St Anthony's Hospital

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Not sufficient evidence to rate
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

This inspection was a focused inspection covering only two services: children and young people's services, and critical care. These two services were not operating at the time of our previous inspection in September 2016. The inspection of these two services has resulted in a change of the overall rating of the hospital given at the previous inspection, from requires improvement to good.

Both services were very small scale and we did not consider we had enough evidence to rate effectiveness and caring.

Our key findings are as follows:

We found good practice in relation to children's services:

- The service managed staffing effectively in relation to activity. There were enough staff with the appropriate skills, experience and training to keep children and young people safe and to meet their care needs.
- There was a lead consultant and lead anaesthetist for children and young people.
- We found high standards of cleanliness
- There were child and young people friendly rooms and a dedicated recovery suite for children
- All staff demonstrated a very caring approach to children and young people.
- Feedback from children and young people and their families was positive.

In critical care we found the following areas of good practice:

- There were high standards of cleanliness.
- There were good levels of compliance with mandatory training.
- Policies were readily available which was useful to the resident medical officers (RMOs) who did not all work regularly at the hospital.
- We noted that the provider had an action plan to ensure compliance with all critical care standards by September 2017.

There were areas where the provider should make some changes to help the children and young people's service improve:

- Paediatric staff should monitor the temperature of every child in the intraoperative phase and in recovery to ensure they maintain a normal temperature.

In critical care the provider MUST ensure that:

- Managers must review the trigger threshold for activating a duty of candour response if there is sub optimal care, even when there is no or low harm.

In critical care the provider should ensure that:

- Managers should ensure that systems and processes in the hospital to lead to all surgical patients being pre-assessed including considering the likely need for critical care. Similarly the bookings process should ensure bookings for relevant cardiac procedures include input from the critical care team. This would help ensure that sufficient staff are available to care for high dependency patients.
- All critical care patients are reviewed by a doctor twice a day and have their treatment plans updated daily.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Overall summary

St Anthony's Hospital is operated by Spire Healthcare. The hospital has 92 beds in en-suite rooms. Facilities include six operating theatres (three with laminar flow), a cardiac catheter laboratory for cardiac procedures and an eight-bed level three critical care unit, and X-ray, outpatient and diagnostic facilities.

St Anthony's provides surgery, including critical care, medical care, services for children and young people, and outpatients and diagnostic imaging. In this inspection we only inspected critical care and services for children and young people. These services had been suspended at the time of our inspection in September 2016 and had since re-opened. The children's outpatient service opened in 2016 and sees about 150 children a month. The children's ward, for day case surgery for children over three years old, opened in late February 2017.

The hospital carries out some surgery for adult NHS patients some of whom might be in critical care.

This inspection was a focused inspection looking only at critical care and services for children and young people (including children's outpatients not inspected as part of outpatients in September 2016). We visited unannounced on 6 June 2017, and made two follow up visits by arrangement with the hospital on 12 and 13 June 2017 to observe children's outpatients and a children's surgery list which had not been able to inspect on 6 June 2017.

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

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

Services we rate

We rated critical care as requires improvement for safe and good for responsive and well led. We rated children's services as good for Safe, Responsive and Well-led. We did not consider there was sufficient evidence to rate Effective and Caring for either service because there were few outcome measures for either service and we saw only a small number of patients during our inspection.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	**Is surgery safe?** We rated safety as requires improvement because: • The hospital was not reporting all serious incidents requiring to be reported externally, promptly and systematically. One never event had not been reported. • Ward staff did not always react promptly to patients who were becoming more unwell because nursing records were not always correctly completed. • There were no mortality or morbidity meetings. • Procedures in theatre were sometimes carried out without patients being fully pre-assessed for risk factors before surgery. • Theatre lists sometimes overran and continued into theevening. However; • Equipment was well maintained and cleaning and infection control was good. • Medicines were generally well managed. • There were enough staff on duty during our inspection. **Is surgery effective?** We rated effectiveness as good because; • Policies followed NICE and other guidelines for clinical practice. • Pain was assessed and managed appropriately. • Consultants were on call 24 hours and two RMOs were available 24 hours a day, seven days a week. • On call pharmacy advice was available 24 hours a day. However, • There was limited data on patient outcomes. The hospital was submitting current data to the Private Healthcare Information Network (PHIN),

Summary of findings

an organisation that publishes independent hospital data to help patients make informed healthcare decisions, so data would be available in the following year.
- Multidisciplinary working and recording of MDT discussions was still at an early stage of development.

Is surgery caring?

