. However, on observation, staff did not always clean their hands prior to or following patient contact. Therefore, staff were not following national expected infection control standards. The National Institute for Health and Care Excellence (NICE) clearly states that healthcare workers must, "decontaminate their hands immediately before and after every episode of direct contact or care" (NICE, Infection Prevention and Control, Quality Standard QS61). This is because effective hand decontamination significantly reduces incidence of preventable healthcare-associated infections.
- Records reviewed showed that a "hand sanitiser audit" was carried out in all clinical areas twice per year. The audit data was displayed on the hospital's clinical scorecard. Staff were not able to interpret this data when asked and we found it difficult to understand. We were concerned that the "hand sanitiser audit" was limited to measuring the amount of hand gel remaining in dispensers within clinical areas, and it did not include hand washing. The audit was also not service specific.
- Infection control training was part of annual mandatory training. Records confirmed that 95% of staff had completed mandatory training in the last year.

Safety Thermometer

- The service did not use the "Paediatric Safety Thermometer", which is a national tool designed to measure commonly occurring harms in people who use children and young people's services. We were told that this was not an appropriate tool due to the small number of children and young people accessing the service.
- A senior manager told us that the service was in the process of introducing a clinical score card specific to children and young people's services. However, we requested documentary evidence of this and this was not provided. A clinical score card is used to measure clinical performance.

Environment and equipment

- There were no separate waiting areas for children in the outpatient department (OPD). Staff confirmed that children and young people were seen throughout the department. However, effort was made to ensure that children and young people were seen together either at the beginning of the day or at the end to mitigate risks of mixing adult and child areas. There had been no risk assessment undertaken for OPD in relation to areas where children waited and were seen. This meant that we were not assured that all steps were taken to ensure that the environment was safe for children and young people.
- There was also no separate recovery area for children. Staff told us that this was due to the low number of children who were admitted for surgery. One bay in recovery was adaptable to becoming a children's bay as required and had curtains, which were used to separate children and adult areas.
- Children and young people were admitted to the general ward for day surgery and always had single rooms with en-suite facilities. Staff confirmed that they always tried to ensure that children were nursed in the rooms next to the staff desk. This meant that nurses were within close proximity to the children they were allocated.
- Risk assessments were carried out on rooms where children and young people were admitted. We looked at patient records, checked rooms, and found that these assessments had been carried out. Ligature assessments however were not part of this assessment. In both rooms where children had been nursed on the day of our inspection, there was a cord hanging from the window blind. Whilst the cord was relatively short, we considered it long enough to be a ligature risk. We raised this issue with senior hospital managers who responded and took immediate action to remove these in the rooms concerned and implemented a more robust risk assessment. However, we were not assured that only these two rooms were used for children, which meant that children safety could still be at risk.
- We were concerned that anybody external to the hospital could access the ward area during daytime hours. This was because there were no security restrictions between the hours 8am and 10pm. This meant that children were being nursed in an unsecure area during this period. We also walked into the recovery area without seeing any security restrictions.

- We asked for a copy of the hospital's abduction policy for children and young people. The hospital was not able to provide us with this. Senior staff confirmed the absence of this policy. We raised our concerns to senior hospital managers about the access issue and asked them to take immediate action. Whilst there was reference to child abduction in two of the provider's policies there was not a specific child abduction policy in place, and staff were not aware of the hospital's policies and procedures in relation to child abduction, nor where they could access these.
- We asked to see a copy of the environmental assessments for each area where children and young people were seen and cared for. This included the ward, theatres, recovery, radiology, phlebotomy and the outpatients department. Senior managers confirmed that these assessments had not been completed. This was despite it being the provider's policy to ensure that a, "Robust paediatric environmental risk assessment should be completed weekly in every area where children are present and general principles of security of children must be applied at all times." The service was therefore not following the provider's policy titled, Procedures for the Care of Children and Young People at Spire Healthcare, 2016, Issue 13. This meant that appropriate security arrangements were not in place to make sure people were safe whilst receiving care. We raised these concerns to senior hospital managers who took immediate action which ensured that risk assessments were in place for all areas where children and young people attended the hospital.
- Suitable resuscitation equipment for children of all age ranges was readily available and regularly checked. We were concerned however to find that in some areas, such as outpatients and recovery, that this resuscitation equipment was not kept separately from adult equipment. Furthermore, on the ward we found that there were three separate bags of equipment for child resuscitation. This included a "grab bag," a "Broselow" resuscitation bag and a newly introduced "Paediatric Emergency Care" (PEC) resuscitation bag. We checked the provider's policy entitled, Procedures for the Care of Children and Young People at Spire Healthcare, 2016, Issue 13. This stated that resuscitation equipment should be an, "Appropriate, standardised paediatric emergency system which conforms to Resuscitation Council (UK) guidelines." The equipment we observed contradicted the Resuscitation Council's (UK) Guidance (2015) since resuscitation equipment was not "standardised throughout the hospital." This meant that there could have been a delay in emergency treatment if required. One senior member of staff told us that different equipment was being used as only a few members of staff had been trained to use the PEC equipment.
- Equipment that we checked had been portable appliance tested (PAT) where required and all equipment had been recently serviced.

Medicines

- Staff stated that they had not received medicines management training and records confirmed this.
- We reviewed seven children's medicine charts and found that medicine had been prescribed appropriately. Both children's weight and allergy status had been recorded.
- Nurses safely administered medicines. We observed a children's nurse use an up-to-date version of the British National Formulary for Children to double check medicine calculations, and then administer medicine safely based on these calculations.
- Medicines were stored securely and controlled drugs were regularly checked.
- Staff could describe how they would safely dispose of medicines.

Records

- We reviewed seven patient records and found that documentation was clear, accurate, and legible. Where a concern had been identified, for example an allergy, action was taken as a result and then recorded.
- Numerous risk assessments had been carried out before surgery for children and young people. These assessments included moving and handling, pain, skin integrity and medical history. However, there was no safeguarding assessment in the "Child's Daycase/ Overnight Pathway." These pathways also had not been reviewed since January 2014 despite a review date of January 2015 recorded on them.
- Patient records were in written format with the exception of the discharge summary, which was electronic.
- Patient records were stored securely throughout the service.

- Staff said that children's notes were easily accessible and one member of staff stated that they had, "Never had any issues with getting hold of children's records."

Safeguarding

- There had been no reported safeguarding incidents for children and young people's services in the past 18 months.
- There was not a suitable children's safeguarding policy in place. There was reference to child protection procedures within the hospital's Care of children at Spire Wellesley policy (version 3). However, the policy lacked detail on how to refer a child or young person to social services in the event of a safeguarding incident, and failed to provide sufficient information about the local safeguarding children's board and its procedures. Nor did it mention necessary child protection law and guidance. This meant that information about current safeguarding procedures were not robust and therefore not accessible to all staff.
- There was an up-to-date hospital chaperoning policy in place, which was accessible to all staff. Staff on the ward demonstrated that they understood and practised this policy.
- There was a named nurse lead for children's safeguarding within the hospital. Staff confirmed they knew this and told us that they felt well supported by this person. We observed notices throughout the service, which showed a photo of this lead and reminded staff how to contact them.
- There was access to a registered nurse, children's branch (RCN) with specialist safeguarding knowledge at all times during a child's admission. However, we were concerned that not all of these staff members were up-to-date with relevant safeguarding training. The safeguarding lead was not up-to-date with level three safeguarding training. We asked for records to show that this person had either previously received this training or, to show that they were booked on to future training. This information was not provided.
- There were 19 consultants who the provider had agreed could admit and treat children within the hospital. Records showed that out of these 19 consultants only one had provided evidence to show they were compliant with safeguarding level three training. We raised our concerns to hospital managers who confirmed our findings.
- The Royal College of Paediatrics and Child Health published an intercollegiate document in 2014 titled Safeguarding children and young people: roles and competencies for health care staff, which is authoritative advisory guidance. Providers should take into account the Royal College's guidance that all registered nurses, child branch, and consultants caring for children, should be level three trained. Our findings demonstrated that this guidance had not been taken into account to ensure children were protected from abuse and improper treatment.
- Senior hospital managers could not easily identify who in the hospital had received role specific safeguarding training and when. These managers told us that this monitoring was part of their job role. This meant that established systems and processes to prevent abuse of children and young people were not in place because training was not being monitored.
- It was not clear how staff sought advice and support outside of the hours when a registered nurse, children's branch (RCN), was on duty. Staff gave conflicting information. The Care of Children in Spire Wellesley issue 3 lacked sufficient detail on how to refer a child or young person to social services in the event of a safeguarding incident.
- Staff confirmed that they knew what constituted a safeguarding incident and how to responsibly report one.
- Patient records showed that there was no initial safeguarding assessment for children who used the service. Staff confirmed this. The provider's policy; Procedure for the Care of Children and Young People in Spire Healthcare: Issue 13 stated that, "it is the responsibility of every staff member to risk assess every patient on a case by case basis" in relation to safeguarding. As there was no risk assessment documented in patient records we were not assured that any assessments were being carried out.