We rated caring as good because:

- All staff introducing themselves and interacted in a friendly way with patients.
- There were systems to collect patient feedback and patients' views were largely positive.
- Nurses had sufficient time to spend with patients to reassure them.
- Most consultants visited patients daily, although sometimes quite late in the evening.

However;

- Some self-paying patients were anxious about unanticipated costs.

Is surgery responsive?

We rated responsive as good because:

- Patients had timely appointments and treatment, that were convenient to them
- Appointment times were flexible including evenings and weekends.
- Cancelled appointments were re-scheduled within 28 days.
- Visitors could come to see patients at any time.

However,

- The hospital should review its support elderly patients and those living with dementia.
- There was little evidence of change of practice in relation to complaints.
- A few patients were not satisfied with their admission experience, although 81% thought it was excellent.

Is surgery well-led ?

We rated well led as requires improvement because:

Summary of findings

- The control of risks needed strengthening to reflect all the risks and to include explicit mitigation actions.
- There were shortfalls in the management of some consultants who booked patients late, did not use pre-operative assessment and did not observe the WHO checklist.
- The analysis of the causes of serious incidents did not go into sufficient depth, and did not translate quickly enough into learning and improving practice.
- The hospital governance structure was very new and processes were not embedded. It was too early to assess its impact.

However;

- The hospital had a clear vision and values.
- There was effective and inclusive leadership in theatres.
- The views of patients were gathered.

Critical care

Requires improvement

Is critical care safe?

We rated safe as requires improvement because:

- The duty of candour had not been activated in any relevant reported incidents.
- Not all patients were reviewed by a doctor twice a day and 30% of doctors did not record the time of visits or provide evidence of reviewing treatment plans daily. Following the inspection, we were told that the hospital was acting on these results and reminding consultants of these requirements via email and verbally when in the unit to improve compliance.
- Half the reported incidents were about unexpected admissions to critical care, which potentially impacted on staffing. Some of this was the result of weaknesses in hospital processes outside the critical care service itself, such as pre-assessment not being carried out or surgery bookings being made without recognising the need for time in ITU.

However

- The critical care unit was visibly clean and we observed staff complying with infection control policies.

Summary of findings

- Staff were 96% compliant with mandatory training topics.
- Systems and processes for incident reporting, and medicines management were reliable and appropriate.

Is critical care effective?

- We did not rate this service because the numbers of patients were small and there was therefore limited data.

Is critical care caring?

- We did not rate because there were too few patients to make a judgement

Is critical care responsive?

We rated responsive as good because:

- Staff took account of the different individual needs of people using the service.
- The admission and exclusion criteria were clear.
- There was adequate capacity on the unit.
- Staff were aware of how to support patients with dementia.

Is critical care well-led?

We rated well-led as good because:

- There was clear leadership.
- Staff felt well supported by senior staff who were approachable.
- There was evidence of learning and improvement from audit results.

Services for children and young people

Good

Are children and young people's services safe?

We rated safe as good because:

- The service managed staffing effectively in relation to activity. There were enough staff with the appropriate skills, experience and training to keep children and young people safe and to meet their care needs.
- There was a lead consultant and lead anaesthetist for children and young people.
- We found high standards of cleanliness
- There were child and young people friendly rooms and a dedicated recovery suite for children

Summary of findings

However

- Staff did not consistently measure the inter-operative temperatures of children in theatre.

Are children and young people's services effective?

- We did not rate this service because the numbers of patients were small and there was therefore limited data.

Are children and young people's services caring?

- We did not rate this service because the number of patients was small and there was limited outcome data.

Are children and young people's services responsive?

We rated responsive as good because:

- Staff took account of the different individual needs of the different age groups using the service.
- Parents and their children could choose the timing of their appointments and procedures.
- Parents or other adults could spend time with children on the ward.
- Waiting times were short and there had been no surgical cancellations by the hospital.
- Children were able to provide feedback using a child-friendly patient survey.

Are children and young people's services well-led?

We rated well-led as good because:

- There was clear nursing leadership within services to lead effectively.
- Staff felt well supported by senior staff who were approachable
- There were high levels of staff and patient engagement and satisfaction.

Outpatients and diagnostic imaging

Good

Are outpatient and diagnostic imaging services safe?

We rated safe as good because:

Summary of findings

- Staff understood their responsibilities to raise concerns and report incidents and near misses.
- Medicines were managed and stored safely.
- Clinical and waiting areas were visibly clean and we observed good infection prevention and control measures.
- All staff had received mandatory training that was relevant to their role.

However:

- Some patients could have two hospital numbers which meant that records may not be complete.
- There had been no MRI resuscitation simulation training sessions. This meant that if there was an emergency within the scanner, staff may find it more difficult to remove a patient quickly.

Are outpatient and diagnostic imaging services effective?

We did not rate effective.
We found:

- There was a good multidisciplinary team approach to care and treatment.
- Staff had the right qualifications, skills, knowledge and experience to do their job.
- Work had started on measures to reduce the radiation dose level that patients received.
- There were many opportunities for continuous learning provided within the department.However we also found:
- Not all staff had received appraisals in line with the provider's policy.
- Local clinical pathways and policies kept within the outpatients department did not appear to have been reviewed recently and it was not clear if they were up to date in line with best practice guidelines.

Are outpatient and diagnostic imaging services caring?

We rated caring as good because:

- Patients received supportive care and treatment.
- Staff were very caring towards patients and supported them emotionally.

Summary of findings

- Interactions between staff and patients were positive.
- Information about care and treatment was made available when requested by patients.

However:

- The process for clarifying costs of blood tests with the patient was unclear. This could mean that patients were not informed of all the costs of tests taken before agreeing to them.

Are outpatient and diagnostic imaging services responsive?

We rated responsive as good because:

- Services were planned and delivered to meet the needs of the local population. New equipment had been introduced in response to patient needs.
- Services coordinated appointments to enable patientsto see a number of health care professionals in one day.
- There were clear examples of changes that had been made following complaints to improve the service provision.

However:

- In a 2016 assessment the department had 11 failures out of 22 dementia-friendly environment measures.

Are outpatient and diagnostic imaging services well-led?

We rated well-led as good because:

- The vision for the hospital was clearly understood by all staff within the department.
- With the change of provider, there had been large-scale changes; however most governance processes now appeared to be robust and working well.
- Staff were focussed on providing the best service they could for all patients.
- There were regular opportunities for staff to communicate with senior managers and all staff told us that there was a friendly and supportive management structure.

However:

Summary of findings

- The paediatric governance provisions were not yet in place and the strategy not completed, although the service was intended to re-start within three months.
- Team meetings were not yet planned on a regular basis in the outpatients department, which meant that there was the potential for missing the opportunity to share information.

Summary of findings

Contents

Good

St Anthony's Hospital

Services we looked at

Critical care; Services for children and young people;

Summary of this inspection

Background to St Anthony's Hospital

St Anthony's Hospital is operated by Spire Healthcare. Spire Healthcare Limited acquired St Anthony's Hospital in May 2014 from the Roman Catholic charity, Daughters of the Cross, which had run the hospital since 1904. It is a private hospital in Sutton, Greater London. The hospital primarily serves the communities of south-west London.

It is registered to provide the following regulated activities:

• Diagnostic and screening procedures

• Surgical procedures

• Treatment of disease, disorder or injury

The hospital's current registered manager has been in post since 2 May 2017.

The hospital has been inspected once under its current ownership in September 2016. The hospital was rated requires improvement overall. It had requirements to improve governance.

Our inspection team

The team that inspected the service comprised three CQC inspectors, and two specialist advisors, one with expertise in critical care and one with expertise in children's services.

Roger James, inspection manager, oversaw the inspection.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before our inspection, we reviewed a range of information we held about the hospital and each core service. We visited unannounced on 6 June 2017, and made two follow up visits by arrangement with the hospital on 12 and 13 June 2017.

As part of the inspection process, we spoke with members of the senior management team and individual staff of all grades. We visited the critical care and paediatric areas, observed direct patient care and reviewed patients' records of care and treatment.

Information about St Anthony's Hospital

- The main services at St Anthony's hospital are elective surgery for adults, and adult outpatient services.
- The hospital had provided children and young people's elective surgery until June 2016, and outpatients, diagnostic imaging and physiotherapy for children and young people until September 2016 when a decision was made to temporarily suspend the children and young people's services service at the hospital because they did not meet all current standards. Child outpatient services resumed in November 2016 and child day case surgery started in March 2017.
- Children and young people's services have their own paediatric nursing and healthcare assistants, both in outpatients and the children's ward.

Summary of this inspection

- The hospital has a children's ward, for day case surgery only, and a children's outpatient service separate from the adult outpatient area, with its own waiting area and clinic rooms.
- The hospital has a critical care unit for adults, supported by specialist staff. This reopened in early December 2016.
- During the inspection, we visited the children's ward, theatres and children's recovery, the children's outpatient department, and the critical care unit and an adult ward. We spoke with 12 staff including; registered nurses, health care assistants, reception staff, medical staff and senior managers. We spoke with 3 child patients and seven relatives. During our inspection, we reviewed four sets of child patient records.
- There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection.