Mandatory and statutory training

- Staff in inpatient areas stated that they were up-to-date with their mandatory training. Records confirmed that 95% of all ward staff had received mandatory training within the past year.
- Mandatory training included fire safety, health and safety, basic life support, infection control, safeguarding

children level one and two, safeguarding adults, manual handling, compassion in practice, equality and diversity, managing violence and aggression, and information governance.

Assessing and responding to patient risk

- There was an up-to-date policy entitled, Care of Children at Spire Wellesley Hospital which set out safe and agreed criteria for admission of children and young people. The policy stated "Only well children, without pre-existing medical conditions" were accepted for admission. Staff confirmed this. Therefore, all admissions were expected to be low risk.
- All admissions were agreed by the nurse manager and admitting consultant. All pre-operative assessments were carried out by an RCN.
- Paediatric Early Warning Scoring (PEWS) tools were in use in inpatient areas. Records confirmed that these were being completed accurately. When completed, early warning tools generate a score through the combination of a selection of routine patient observations, such as heart rate and blood pressure. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation. The service only used two different PEWS charts, one for aged 18 months to eight years and another for nine to 15 years. Whilst we recognise that PEWS charts and calculations vary between hospitals, the broad age range on either charts meant that there was not appropriate scoring charts available for all age groups as per national guidance. Senior staff confirmed that there was not a PEWS policy for the hospital.
- We reviewed the provider's Patient Transfer Policy. This policy set out procedures for the escalation and transfer of a seriously unwell child. This was necessary in the event that a child's condition deteriorated after surgery. There was a service level agreement (SLA) with a nearby NHS trust to support this policy.
- At all times during a child's admission there was a senior registered nurse, children's branch (RCN) and children's trained anaesthetist with current Advanced Paediatric Life Support (APLS) skills on duty, and records confirmed this. Therefore, there was always suitably qualified staff available to ensure a child could be kept safe up to and during transfer. This was in line with national standards issued by The Royal College of Surgeons (2013).
- Staff confirmed that there had been no transfers of children and young people due to deterioration in the past 18 months.
- Records confirmed that the World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery was used. It was embedded in to the provider's Surgical Safety Checklist. This had been completed thoroughly in all of the seven patient records checked.
- Children and young people were nursed in private closed rooms before and after surgery. We asked staff how children were kept safe at all times when they did not have a parent or carer visiting. Staff told us that the child's parents or carer always stayed with the child and that in the event that the child was left for a period, the nursing staff would make arrangements to ensure that they would stay with the child.
- We saw that when a child was discharged from the service they were given all the relevant contact information for the department should they need advice and support. In the event of an emergency, they were advised to attend their local A&E department or call an ambulance as required. There was also an information leaflet given to the parent or carers, which supported this discussion.

Nursing staffing

- The children's and nursing establishment had been recently calculated and was outlined in the Procedure for the Care of Children and Young People in Spire Healthcare policy. This was one registered nurse, children's branch (RCN) to four children. Staff confirmed that children would not be admitted unless two RCNs were on site.
- There was a suitable process in place to identify staffing requirements when children were admitted. The booking process ensured that once the manager accepted an admission booking, they would only provide the service on the days that there were two RCNs available, and sufficient theatre staff with appropriate children's training and skills in terms of Paediatric Immediate Life Support (PILS).
- There were three permanent RCNs employed by the service, two of which were full time and the other part time. One of the nurses was the service manager and all three nurses provided inpatient services to children. Staff told us that they worked on a flexible shift basis to meet the needs of the service.

Inadequate

Services for children and young people

- There were occasions where children were admitted to the hospital overnight, one example given by staff was due to a child experiencing significant pain following tonsillectomy. In this incidence, staff explained that one of the RCNs did overtime and came in to cover the night shift, whilst the senior nurse was on call if required. This demonstrated that the service could adapt to changes in planned care.
- Children were cared for in recovery by a registered adult nurse, in addition one of the two RCNs were called prior to the child entering recovery so that they were in attendance during the recovery phase.
- Bank and agency staffing was not used.
- We analysed nursing staffing rotas for inpatient areas for the past six weeks and found that there was always a sufficient number of staff on duty to ensure safe care. There was always a good skill mix, two of the three RCNs were senior nurses, and all three were experienced. This meant that all child inpatients received direct nursing care from an RCN and that one of these nurses was responsible and accountable for the duration of the child's pathway.
- There was always a senior RCN on duty Monday to Friday, which ensured access to a children's trained registered nurse should a parent/carer or member of staff need advice.
- The OPD was staffed by adult registered nurses. Staff said that they felt well supported by the children's nurses and worked with them as needed.

Medical staffing

- In total, there were 19 consultants with practicing privileges to admit and treat children at the hospital. There were five paediatric anaesthetists. Medical staff were predominantly employed by other organisations (NHS organisations) in substantive posts and had practising privileges to work at Spire Wellesley. A practising privilege is, "Permission to practise as a medical practitioner in that hospital" (Health and Social Act, 2008).
- Consultant surgeons were responsible for their admitted patients on a 24 hour basis. There was also a resident medical officer (RMO) on site and available 24 hours a day, seven days per week for immediate medical advice. The RMO had at least 6 months paediatric experience.
- There was an SLA in place for 24 hours a day, seven days per week paediatric consultant support, when the lead paediatric consultant was not available. This was between the hospital and local NHS trust. Staff were aware of this arrangement.
- The hospital held quarterly medical advisory committee (MAC) meetings, which were minuted. We looked at the last three meetings minutes and found that a paediatric trained anaesthetist attended as representative for the children and young people's service. A paediatrician, working within the outpatient department, provided an advisory role for the service.

Major incident awareness and training

- The hospital was not a major incident receiving centre and therefore there was no major incident training or policy.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement because:

- Local polices did not always reference evidence based practice, relevant legislation and national guidance.
- There was a lack of system and processes in place to show that the provider was monitoring outcomes for children and young people who used the service.
- Staff competencies were not in place for staff in the outpatient department who cared for children and young people.
- Multidisciplinary team meetings did not occur for the service.

- A senior manager told us that a clinical scorecard specific to children and young people's service had been developed. We requested a copy of this scorecard, however, this was not provided.
- There were no audits conducted for the service and also no evidence to suggest that the service had assessed the need to audit or monitor areas of children and young people's services.
- We were not assured by senior staff that there was an effective process for monitoring of readmission rates for children and young people.

However:

- Patients told us that pain management was effective.
- Nutrition and hydration was appropriately assessed and food choice was good.

Evidence-based care and treatment

- We reviewed five policies, which related to children and young people's services. All of the national policies checked were up-to-date and had review dates on them. The majority of policies and procedures were developed by the Spire group nationally. They were available to staff electronically via the intranet and in clinical areas in paper form. However, some of the local policies did not refer to relevant guidelines and legislation. This included the Care of Children at Spire Wellesley, 2016, Issue 3. The child protection section of this policy did not refer to relevant legislation or national guidance.
- Staff said that all registered nurses, children's branch (RCN) were participants in the national Spire Paediatric Steering Group, which met once to twice per year. This was described as a forum and support group where evidence based care and new guidelines were discussed. Staff confirmed that these meetings were not minuted.

Pain relief

- We reviewed two children's patient records and found that pain assessments following surgery happened regularly.
- Child friendly pain charts were used to assist children to express any pain they were experiencing.
- Parents said that the nurses had regularly assessed their child's pain and given pain relief as required.
- Medication charts we looked at showed that pain relief was given in a timely way. We also observed this as one child was in discomfort following surgery and we saw that the nurse was quick to respond and that the child's pain was managed effectively.

Nutrition and hydration

- On admission, children's dietary needs were assessed and the kitchen informed as required. Food could be provided according to the children's needs e.g. dairy free and age appropriate foods.
- Food and fluid charts were accurately completed in the patient records reviewed.
- Inpatients and their parents or carers received three meals a day from a self-choose varied child and family menu. We observed nursing staff assist children to decide what meal they would like to order. If a child missed a meal then the kitchen could be called at any time for food. Water jugs were provided and were full in both of the patient rooms we checked.
- On the ward, parents and carers had access to tea and coffee making facilities.

Patient outcomes

- A senior manager told us that a clinical scorecard specific to children and young people's service had been developed. We requested a copy of this scorecard, however, this was not provided.
- A senior manager confirmed that children and young people's services did not participate in any national audits. This meant that we were not assured children and young people's care and treatment outcomes were monitored and compared with other services.
- There was also no evidence to suggest that the service had assessed the need to audit areas of children and young people's services.
- We were not assured by senior staff that there was an effective process for monitoring of readmission rates for children and young people.

Competent staff

- Medical staff stated that they had completed their yearly appraisal for the hospital and revalidated their medical registration. This process was conducted by a responsible officer (RO) - a designated doctor based at a local NHS trust. Staff said that if the RO had any concerns about medical staff performance they would feed this back directly to hospital managers.
- Consultants who cared for children were subject to a biennial review of their practising privileges. They were also linked to a nearby NHS trust where they also worked which ensured up-to-date relevant experience and educational opportunities.
- We requested a training matrix for doctors to determine when role specific training and appraisals had taken place. The service provided us with this. However, we found that this was not up-to-date and was not being monitored and acted upon appropriately. Senior managers confirmed this and could not tell us who had received training and when.

- We asked to see the "Practising Profile" for three consultants at random. This outlined their practising privilege rights and displayed training required dependent on job role. This training was limited to paediatric resuscitation and child protection training. One consultant's profile had "not applicable" next to child protection level three training. When we showed senior managers our findings, they confirmed that training needs had not been analysed appropriately.
- Staff confirmed that all registered nurses each had revalidation booklets, which they were working through to support their revalidation process. We reviewed these blank documents, which were thorough. They also had yearly appraisals and twice-yearly one to one meetings with managers. Records confirmed these meetings took place.
- We were provided with a brief training matrix for all registered nurses, children's branch (RCN), which were entitled, Training needs analysis and matrix; paediatric team 2016. Role specific training had been identified, which included level three safeguarding, paediatric pain management, BPLS, Advanced Paediatric Life Support (APLS) and management of ankyloglossia (tongue-tie). This matrix did not include children and young people's competencies or medicines management.
- There was poor compliance with the training requirements identified, for example, none of the RCNs had completed pain management training. Records did not contain dates to show when other training was completed. We asked a manager to confirm when such training had taken place. However, they were unable to tell us.
- Paediatric competencies were in place for nursing staff caring for children in the ward and in theatres, however, not for nursing staff within the outpatient department.
- It was difficult to determine how many nurses who worked with children, young people had completed BPLS, and PILS since the service did not collect this information for each service area. Senior staff we spoke with confirmed that this breakdown of information was difficult to obtain. All staff we spoke with on the ward and in recovery told us that they had received BPLS and PILS training in the past year. One set of training records showed that 75% of ward staff were trained in these subjects.

Multidisciplinary working (in relation to this core service)

- At the time of our inspection there were no multidisciplinary team (MDT) meetings occurring for children and young people's services. However, the manager told us that they were in the process of developing these.
- Staff stated that staff from all services worked well together. We observed that there was a good rapport between staff and specialties.

Seven-day services

- Consultants were on call for the duration of their patient's stay. There was an RMO on site 24 hours a day, seven days a week, and an on call hospital manager, physiotherapist, radiologist, pharmacist, and theatre team at all times.
- The hospital had an SLA with a nearby NHS trust for 24-hour access to consultant paediatrician advice and support and for emergency transfers.

Access to information

- Staff had access to patient details such as personal details and booking information via the hospital computer system. This system was password controlled.
- Patient records were paper based and kept onsite for four months following discharge. There was an accessible external storage centre after this period. Staff stated that they have had no issues with access to patient records.
- The service used electronic discharge summaries, which were sent to the child or young person's GP following discharge. This happened in a timely manner and sufficient information was communicated. Staff explained that the GP would be the main port of call should the hospital need to get in touch with health visiting or community paediatric services.

Consent

- Appropriate child and young people consent forms were in place. Consent forms were correctly completed and appropriately signed in all seven of the patient records we reviewed. We found that one of the consent forms used for a child was an adult consent form.
- Parents confirmed they had been given sufficient information about their child's procedure and had signed the consent form on behalf of the child prior to their operation.
- The hospital had an up-to-date consent policy, which outlined the process for gaining valid consent from

children and young people for examination and treatment. The policy also described, "Gillick competence", which is a legal requirement to determine whether a child had sufficient understanding and intelligence to enable them to understand fully what was proposed.

- Staff were able to describe how to obtain valid consent and assess "Gillick competence" in line with the policy.
- A senior staff member stated that consent training was not part of mandatory training nor had this been identified as a training need for staff working in children's and young people's services. However, records provided demonstrated that consent training is part of the mandatory Mental Capacity Act training, which all staff have to undergo.

Are services for children and young people caring?

Good

We rated caring as good because:

- Feedback received from children and their parents was positive; parents said that staff went above and beyond to support them and their child. We observed staff acting in a caring and sensitive manner to children and their families at all times.
- Parents said they felt involved in their child's care and treatment and understood the plan of care in place.
- The "Ispire" children's booklets, which included child friendly information about the hospital and care provided, were effective to support children to be involved in, and understand their care.
- Staff provided excellent emotional support to children and families.
- The same registered nurse, children's branch (RCN) cared for the child from pre-admission assessment to discharge which ensured continuity of care.
- Staff were seen to be supportive both to children's and the parent's needs.

However:

- The hospital could not provide the results of the patient survey for the past 12 months because the information held about this was not broken down per service.

Compassionate care

- Staff consistently acted in a friendly and caring manner with children and their parents. Staff responded to patient needs promptly and always knocked before entering patient rooms.
- One parent told us that staff were, "Brilliant" and another said, "Everyone has been really attentive."
- Staff gave children and their parents or carers satisfaction surveys on discharge from the ward. We requested the results of this survey for the past year. However, were told that these were not kept by service type and that the results were hospital wide. Therefore past results specific to children's and young people's services could not be analysed.

Understanding and involvement of patients and those close to them

- The two parents we spoke with said that they felt involved in their child's care and understood their child's care plan.
- Children were given a booklet called, I-Spire at the hospital. It included child friendly information about, "all you [the child] need to know about your stay with us." This included things they needed to take to hospital, things to tell their parent or carer such as not to eat anything the morning of the operation, and things they may see. This encouraged children to understand and be involved in their care.
- Parents were also given a variety of written information about the hospital and the care and treatment their child would receive.
- Inpatients had a named RCN and their nursing care was delivered and overseen by this nurse throughout their stay. Parents confirmed they knew who their child's allocated nurse was.

Emotional support

- Staff were compassionate. We observed the ward nurse support a child emotionally when they were upset due to pain following surgery. They were also prompt to respond and provide pain relief.
- Parents said that all staff had been supportive and sensitive to their and the child's needs during the admission. One parent said that the nurse regularly came in the room to check on the parent whilst their child was in theatre to see if they needed anything.

Inadequate

Services for children and young people

- A senior registered nurse, children's branch (RCN), conducted all pre-operative assessments and was also the person who predominantly cared for children and young people on the ward, which ensured continuity of care.

Are services for children and young people responsive?