Activity

- In the period November 2016 to June 2017 there were 27 child day case episodes of care recorded at the hospital. All these were privately funded through insurance or self-pay. Most children were in the 6-12 age range with 4 children under 6 and 9 over 12.
- The majority (18) of procedures were ear, nose and throat (ENT) including removing tonsils and adenoids, or inserting grommets to improve children's hearing. Other procedures included procedures to examine the digestive tract or the colon and rectum (gastroscopy and colonoscopy).
- There were on average 150 outpatient attendances a month in the reporting period.
- 44 children had diagnostic imaging between 31 October 2016 and 1 June 2017, of whom 5 had MRI scans.
- There were 131 episodes of adult critical care between March and May 2017.

There were

- No Never events in critical care or children's services.
- No serious incidents in children's services.
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA).
- No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA).
- No incidences of hospital acquired Clostridium difficile (c.diff).
- No incidences of hospital acquired E-Coli.
- There had been no complaints about children's or critical care services.

Services accredited by a national body:

- Sterile Services Department is registered by the Medicines and Healthcare products Regulatory Agency (MHRA)
- Registered pharmacy.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal.
- Interpreting services.
- Grounds Maintenance.
- Laundry.
- Maintenance of medical equipment.
- Responsible Medical Officer (RMO) provision.

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

For detailed findings, please see report previously published.

Are surgery services responsive?

Good

For detailed findings, please see report previously published.

Are surgery services effective?

Good

For detailed findings, please see report previously published.

Are surgery services well-led?

Requires improvement

For detailed findings, please see report previously published.

Are surgery services caring?

Good

For detailed findings, please see report previously published.

Requires improvement

Critical care

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

Are critical care services safe?

Requires improvement

Incidents

- There was a good reporting culture. Staff said staff more readily reported incidents since Spire Healthcare had taken over the hospital. The resident medical officers for critical care (RMOs) reviewed all critical care incidents themselves. There were 45 incidents reported in critical care since 1 January 2017, of which 23 were unplanned transfers and one transfer out. There were six incidents mentioning staffing impact of unplanned admissions or staff requesting additional support but no instances where minimum staffing levels had been compromised for the number of patients in the unit since opening
- Staff at all levels had incident training and understood what to report as an incident and how to report incidents using the electronic reporting system and said they received feedback and learning from incidents from the critical care unit manager
- Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. There were no never events reported in critical care between 1 January 2016 and June 2017. All staff we spoke with knew how to report such incidents using the electronic reporting system. They gave us examples of incidents which had been reported.
- There were two incidents graded severe and 15 incidents of moderate harm.
- Nurses were able to give examples of shared learning from incidents including learning across the hospital.
- Hospital mortality and morbidity (M&M) meetings took place quarterly and included deaths within 30 days of surgery. We had reviewed the minutes of these meetings and saw they discussed all serious adverse events (SAE) and additional case studies. Each of the SAEs or case studies had actions and learning arising from them, which were discussed at the meeting.
- Staff explained to us the duty of candour and the importance of being open with patients and families about mistakes. They were able to give an example of how they would meet the duty if an incident occurred. However, a review of incident reports indicated that duty of candour had not been activated in any relevant reported incidents, including after a death where a lesson learned had been about response to sepsis.

Clinical quality dashboard

- The hospital used a clinical quality dashboard to record patient harm and harm free care. It provided a quarterly snapshot audit for patient and their families to see, of the prevalence of avoidable harms. Examples of indicators were venous thrombo-embolism (VTE) risk assessment compliance, falls, pressure ulcers and pain scores. However the scores were aggregated for the hospital as a whole and not displayed by ward.
- The dashboard for Q1 and Q2 2017 indicated that urine output had been recorded in 100% of cases.
- The unit did not audit compliance with NICE QS3 Statement 4 which required re-assessment of patients within 24 hours of admission for risk of VTE and bleeding.
- We saw staff put action plans in place where targets were falling short of targets.