Good

We rated responsive as good because:

- The service was planned to ensure that registered nurses, children's branch (RCN), cared for children and young people throughout their admission and access and flow was observed to be seamless.
- The service had not received any complaints and it responded appropriately to negative feedback by using the information to improve the service.

However:

- Cancelled operations were monitored through the hospital's risk management system and there had not been any cancelled operations for children and young people between January 2015 and April 2016. However managers were unaware of this data and therefore were not monitoring cancellations for children and young people's services.
- There were no dedicated children's play areas or waiting rooms throughout the hospital.

Service planning and delivery to meet the needs of local people

- The services available to children and young people were privately funded. Therefore, services were planned according to service demand. From January 2015 to December 2015, only private patients were seen by the service.
- Children and young people could access the service through either self-referral or their GP.
- We asked senior staff how children, young people, and their families were engaged and involved in the design and running of the service. This was limited to patient satisfaction surveys. There was not a children's and/or a parents/carers panel or advisory group.
- There were "Child day-case/overnight stay care pathways" for children and young people undergoing elective surgery, which were in use.
- The service mitigated the risk associated with mixing children and adult areas by ensuring that where possible, children's outpatient clinics were run at times where minimal adults were seen and by providing individual side rooms for admission and post-operative care.
- Children were prioritised to be first on theatre lists.
- Senior members of staff said that the service did not monitor and record waiting times for operations and outpatient appointments.
- There were no separate waiting or play areas for children and young people throughout the service. Managers confirmed that there were no plans to introduce these areas in the future.
- Younger children were given teddy bears and bravery certificates to take home if they wanted them.
- If a child required an overnight stay then the hospital provided a bed for the parent or carer so they could sleep in the same room as the child. Parents or carers were provided with meals from the family menu throughout their stay and they could help themselves to tea and coffee facilities.

Access and flow

- Staff stated that because of the low numbers of children and young people seen and admitted at the hospital, there were no problems with access and patient flow. Service activity between January 2015 and December 2015 is displayed in the first section of this report, under the heading, "Information about the service."
- Only well children and young people, without pre-existing medical conditions, over three years of age, were admitted. Therefore, all children on admission were low risk.
- Children were always a priority on surgery lists and were either seen first on the morning or afternoon list, and their admission time would vary according to this. Therefore, children were seen in a timely way.
- Staff reported that bed occupancy was never a problem since admissions were elective and there were no more than four children admitted for surgery per day.
- Parents confirmed that service access, flow was seamless, and that procedures happened in a timely way.

Inadequate

Services for children and young people

- The provider did not monitor the number of cancelled operations for the service. A senior member of staff confirmed this and said that as far as they were aware no operations had been cancelled on any admission day.
- During January 2015 to December 2015 there had been eight overnight stays following surgery, which were not expected. Staff confirmed that because registered nurses, children's branch (RCN) worked flexible hours that shifts were always covered including nights where needed. They also stated that they have never had to transfer a child or young person because the hospital could not provide staffing.

Meeting people's individual needs

- The access criteria for the service meant that children and young people who used the service did not have complex needs.
- Hospital information was displayed on notices in many different languages. Staff had access to a translation service if patients required this.
- Staff wore badges, which displayed their name and job role. On the ward, there was a display board with photos and names of the staff that worked at the hospital. This meant that children and parents or carers were able to recognise their allocated nurse.
- There was a lack of toys and entertainment for all children across the service. This is despite the provider's policy; Procedure for the Care of Children and Young People in Spire Healthcare: Issue 13 stating that all children's areas, "should have access to age appropriate toys and activities", and that children should have, "age/ gender appropriate bedding put in their room". However, children were encouraged to bring in their own toys and entertainment prior to admission.
- Staff encouraged children to bring in their own toys. We did however see that children were given the, I-Spire at the hospital booklet which included, "fun games and all you need to know about your stay with us." There was not an age appropriate alternative for young people however. If young people had an IPad, they could bring it in and the hospital provided free wireless internet connection.

Learning from complaints and concerns

- There had not been any complaints reported for children and young people's services between January and December 2015.
- There were notices throughout departments informing patients about what to do if they wanted to make a complaint. There were also patient information leaflets in each area supporting this process.
- Because there had been no complaints, we were unable to judge whether the service was responsive to such concerns. We did however note that the service was responsive to general patient feedback. One example was that a parent had fed-back that the adult meals were different from their child, which the child did not like. Following this feedback, the service was in the process of introducing new family menus.
- Staff said that if a patient or parent/carer raised a concern to them that they would try to resolve the issue straight away. Alternatively if this was not successful they would give the patient a how to make a complaint leaflet.
- There was a child-friendly inpatient satisfaction survey given to all patients and parent/carers on discharge.

Are services for children and young people well-led?

Inadequate

We rated well-led as inadequate because:

- There was no effective risk management within the service. There were risks that were identified but not managed. For example, the environment did not meet the needs of children and young people and staff had not had not been competency assessed to ensure they could manage children appropriately.
- Throughout the service it was evident that, at times, local policies were not being followed.
- There was a lack of quality measurement within the service. There were no audits undertaken specific to children and young people's services.
- Multi-disciplinary team meetings did not take place for children and young people's services.
- There was a lack of medical leadership for children and young people's service, and children were not well represented at the hospital's medical advisory committee (MAC) meetings.

However:

- There was a clear service vision and strategy, which staff knew.
- The culture of the service was positive and staff worked effectively as a team, were dedicated and very passionate about children and young people's services.
- Staff, children, and their families were engaged with the service and their views assisted service development.

Vision and strategy for this this core service

- The service had a strategy for children and young people's services in the form of a policy entitled, Care of Children at Spire Wellesley. This set out specific goals for the service with a clear service vision and philosophy.
- Staff were able to describe this policy and the service vision.
- There were concise standard operating procedures for children and young people set out in the provider's document: Procedure for the Care of Children and Young People in Spire Healthcare: Issue 13 and the Spire Wellesley version: Care of Children in Spire Wellesley Hospital, 2016, Issue 3. These documents had recently been reviewed, were ratified appropriately, and had a clear review date. Staff we spoke with were familiar with these documents. The manager confirmed that they and the paediatric consultant lead were responsible for the review and updates of these documents.

Governance, risk management and quality measurement for this core service

- The hospital used a general clinical scorecard system, which assisted the monitoring of clinical performance through a red, amber, green coloured system to determine compliance with set standards and risk. However, staff were unable to interpret elements that reflected children and young people's service as the information was not available per service division. A manager told us that a children and young people's specific scorecard had been developed and was being implemented. We requested evidence of this, however, this was not provided.
- There was no effective risk management within the service. This included environments not being secure, a lack of risk assessments for areas where children were cared for, poor compliance with all training including safeguarding training, which was not monitored appropriately, and a safeguarding policy, which was not fit for purpose. Senior staff did not know what a risk register was. We requested a copy of the risk register for children and young people's service; we were told that there was not one. This meant that there was not a robust system to record and manage risks specific to the service.
- There was a lack of quality measurement within the service. There were no audits undertaken specific to children and young people's services. Records and senior staff confirmed this. Therefore, there was no system to monitor quality and systems to identify where actions should be taken. This was despite the provider's policy Procedure for the Care of Children and Young People in Spire Healthcare: Issue 13 stating that, "Regular multi-professional clinical audit will be undertaken," and that, "the local hospital audit programme should include children's services at least on an annual basis."
- Senior hospital managers were responsible for managing and monitoring service level agreements (SLAs) with other providers. Records confirmed that this occurred.
- The RCN lead attended three monthly hospital-wide clinical governance meetings and represented children and young people's services. There were also monthly head of department meetings, which they attended. These were held monthly and both meetings were minuted. We reviewed the minutes of the last three meetings.
- Regular children's and young people's service meetings were held for registered nurses, children's branch (RCN) and these were minuted. However there was no set agenda for the meetings, the minute meetings were brief and we found that action was not always taken as proposed at the meeting". This included the action within the meeting minutes of 21 February 2016 which read: "The Hospital has taken full delivery two new Paediatric Emergency Systems, as replacement to the old Broselow bags, which will be decommissioned from use by 30/03/2016". However we found that Broselow bags were still in use during our inspection in May 2016.
- Staff stated that all RCNs participated in the national Spire paediatric steering group, which was described as forum that met once to twice yearly. We asked for records to confirm this. However, we were told that these were not kept.
- A senior member of staff told us that registered nurses, children's branch (RCN) were linked to a local NHS

paediatric unit and visited on occasions to get ideas to improve children and young people's services at the Spire Wellesley Hospital. This was informal and no record was maintained to evidence this.
- The service did not hold multidisciplinary team (MDT) meetings. A senior member of staff told us that they were planning to introduce these in the future.

Leadership / culture of service

- Children's and young people's services were led by a senior manager who was a qualified RCN. There was also an inpatient senior RCN who worked and took lead on the ward and undertook pre-admissions.
- We asked the children and young people's lead who the medical lead was for the service. They informed us that there was no dedicated medical lead. However, a paediatrician provided an advisory role for the service. This was a passive role; this individual did not undertake surgical procedures at the Spire Wellesley but worked within the outpatient department only. They reviewed children and young people policies and guidelines. They provided advice on matters relating to the service but did not attend the medical advisory committee.
- Our concerns were heightened since the only representative for children and young people's services attending the hospital's medical advisory committee (MAC) was a paediatric anaesthetist.

Culture of the service

- Staff were dedicated and passionate about the service they provided to children and young people at the hospital.
- All staff stated that they enjoyed their job and that they felt well supported in their role. One staff member told us they, "Loved working at the hospital," and another said, "It's a brilliant job and we provided excellent care to children and their families, they are central to everything we do."
- Staff felt they were able to freely raise concerns if needed. They also knew about the provider's whistle-blowing policy.
- There was an effective system in place, which ensured that parents and carers clearly understood the terms and conditions of the services being provided to their child, and the amount and method for payment of treatment were transparent. Parents we spoke with confirmed this.

Public and staff engagement

- There were regular staff meetings and relevant information was disseminated from managers. This information was also electronic via emails and the intranet.
- Staff told us that they felt actively engaged in the service and that their views and ideas were used in the planning and delivery of the service. One member of staff said that it was their idea to introduce "grab bags" for children's resuscitation. We observed that these bags were in use.
- Staff gave out patient satisfaction surveys to children and young people and to their parents or carers on discharge. Whilst we observed that that completed surveys were reviewed by the manager, there was no record that this took place.

Innovation, improvement and sustainability

- Staff of all levels were asked about innovation, improvement, and sustainability. Examples included introduction of resuscitation "grab bags" and family food menus. Staff did not provide us with any other examples.
- Three members of theatre staff had been selected for further training in advanced paediatric life support to increase the number of staff trained per shift.
- The service used the ISpire at the hospital booklet which included, "fun games and all you need to know about your stay with us." Younger children were given teddy bears and bravery certificates to take home if they wanted them.
- Continuity of care for admitted children and young people was excellent. A senior RCN conducted all pre-operative assessments and was also the person who predominantly cared for children and young people on the ward which ensured continuity of care. This included follow up telephone calls following discharge.

Good

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Good

Information about the service

The Outpatient and Diagnostic Imaging department at Spire Wellesley consists of two areas on the ground floor of the hospital, the main outpatient area, and the Pier Suite. The outpatient area has 14 consultation rooms, a phlebotomy room, and a minor injuries room. The Pier Suite has eight consultation rooms and a health assessment room. There is a separate reception and waiting area for the diagnostic imaging department.

The outpatient department supported the large number of specialities treated within the hospital, such as cosmetic surgery, gastroenterology, gynaecology, orthopaedics, paediatrics, pain management, rheumatology, and urology.

Diagnostic imaging services included a computerised tomography (CT) scanner, mobile x-ray, a magnetic resonance imaging (MRI) scanner, plain-film, fluoroscopy and ultrasound.

Between January and December 2015, there were 53,703 patient appointments consisting of 18,802 initial appointments and 34,901 follow up appointments. NHS patients accounted for 22% of first appointments and 43% of follow up appointments. Children accounted for 3% of the overall number of appointments.

All areas of outpatients and diagnostic imaging were visited as part of the inspection. We spoke with four patients and 23 members of staff, including nursing staff, consultants and allied health professionals. We reviewed 12 patient records and analysed information provided by the hospital.

Summary of findings

Overall, we rated the Outpatients and Diagnostic Imaging service at Spire Wellesley Hospital as good because:

- There was evidence of clinical practice changing to enhance patient safety following a reported serious incident in another department.
- There were processes in place to ensure equipment was checked, serviced and ready for use.
- There was a process in place to ensure oversight of each consultant's practising privileges, and scope of practice by the medical advisory committee (MAC).
- Patients were seen and treated within national guidance timeframes.
- Radiology and pathology reports and results were available to appropriate staff via secure electronic systems.
- Patients were very happy with the level of care they received.
- Staff's interactions with patients were polite, friendly, and helpful.
- The hospital was mindful of the needs of patients from various religions and backgrounds and translation services were available.
- "You said, we did" notices were displayed in patient waiting areas showing changes made as a result of complaints received.
- Lessons learnt from complaint investigations were shared with staff through regular team and committee meetings.

However:

Good

Outpatients and diagnostic imaging

- Patient records were not always fully complete or legible.
- Hospital policies were not up to date and did not reflect best practice.
- Incident reporting was minimal within the diagnostic imaging department

Are outpatients and diagnostic imaging services safe?

Good

We rated safe as good because:

- Staff could describe what constituted an incident and provide examples. There was evidence that practice had changed following a serious incident.
- Learning from incidents was shared with all staff via email or via the monthly team meetings held in departments.
- Staff understood their responsibilities under the duty of candour, and records confirmed that this practice occurred, as required.
- There were processes in place for maintenance and testing of equipment to ensure it was safe to use.

However:

- Records were not always fully complete or legible.
- Incident reporting was minimal within the diagnostic imaging department. Staff we spoke with stated that there had been no incidents or near misses reported in the past 10 years.
- Staff did not record medicine fridge temperatures consistently and appropriate escalation did not occur when temperatures fell outside recommended parameters.
- Most areas of the outpatient department were visibly clean and tidy however there were issues found within two areas, the plaster room and one consultation room.

Incidents

- The hospital had an electronic incident reporting system. Staff also had the option of completing a paper incident report which their line manager would upload with them on the incident reporting system.
- The hospital had reported, no 'never events' between January and December 2015. A never event is 'a serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined'.
- The hospital had reported a serious incident in January 2016 that involved failure to undertake a pregnancy test prior to surgery. Following investigation, policy

amendments ensured that all women of childbearing age were pregnancy tested prior to surgery. Outpatient staff stated this was happening, and monitoring was undertaken as part of the quarterly clinical scorecard measures. Data provided demonstrated 100% compliance in January, and 96% compliance in February 2016.

- Outpatient staff could provide recent example of incidents which had occurred in other departments and stated they received information and learnings via hospital emails or discussion at monthly departmental meetings. Monthly safety bulletins were sent to heads of department and consultants.
- We were concerned about the lack of incidents reported within diagnostic imaging. Staff we spoke with stated they had not reported any incidents in the past 10 years. Data available at the time of inspection demonstrated very limited reporting.
- Staff within outpatients were aware of duty of candour requirements.

Cleanliness, infection control and hygiene

- Patient waiting areas in outpatients were visibly clean and tidy. Hand sanitizer gel was available at reception entrances.
- Staff had participated in a hand hygiene audit in 2015 which was carried out by the Infection Prevention and Control Lead (IPCL). This was a practice-based audit where the IPCL observed each member of staff washing their hands and then assessed the effectiveness of this with the member of staff. We were informed post inspection that the IPCL then discussed handwashing techniques with staff involved in the audit to improve their individual practice.
- Daily cleaning schedules were in place to monitor room cleaning in the outpatient department. However the plaster room was not visibly clean. There were dead insects on the windowsill and the surrounding area was visibly dirty and dusty.
- Within the main outpatient area, a dressing trolley in consultation room six contained a cardboard tray stained with dried fluid.
- Records showed that there had been no incidences of Clostridium difficile (Cdifficile), Methicillin-sensitive Staphylococcus aureus (MSSA), or MRSA within the reporting period January to December 2015.
- Within diagnostic imaging, the changing and waiting areas for radiology services were visibly clean. There were disposable fabric curtains in patient changing areas outside the main x-ray and fluoroscopy waiting areas to help reduce the spread of infection.
- Phlebotomy and minor operation rooms both had vinyl flooring, and disposable blue curtains to allow for regular cleaning and decontamination.