Requires improvement

Critical care

Cleanliness, infection control and hygiene

- All areas on the unit were visibly clean and tidy and infection control appeared well-managed despite evidence of some weaknesses in the first quarter's audit.
- A housekeeper was available all day to assist with cleaning needs. We saw evidence of cleaning in all areas throughout the day according to cleaning schedules and evidence of regular cleaning audits.
- Staff were aware of the infection control policies. We observed compliance with these: staff washing their hands, arms 'bare below the elbows', using personal protective equipment appropriately and using hand sanitisers when entering and exiting the Critical care unit (CCU).
- The hospital's Infection Prevention and Control (IPC) manager ran a quarterly audit. We noted that the January – March 2017 audit showed only 12.5% of cleaned items in storage had a green 'I am clean' sticker compared to the Spire target of 100% and sharps boxes were not always closed. Improvements had been made following these results and in both cases compliance was 100% in Q2 (April to June 2017). On our inspection, all equipment in the storage area was clean and labelled to identify when the last clean had taken place. This was evidence that the manager reviewed the outcomes of the audit and implemented actions where required.
- Staff said there was access to deep cleaning and which took place when and if required and we saw evidence of this.
- There was an onsite microbiology laboratory which sent results electronically to clinicians.
- If a patient required isolation precautions, they would be accommodated in a side room. There were six single rooms.
- The unit's compliance with recording the 'prevention in infection in vascular access form' for the arterial line (89% Q2) and central venous catheter line (80% Q2) each shift was below the target of 100% in both Q1 and Q2. This score had fallen since the previous quarter.

Environment and equipment

- The unit provided mixed sex accommodation for critically ill patients in line with the Department of Health guidance. There were some single rooms and curtains to maintain patients' privacy.
- Staff checked the emergency trolley daily. The drawers had tamper-evident plastic tabs. The checking records for this, and other emergency equipment were up to date and complete.
- Staff told us they had access to the equipment they required. There was storage for equipment in the critical care area, some in a bay and some in a cupboard. Storage was neat and tidy.
- Electrical equipment we saw was clear and had been safety tested.

Medicines

- We found that medicines were stored securely and appropriately. There was a log book for medicines and another log book for the Controlled Drugs (CDs); both the medicines and CDs were stored in separate locked cabinets. Keys to medicines cupboards were held within restricted access treatment rooms. Access to these rooms was only authorised via a security pass card. The nurse in charge was responsible for the keys and delegated this responsibility to another suitable person in their absence.
- Controlled Drugs (CDs) were securely stored in locked cupboards with access restricted to authorised staff in accordance with legal requirements, and in line with the Spire policy on the management of controlled drugs, clinical policy 14. We saw staff completed the CD registers correctly, and double-signed entries to provide evidence of an authorised witness to checks
- We reviewed entries between March and May 2017, which showed correct records of medicines being removed for patient use, amounts taken and the balances remaining in the cabinets. Nurses checked the balances of medicines daily.
- The medicine fridge in the unit was locked and there was no public access to this area. Records showed the fridge temperature range was checked daily in line with Spire clinical policy 13. Staff were able to explain that if the temperature was outside the range recommended by their manufacturer, they would report this to pharmacy for removal and disposal if required. The blood fridge was kept in the critical care unit where it was accessible to theatres and to the critical care unit.

Records

- Patient records were stored securely. They were mainly on paper in ring binders which were confidentially stored in the unit and notes were available to doctors,

nurses and other healthcare professionals. The paper confidentially stored in the unit and notes were available to doctors, nurses and other healthcare professionals. Records were not left open or on display.

- We reviewed in detail, four sets of current patient notes. All notes were fully and correctly completed, legible, dated and signed where appropriate. They showed risk assessments for pressure sore risk, moving and handling risks, falls and nutritional status and activity of daily living assessment. Sepsis screening was carried out if indicated. We noted that all staff treating patients made entries: nurses, the surgeon the anaesthetist and the RMO.
- However, we saw from the hospital quarterly audit that doctors' notes did not state the time in many cases. Only 14% were timed correctly in Q1 and only 30% in Q2. In Q2 only 60% of treatment plans were reviewed and documented on doctors' notes every day which meant doctors were not complying with Spire policies and good practice in record keeping. Following the inspection, we were told that steps were being taken to address this.

Safeguarding

- Spire Healthcare provided a national safeguarding policy for its hospitals.
- As a prompt for staff, the names and photographs of the hospital safeguarding leads were on the wall in ward offices, with details of how to report concerns.
- The policy and service level agreement for safeguarding referrals was available for staff to access on the intranet.
- The staff we questioned were able to explain their understanding of safeguarding and the principles of safeguarding. They were able to identify potential signs of abuse, including verbal and emotional abuse, and the process for raising concerns and making a referral.
- Paediatric admissions were not accepted on the critical care unit. There was a protocol with an acute hospital for admitting children if necessary in an emergency.