Environment and equipment

- Staff told us that there were three ear nose and throat (ENT) consultants who brought their own equipment into the outpatient department for use within consultations. There was no effective system in place to monitor that this equipment was serviced regularly and safe for use. There was a hospital policy to cover use of personal equipment, but this was five years and three months out of date. We highlighted this with the senior management team and the policy was reviewed and updated prior to the unannounced inspection on 31 May 2016.
- The majority of equipment used within the outpatient department was disposable. Staff sent re-usable equipment to the hospital central sterilisation department (CSSD) for decontamination and sterilisation.
- There was a process for maintenance of equipment and service records were in place to ensure patient safety. We reviewed 24 pieces of equipment in the outpatients department; all were in date for maintenance.
- Lead aprons and shields were available for use by staff and patients within diagnostic imaging for protection against radiation exposure. Staff wore dosimeters, which were monitored monthly, to ensure that staff were not exceeding safe radiation dose levels.
- Radiology changing rooms for patients had lockers to enable patients to store clothes and valuables securely whilst being imaged.
- The annual Patient Led Assessment of the Care Environment (PLACE) completed in February to June 2015 showed that the hospital exceeded the England score in all four areas: cleanliness; privacy dignity and well-being; condition, appearance and maintenance.

Medicines

- Systems to ensure medicines were stored at appropriate temperatures were not effective. Staff did not accurately

record medicine fridge temperatures and had not escalated when temperatures exceeded the recommended range. We highlighted this to the nurse in charge, who took immediate appropriate action.
- Prescription pads were stored securely within the nurses' office in a locked cupboard in the main outpatient area.
- Diagnostic imaging staff confirmed that there were five patient group directions (PGDs) in use within the department. PGDs allow specified health care professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition, without the need for a prescription or an instruction from a prescriber. Examples of PGDs used included; injections containing saline, contrast media injections for imaging, magnetic resonance imaging (MRI), computerised tomography (CT).
- Medications were stored securely within the diagnostic imaging department with the senior radiographer on shift having control of the keys.

Records

- A small number of Consultants kept outpatient medical notes for patients, including the initial referral letters, off site. However, the hospital has a process in place in order to access these documents on request.
- Data provided by the hospital stated 22% of consultants did not use the medical records service. The hospital approved a single patient record plan, dated May 2015. This plan also identified a lack of internal traceability of records. Actions in this plan were vague, for example one action was to contact identified consultants "and engage around converting to Spire held OPD records". Implementation of a bar code scanning system to allow full internal tracking and audit of system was an action with a target date of July 2016.
- Security of medical records was not robust. Patients' notes were in an unlocked notes trolley, in an unlocked consultation room. Computer screens were not locked leaving patient information accessible. This meant that there was a risk that patient identifiable information could be accessed and confidentiality breached. Staff had not identified this as a risk. Following the inspection, the hospital managers took action to address the concerns highlighted.
- The 2016 audit plan details a range of medical records audit, all of which are performed on a quarterly basis and reported through the clinical scorecard.
- Outpatient notes were not always fully complete or legible. Of 12 sets of notes reviewed 10 were legible with entries dated, two were not legible and only eight were signed by the clinician providing care or treatment.
- In the main consultation rooms there were guidelines displayed for consultants regarding information governance (IG) dated April 2013. These had not been reviewed to ensure that the information was current.

Safeguarding

- Records confirmed that staff had received relevant safeguarding training for adult patients. Staff could describe what constituted a safeguarding incident and stated that they would escalate concerns to the safeguarding lead or matron.
- Within The Pier Suite outpatient waiting area, there was a hospital noticeboard, which contained contact details and photos for the safeguarding children and safeguarding adult's leads.
- Data provided demonstrated that between January and March 2016 61% of outpatient staff and 100% of diagnostic imaging staff had completed level two safeguarding children's mandatory training, which exceeded the quarterly trajectory of 25%.

Mandatory training

- Mandatory training included fire safety, infection control, safeguarding adults and children, manual handling, compassion in practice, equality, and diversity and information governance.
- Compliance for outpatient and diagnostic imaging staff was 78% as of March 2016. This was significantly higher than the quarterly trajectory of 25%.

Assessing and responding to patient risk

- Diagnostic imaging staff told us that imaging procedures where patients required sedation occurred in theatres where an anaesthetist would be available. All procedures conducted on the ground floor were procedures completed under local anaesthetic.
- There were illuminated warning notices activated outside each imaging room to alert patients and staff that an x-ray was in progress.
- A local policy for transfer of a deteriorating patient to a nearby NHS trust had just been implemented (issue one of the policy was dated 9 May 2016). Review of the clinical risk team meeting minutes from 11 April 2016

identified that a meeting had taken place between the hospital senior team and the identified local NHS hospital and some amendments were due to be made to the policy prior to final agreement.

Nursing staffing

- There were 8.2 whole time equivalent registered nurses and 7.8 whole time equivalent healthcare assistants employed within the outpatient department. There were no nursing vacancies within the outpatient service as of January 2016. Staffing skill mix within the outpatient department consisted of 49% nurse managers, 45% nursing staff and 6% health care assistant.
- Senior nurses reviewed clinic lists weekly, and then on a daily basis, to plan and ensure that a sufficient number of suitable staff were on duty at all times.
- The nursing staff worked flexibly to provide cover for the clinic requirements with the occasional use of regular bank staff to cover any gaps. We reviewed recent rotas that demonstrated that approximately three shifts per week were covered by bank staff. Bank staff received a local induction.
- Radiographers were available on site and provided diagnostic imaging services Monday to Friday between the hours of 8am and 8.30pm.

Medical staffing

- There were no consultant members of staff directly employed by the hospital, they provided their specialist services by working under the hospital's 'practising privileges', which were regularly reviewed with the medical advisory committee
- Consultants were available within the outpatient department between 8am and 8pm Mondays to Fridays and on Saturday mornings.
- There was a resident medical officer, (RMO) present in the hospital, to provide immediate medical advice when required.

Major incident awareness and training

- There was a business continuity plan in place, which covered emergencies such as floods and fire, and staff knew how to access this documentation. Staff we spoke with stated that they had not received major incident training.
- The hospital had a policy entitled, Power failure process, which was listed as version three and had been update in April 2016.

Are outpatients and diagnostic imaging services effective?

We do not currently rate outpatient and diagnostic imaging services for effective. However, our findings demonstrated:

- Policy management was not effective. Timely review of policies did not take place and did not reflect the latest national best practice.
- Clinical supervision was not undertaken consistently.

However:

- Local audits were undertaken with actions identified to improve service delivery.
- Records confirmed that outpatient and diagnostic imaging staff were 100% compliant with achieving their annual appraisal within 2015.
- Radiology and pathology reports were available to all necessary staff via secure electronic systems.

Evidence-based care and treatment

- Local policies were out of date for review and therefore it could not be assured that latest national best practice guidance was reflected. We saw examples of policies not containing guidance released as far back as 2002. 16 out of 18 policies reviewed within the outpatient department were out of date with the majority due for review in 2013. Senior nursing staff acknowledged the large number of out of date policies, and stated they were working with the governance lead to address this.
- Clinical guidelines and hospital operational procedures were stored in hard copies located within lever arch folders within the staff dining area but these were not kept up to date. For example one policy had been noted as "withdrawn" from the folder index without any reference to the new or replacement policy. Staff stated that policies were available electronically on the hospital intranet. However, there was some delay in staff finding the policy updates when requested.
- Monthly Spire bulletins were circulated to heads of departments and contained information such as safety alerts from the Medicines and Healthcare Regulatory Agency (MHRA) and Medical Device Alerts (MDA).