Mandatory training

- A review of the training audits showed that 96% of permanent nursing staff had completed all mandatory training, compared to a target of 95%. We reviewed records of the training of bank staff which showed they had completed 89% of mandatory training refresher modules for the current training year. We were told that bank staff were required to complete all their modules before they were accepted to work in the unit when they first join the hospital bank.
- The mandatory and statutory training programme covered equality and diversity, health and safety awareness, infection control, compassionate practice, adult and child safeguarding (levels 1 and 2), fire safety and manual handling. There were additional, role-specific modules on topics such as the mental capacity act and deprivation of liberty safeguards, safe transfusion, incident reporting and controlled drugs.
- It was Spire policy that all staff including bank staff must complete Information Governance training annually. Staff told us they had completed this training.

Assessing and responding to patient risk

- As a private hospital St Anthony's admitted patients for elective surgery who would be expected to be lower risk than a hospital taking a wider range of patients, which in itself controlled risks. The intention was to identify all patients likely to require critical care at their pre-assessment check. Nonetheless there were 28 unexpected admissions in six months of which 9 were due to the process not being effective. Following the inspection, we were told that the hospital had reviewed this process and from April to June 2017 there were 2 avoidable unexpected admissions compared to 7 in January to March 2017 which showed good improvement.
- Patients in critical care typically had a short length of stay.
- Critical care staff provided outreach services to the rest of the hospital. They were contactable by phone and visited and assessed deteriorating patients, including attending crash calls.
- The hospital used a nationally recognised early warning tool, NEWS, which indicated when a patient's condition may be deteriorating and they may require a higher level of care. Staff were able to show how they would use early warning scores in relation to identifying risks to patients and how the escalation process would evolve once patient risk was determined.
- Staff were able to show how they would use early warning scores to identify risks to patients and how the escalation process would evolve once patient risk was determined.

Requires improvement

Critical care

- Patients who might need critical care after surgery were identified in pre-operative assessment clinics so the service could plan staffing.
- There was always a cardiac RMO when heart surgery was being undertaken, as these patients would be in the critical care unit after their procedure.
- The hospital used a sepsis screening tool and pathway. All staff were aware of the sepsis management process and knew when and how to use the sepsis pathway. They could also explain how they would conduct assessments and measures needed to be taken to manage risk to patients
- The four patient records we reviewed all included completed risk assessments for venous thromboembolism, pressure areas and nutrition.
- There was a signed agreement for referring patients to NHS services if necessary. One patient was transferred out (March 2017) since the unit reopened.
- The unit assessed patients for the risk of blood clots but was not achieving 100% compliance with the national requirement set by the National Institute for Health and Care excellence (NICE). In quality standard 3 that 'All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool'. The unit scored 90% in Q2.

Nursing staffing

- Nurse staffing levels were adequate for the level 1, 2 and 3 care being provided during the inspection.
- Nurse staffing levels met the guidelines for the provision of intensive care services 2015 (GPICS). Such patients require higher levels of care and more detailed observation or intervention. They may have a single failing organ or require post-operative care. There was a 2:1 staff to patient ratio at the time of the inspection which was more than adequate for the levels 1, 2 and 3 care being provided during the inspection. Level 1 care is for patients needing more than routine care or are at risk of their condition deteriorating and may often be cared for on a normal hospital ward with advice from the critical care team.
- Staff were aware of the national requirement to provide 1:1 nurse to patient ratio for someone needing level 3 critical care.
- The hospital used a planning tool used to establish the number of nursing hours required for each patient bed. They had not needed to use agency staff since re-opening in November 2016. The CCU used a bank of temporary staff who mainly worked at a nearby NHS Hospital. Agency staff were rarely used, we were told that only one agency staff member had been used since June 2016. Staff assessed the training and competence of bank staff when they first worked at the hospital. The manager sought to use staff familiar with the unit. The unit told us they complied with the requirement that they should not utilise greater than 20% of registered nurses from bank/agency on any one shift when they were not their own staff.
- The average bed occupancy rate in the critical care unit had been below the national average when the unit was open in the previous year, 2016. During the inspection there were three patients on the ward, less than half the capacity of the ward although routinely only four beds were in operation.