Good

Outpatients and diagnostic imaging

- The hospital achieved 93% compliance within the 2015 radiation protection supervisors' regulatory quality audits, this showed that national and local guidance was being followed appropriately to protect patients and staff from avoidable harm.
- We saw evidence of diagnostic imaging quality assurance audits being completed within 2016, this ensured that the safety of equipment had been tested and where any actions were required, these were developed into an action plan and monitored.

Pain relief

- Pain relief patient group directives were not used within the outpatient department. However, these were used within diagnostic imaging to ensure prompt response to patient need.
- Consultant-led pre-assessment outpatient clinics reviewed and managed patient pain effectively.

Patient outcomes

- Local audits were undertaken. We reviewed two outpatient audit reports for record keeping and pre-procedural pregnancy testing which had been completed within 2016. These had been analysed and an action plan created to improve service delivery.
- The Spire Clinical Scorecard benchmarked patient outcomes across the network of 38 hospitals. This cross-hospital benchmarking promoted a healthy competitive culture, with the overall aim of providing the highest possible level of patient care.

Competent staff

- Nurses and health care assistants completed regular competencies specific to their job role. Health care assistant competencies included; chaperoning, point of care testing, aseptic non-touch techniques, safeguarding children and adults, and medical devices.
- The interim outpatient manager confirmed that clinical supervision was available to support staff on request. External training was available for staff if was identified within their 'Enabling Excellence' annual appraisals.
- Data provided showed that 100% of outpatient and diagnostic staff had completed their annual appraisal for 2015.There were monthly reflective practice sessions, which included revalidation discussions for outpatient nursing staff, who confirmed they found these supportive. Consultant's fitness to practice and appraisal were reviewed annually in order to maintain practicing privileges at the hospital.

Multidisciplinary working (related to this core service)

- Weekly hand clinics involved multi-disciplinary input including a consultant, a nurse, and a hand therapist.
- Where possible one-stop clinics were held for patients to enable them to see multiple specialists about their treatment in one hospital visit. An example given was that of mammography clinics, where patients could receive consultation and the necessary diagnostic procedures at the same time as their consultation thus preventing the need for multiple appointments.

Seven-day services

- Outpatient services were provided six days a week from Monday to Saturday and radiology services were available Monday to Friday.
- There was an on-call system available for out-of-hours outpatient treatment concerns and there was an on-call system available for out-of-hours plain film diagnostic imaging in the event of an inpatient emergency.
- The onsite pharmacy located within the Pier Suite was open between 9am and 5pm Monday to Friday each week. Outside of pharmacy core working hours, matron and the RMO could access the department to gain medications should it be required.

Access to information

- Diagnostic images and reports were available electronically on the picture archiving communication (PAC) system, to the appropriate members of staff via a password system.
- The diagnostic imaging manager confirmed that radiologists reported on plain film x-rays within 24 hours which meant that referring consultants could review the report promptly in order to make a diagnosis for their patient.
- Pathology results were available electronically for staff to access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Outpatients and diagnostic imaging

- There were two standardised consent forms used for adults undergoing invasive and diagnostic procedures. We reviewed 12 sets of patient notes, two of which had completed consent forms.
- Nursing staff stated that for minor procedures, such as taking blood, verbal or implied consent would be appropriate however minor operations would require written consent to be obtained from the patient. We raised concerns during the inspection that written consent had not been undertaken for a procedure involving injection into the joints and nor had any consideration been made to the capacity of the patient.
- Department of Health guidance 2009 states, "For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question. Although completion of a consent form is in most cases not a legal requirement the use of such forms is good practice where an intervention such as surgery is to be undertaken." We were not assured that the hospital provided clarity or training to staff for the appropriate recording of consent in line with best practice guidance.
- Senior staff took action following our concerns to improve practice. This included ensuring clinicians were aware of the recommendation to document verbal consent where this is relied upon for minor procedures and instructions for all documents attached to referrals to be printed off and used for referral assessment.
- Nursing staff in the outpatient department were not familiar with the Mental Capacity Act (MCA). When questioned examples provided by staff included "poor care on the ward," and "child protection".
- There was a policy entitled Restraint of confused/ disturbed patient dated August 2015. We considered this title of policy to be inappropriate. The use of the term "Disturbed" is not respectful and dignified when describing a patient who lacks mental capacity. Following review this policy was found to be a theatre policy and was removed by senior staff once brought to their attention.
- Staff were not clear regarding Deprivation of Liberty Safeguards. There were two versions of a Deprivation of Liberty Safeguard policy found on display during the inspection. When questioned the senior managers were not sure which the appropriate version was or where these had originated from.
- Following concerns raised the hospital arranged two additional face to face sessions with members of the Spire legal team to cover Deprivation of Liberty Safeguards and 43 staff attended the session.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because:

- Patients were very happy with the level of care they had received.
- Staff interactions with patients were polite, friendly, and helpful.
- Patients had access to 'please talk to us leaflets' in waiting areas to feedback on their care and treatment experiences.

Compassionate care

- Patients were happy with the level of care they had received. One patient said that staff were always friendly and welcoming. They said that they were very pleased with the care provided and could not fault anything.
- We observed reception staff discussions with patients and found them to be polite, friendly, and helpful. Staff treated patients with dignity and respect. Staff were aware of the need to lower their voices to promote confidentiality in an open waiting area.
- There were chaperone service notices in patient waiting areas. Consultation rooms had a pager system to request chaperone assistance for patients. This rang through to the staff desk and a health care assistant or nurse would attend to support the patient. In two of the 12 sets of records reviewed staff had recorded that chaperones had been utilised.

Understanding and involvement of patients and those close to them

- 'Please talk to us' leaflets were available in waiting areas for patients to provide feedback on the care and treatment they had received.
- A senior hospital manager sent an acknowledgment letter to every patient following receipt of a completed patient survey. The hospital website also had a patient feedback and complaints link.

Good

Outpatients and diagnostic imaging

Emotional support

- Feedback from patients confirmed that staff provided emotional support when required to help them cope emotionally with their care and treatment.
- Written information leaflets were available within the outpatient department to inform patients of varying conditions and forms of treatment.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good because:

- There were no waiting lists for patients attending outpatient clinics.
- Patients generally had short waiting times once they had arrived in outpatient clinic and diagnostic imaging.
- Appointment letters provided full contact details and information prior to the patient visit.
- A variety of drink options, reading materials and television were available for patients in waiting areas.
- Translation services were available for patients and relatives.
- The hospital had spoken with representatives from the Jehovah's Witness faith and had information for staff and patients, for patients non-consenting to blood transfusion.
- "You said, we did" posters were displayed in patient waiting areas showing changes made as a result of complaints received.

However:

- Staff were unaware of the red flag system, described on the patient notice board within the Pier suite, to demonstrate when patients may require additional assistance.
- There was no formal system for monitoring if patients were happy with complaint investigations.

Service planning and delivery to meet the needs of local people

- There were specialist outpatient clinics running that included audiology, gynaecology, orthopaedics, paediatrics, and cosmetic surgery.
- The main outpatients department ran clinics into the evenings to enable patients to attend the clinic outside of working and school hours.
- Spire Wellesley had a service level agreement in place to undertake treatment of NHS patients within a set specialty agreed between the hospital and the local NHS trust. This showed collaborative working to reduce patient waiting times and improve access to treatment.
- The hospital had outgrown its original footprint and planning permission had been granted to extend and build a separate administration building. This would then enable a further six consultation rooms.

Access and flow

- Outpatient and diagnostic imaging both consistently exceeded the target of 92% of patients receiving their referral to treatment within 18 weeks between January and December 2015.
- Any patients who did not attend (DNA) an appointment, were followed up by a phone call from the business administration team, to ensure that they were safe and to rearrange an alternative appointment date if applicable.
- A patient having a computerised tomography (CT) scan stated they had waited only one week between consultant appointment and scan appointment, which they were happy about.
- Two of the four patients we spoke with in the outpatients department said that they had never had to wait more than 10 minutes for their appointment once they had arrived in the waiting room. The third patient told us about a delay with their appointment, the patient told us that the reception staff did not offer an explanation but the consultant apologised.

Meeting people's individual needs

- Information sent to patients ahead of their appointments was appropriately informative. Appointment letters confirmed the appointment dates, the name of the consultant, contact details for the hospital reception, and provided information about fasting protocols for patients undergoing a general anaesthetic.
- Magazines and hot drinks were available for patients in waiting areas.