Medical staffing

- The hospital had a lead consultant for critical care, which met the requirements of the Guidelines for the Provision of Intensive Care Services, 2015. The role of the consultant was oversight of policy and performance. There was always medical cover in the hospital from a registered medical officer for intensive care.
- Critical care registered medical officers (RMOs) were supplied by a private agency. They were senior registrars in anaesthetics. They worked 24 hour shifts. We were told they did the last ward round at 10pm and were then on-call, on site. Their role included assessing patients on the wards when called by staff. Responsibility for decisions lay primarily with the patient's consultant or the on-call consultant intensivist, from the same agency as the RMOs. The RMOs said there was no difficulty contacting an on-call intensivist when required but that they were empowered to make decisions in the absence of the lead consultant.
- We were told consultants saw patients within an hour of admission to CCU and carried out morning and afternoon reviews. Although this was evidenced in patient records that we reviewed, audits showed doctors did not always review patients morning and afternoon. Only 50% of patients had an afternoon review in Q2. This was worse than in Q1, where the score was 80%. The Spire target was 100%.
- The RMO we spoke with told us the workload was generally light and sometimes there was little ward activity. We also observed this during the inspection.

Requires improvement

Critical care

- The hospital also employed cardiac RMOs who supported peri-operative care of cardio-thoracic patients.
- Consultants were required by the practising privileges arrangement to be able to attend this unit within 30 minutes.

Major incident awareness and training

- The hospital had an emergency plan and procedures in place in the event of a major incident such as fire or flood or prolonged loss of services
- The majority of hospital staff had completed training in fire safety. There was 36 hours supply of electricity from a back-up generator and back up batteries for some equipment.

Are critical care services effective?

Not sufficient evidence to rate

We did not rate effective because there was limited information on outcomes for patients.

Evidence-based care and treatment

- The hospital had carried out a self-assessment against critical care standards. We checked policies and guidelines and found they were based on up to date guidance from the National Institute for Health and Care excellence (NICE). There were policies on CCU operational management, admission and discharge and outreach, and standard operating procedures and clinical guidelines for the critical care unit. There was a sedation policy to cover analgesia and sedation to prevent pain and anxiety, permit invasive procedures and reduce stress and oxygen consumption.
- Staff we spoke with demonstrated awareness of the policies and how to access them on the intranet. There were also paper copies in the unit.
- We saw that care followed NICE clinical guideline 50: Acutely ill adults in hospital: recognising and responding to deterioration.
- The unit complied with NICE QS 3 that patients assessed as at risk of VTE were offered VTE prophylaxis , and NICE CG 50 that covers how patients in hospital should be monitored to identify those whose health may become worse suddenly and the care they should receive.
- A critical care audit plan was in place in line with Spire's central guidance. This included a quarterly audit for the Spire clinical scorecard, and included an audit for sepsis management. The audit showed the unit was not yet meeting some requirements, for example only 20% of patients had delirium scoring commenced on admission in Q1 when the audit was first introduced. This had improved in Q2 to 90% but the Spire target was 100%. This was not in line with NICE quality standard 63 and the GPICS guidelines. Initial results were reported as lower in Q1 as the audit tool included non-relevant patients (such as ventilated, sedated patients) which had been corrected in Q2 and training had been provided to improve correct scoring.
- The service used the national care bundle for pneumonia and followed the NICE sepsis guidance (NICE guideline 51).
- The audit of the intensive care bundle for pneumonia showed oral hygiene and two- hourly suction assessment and documentation was not being undertaken for relevant patients. In Q1 the results were 25% for both (against a 100% target). In Q2 oral hygiene had shown some improvement, to 50%, but the score for two hourly suction assessment and documentation was 0%. Given the small number of patients, this indicated that staff did not seem to fully understand national guidelines. Following the inspection, we were told that these results were in part due to staff not fully understanding the audit tool which has been updated and additional training provided to avoid including non-relevant patients in the audit results as non-compliance (e.g. non ventilated patients).

Pain relief

- Staff told us that where patient's procedures were likely to cause pain, such as abdominal or pelvic surgery, they spoke to patients on the morning of surgery to reassure them about pain and nausea.
- Audit showed CCU staff were recording pain scores four hourly, and checking on pain at least hourly.
- We observed staff assessing pain and using the pain scoring system used hospital wide to. Nurses reviewed the effectiveness of pain relief after giving analgesia. Patients we spoke with said their pain was well managed.
- The team were reviewing what more was needed for the hospital to meet the standards of the Faculty of Pain Medicines Core Standards for Pain Management such as having an acute pain service in the hospital with a

named pain consultant . It was recognised that inadequate relief of acute pain could impact significantly on the rehabilitation of patients after surgery.

Nutrition and hydration

- Nursing staff on CCU assessed patients' nutritional and hydration needs using the malnutrition universal screening tool (MUST). There was no dietitian on site, but a consultant or RMO could arrange for patients to be seen by a dietitian if and when required.
- Water was available and in reach for those who were able to drink.