Good

Outpatients and diagnostic imaging

- The hospital spoke with an advisor from the Jehovah Witness faith and provided information for both patients and staff following a patient's non-consent to a blood transfusion.
- A telephone translation services was available for staff to access. This helped ensure patients and relatives could clearly understand important elements of clinical conversations. The human resources department held a list of staff members who could speak other languages and provide informal translation support. Managers told us that staff would not interpret for patients.
- In June 2015 a red flag system was introduced to demonstrate when patients may need additional assistance for example with mobilisation or educational support. There were documents displayed on the patients' notice board within the Pier Suite outlining the flag system. However, when questioned staff were not aware of this and could not describe the system. Following inspection senior managers stated that this was applicable to ward areas only and removed all reference to the flag system from the notice boards in the Pier Suite.
- The hospital provided patient access to the internet via a wireless network, so that patients could remain in contact with their relatives and social media.
- Wheelchairs were available at outpatient entrances for use by patients.

Learning from complaints and concerns

- Complaints leaflets detailing how to make a complaint within the hospital were available in outpatient areas.
- "You said, we did" complaint and incident posters were available in patient waiting areas to demonstrate actions taken following notification of when things had gone wrong.
- The hospital had responded to patient feedback about parking limitations. Staff parking was moved off-site and a request had been made to the council to extend the parking footprint of the hospital.
- There was no formal system for monitoring if a patient was happy with a complaint response.

Are outpatients and diagnostic imaging services well-led?

Good

We rated well-led as good because:

- Staff were aware of the hospital vision and values
- Staff felt that the culture of the service was open and honest.
- There was a risk and governance structure in place. We reviewed two root cause analysis (RCA) arising from serious incidents in relation to the outpatient department. Learning outcomes were identified and remedial actions taken.

However:

- Incident information was provided to heads of department regularly however the senior team had not raised any concern that the imaging department had minimal reporting in the past 10 years.
- Processes were not effective to ensure that policies were up to date and aligned to best practice guidelines.

Vision and strategy for this this core service

- Spire Wellesley's vision was "To be recognised as a world class healthcare business."
- The six values the hospital were to provide care, succeed together, drive excellence, do the right thing, deliver on their promises and keep things simple. Staff we spoke with were aware of the hospital's values.

Governance, risk management and quality measurement for this core service

- Incident information was provided to heads of department regularly however the senior team had not raised any concern that the imaging department had minimal reporting in the past 10 years
- The outpatient and diagnostic imaging department sit under the hospital-wide risk framework. Members of senior management were individually accountable for risk content and heads of department were responsible for the risk controls implemented

Good

Outpatients and diagnostic imaging

- We reviewed a root cause analysis (RCA) from a serious incident reported from the outpatient department. Learning outcomes were identified and remedial action taken.
- We reviewed a second RCA following an incident where a patient was not given a pregnancy test before undergoing a gynaecology procedure in the outpatient department. There was no Spire guidance or policy around pregnancy testing before minor gynaecological procedures in outpatients. After the incident actions were taken to implement a pregnancy test in local guidance, notify all relevant consultants and amend the pathway for patients undergoing these procedures. Notification was also made to the Spire central team to consider whether a national change may be required
- Processes were not effective to ensure that policies were updated in a timely manner and aligned to best practice guidelines.
- There was a process in place to ensure oversight of each consultant's practising privileges, and scope of practice by the medical advisory committee (MAC). MAC meeting minutes confirmed that on review, if it was found that any consultants had not provided relevant information such as their annual appraisal, they would have their practicing privileges suspended until the appropriate documentation was produced.

Leadership / culture of service

- Outpatient and diagnostic imaging services were led locally by a head of department that reported to the senior management team.
- Staff told us that they felt that they worked in an open and honest culture and that they were supported by their line managers.

Public and staff engagement

- There was a 'meet our staff' photo board within the outpatient area behind the staff nurse desk, but this was blank and did not contain any staff photos for patients to recognise staff members.
- Patients and relatives had access to recent patient survey results. Results of the March 2016 patient satisfaction survey were provided as hard copy documents for patients or relatives to access on the Pier Suite notice board within the patient waiting area.

Innovation, improvement and sustainability

- Senior staff told us about a discussion group to support staff through the nursing revalidation process, they told us this was received well by more junior members of the team.

Outstanding practice and areas for improvement

Outstanding practice

We saw several areas of good practice:

- The care provided by staff to patients and their relatives was seen to be compassionate, kind and dignified.
- Feedback about the service from patients and relatives was consistently positive. 2015 friends and family data demonstrated that between 99% and 100% of patients would recommend the hospital.
- The service benefited from a committed and loyal workforce that understood the vision and strategy for the hospital.
- There was strong local leadership within the oncology service.
- Nursing documentation was clear and up to date with all necessary care plans and risk assessments having been completed.
- Patients felt their pain was managed effectively.
- There were clear and understood procedures in place to support people, living with a learning disability, when they accessed the service.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that a safeguarding children policy and an abduction policy are developed and implemented. These must reflect the requirements of the local children's safeguarding board and other relevant local and national guidance.
- The provider must ensure that processes are in place to ensure appropriate safeguarding risk assessments are undertaken for children and young people accessing services.
- The provider must ensure that all staff working with or responsible for children and young people are trained to the appropriate level for safeguarding children and young people.
- The provider must ensure that there is an effective governance system which yields sufficient management oversight of all the services provided at the hospital.
- The provider must ensure there are effective systems which allow it to assess, monitor and improve the quality and safety of all services
- The provider must ensure there is an effective risk management system to protect the health, safety, and welfare of service users and others who may be at risk.
- The provider must ensure that records are stored securely at all times and that consultant entries are legible and contain all relevant information

Action the provider SHOULD take to improve

- The provider should consider the environment where children and young people are cared for so it meets their needs with a separate waiting area and age appropriate materials.
- The provider should consider reviewing the arrangements in place to ensure the appropriate storage of medicines and blood products.
- The provider should consider reviewing the prescription arrangements in oncology where there were two systems running.
- The provider should consider reviewing infection control arrangements in relation to effective hand hygiene practices.
- The provider should consider improving staff awareness of the needs of patients living with dementia and for patients whom may need a translation service because their first language is not English.
- The provider should consider improving the level and quality of competency checks provided to staff to ensure they remain competent in their roles.
- The provider should consider additional training for all staff to ensure understanding and practical application of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good governance and in particular 17- (1) and (2) (a), (b) (c) and (d) which state: 17(1) System or processes must be established and operated effectively to ensure compliance with the requirements in this part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to – (a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity. (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decision taken in relation to the care and treatment provided (d) maintain securely such other record as are necessary to be kept in relation to (i) persons employed in the carrying on of the regulated activity, and (ii) the management of the regulated activity;

This section is primarily information for the provider

Requirement notices

How the regulation was not being met:

Robust governance arrangements were not in place. There were no established systems and processes in place to ensure staff were working in line with best practice and up to date guidance.

Local service policies, standard operating procedures (SOPs) and flowcharts were not up to date and the process for review was unclear.

There was poor management in relation to monitoring, analysing and learning from incidents.

Root cause analysis (RCAs) and subsequent actions plans were not always completed in detail. Root causes were not always identified which meant potential additional actions were missed.

Effective risk management procedures were not in place. The hospital risk register lacked detail.

Patient records were left unattended and computer screens were not locked which meant security of patient information was vulnerable.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 Safeguarding service users from abuse and improper treatment (1) and (2) and (3) which states: (1) Service users must be protected from abuse and improper treatment in accordance with this regulation. (2) Systems and processes must be established and operated effectively to prevent abuse of service users. (3) Systems and processes must be established and operated effectively to investigate, immediately upon becoming aware of, any allegation or evidence of such abuse. We found that there was not a suitable children's safeguarding or abduction policy in place. Compliance with level three safeguarding training was poor across all staff levels and job roles. This included the lead safeguarding nurse. There had not been an environmental risk assessment for the ward area or any department where children and young people were seen. Established systems and processes to prevent abuse of children and young people, such as monitoring of training and risk assessments were not in place.