Patient outcomes

- The unit had systems to record information on mortality, cardiac arrests and readmission within 24 hours, but there had been no incidents since the unit opened.
- Many patients had a routine recovery.
- The unit did not submit data to the Intensive Care National Audit and Research Centre (ICNARC) and the service had little information on patient outcomes. There was no benchmarking of critical care outcomes within Spire group or with other private hospitals.

Competent staff

- New members of staff reported that they had completed an induction programme to understand the unit and the wider hospital processes and procedures. They shadowed a member of staff to learn the unit's procedures. They had a probationary review after six months based on the National Competency Framework for Adult Critical Care Nurses.
- The hospital's matron was responsible for assessing all resident medical officers' (RMO) qualifications and suitability.
- Nurses had yearly appraisals, which focused on their development and wellbeing.
- The hospital supported nurses through training and one to one meetings with managers, which included bank nurses.

Multidisciplinary working

- Staff told us there was good teamwork between CCU nurses and RMOs and we observed this. Evidence from interviews indicated that that staff worked well together and were able to assess and plan ongoing care and treatment in a timely manner.
- There was a hospital wide MDT meeting on weekday mornings which highlighted possible unplanned admissions from wards. A weekly meeting to look at theatre cases also fed into planning for numbers expected in CCU.
- There was evidence in care plans of some multidisciplinary input. Where there were cardiac issues the cardiac RMO took a greater role than the anaesthetic RMO.
- We were told that a physiotherapist visited patients twice daily and at night if required. There was access to a dietician through the hospital. There was no critical care pharmacist but the pharmacist in the hospital had access to a senior specialist pharmacist for advice.
- The handover procedure for the critical care team when people were discharged to the wards included input from anaesthetists and consultants. A medical discharge summary was written on a standard nursing transfer form, and verbal handover to the receiving ward was provided.

Seven-day services

- The hospital was staffed 24 hours a day, seven days a week in line with the critical care policy. The unit was open whenever the hospital was open. When the hospital had closed over Christmas 2016 the critical care unit was also closed as all critical care patients had been discharged at this time.
- Consultants were available on call at weekends and out of hours as this was part of the hospital's practising privileges agreement. The critical care RMOs did ward rounds at weekends. The RMOs had access to an intensivist.
- Diagnostic imaging and physiotherapy was available on-call out of hours and at weekends. Occupational therapy were not available at weekends for the wards.
- Pharmacy opening times for the on-site dispensary were between 9am and 8pm Monday to Friday, 9am to 1pm on Saturdays and 10 am to 12pm on Sundays. Outside these hours a pharmacist was on call to provide pharmaceutical advice and support to staff.
- A pathology laboratory was open Monday to Friday and on weekend mornings from 09.00 – 13.00. There was a 24hour on-call service available outside of these hours.
- A consultant microbiologist was available 24 hours a day.

Requires improvement

Critical care

Access to information

- Spire policies were available electronically on the intranet. There were paper copies of all policies on each ward.
- Computer stations with intranet were available for staff to use. Blood results and X rays were available electronically
- Staff advised us that bank nurses had access to the same ward training, documentation, updates and information as permanent members of staff.

Consent and Mental Capacity Act

- Staff told us they asked patients for their consent whenever possible before providing any care or treatment, and staff acted in accordance with the patients' wishes. We saw completed consent forms in patients' notes. We also saw staff seeking consent before any intervention or treatment.
- Nurses understood that some patients in intensive care might not be able to make their own decisions possible because of delirium or because they were too unwell. They might need a best interest assessment.
- Staff were familiar with best interests' decisions, and also aware that a patient might make an unwise decision, but that did not mean they lacked capacity.
- The hospital Deprivation of Liberties Safeguards policy and process was also available for staff to access on the intranet. The hospital had not made any applications for Deprivation of Liberty. Staff were aware that in general treatment in the context of life saving medical treatment could be a deprivation of liberty.

Are critical care services caring?

Not sufficient evidence to rate

We were not able to rate caring because of the small number of patients seen.

Compassionate care

- Patient's dignity and privacy was respected. There were two individual rooms for patients requiring the highest level of care. Dignity and privacy for other patients on the unit was maintained by the use of curtains around bays
- We observed caring interactions between staff and patients. Both patients we spoke with were positive about the care they received. One of the patients told us that the staff had been "highly attentive" and were available at all times. One of the patients told us that the nursing staff came immediately when they rang their call bell "at any time of night".
- In our conversations with staff, nurses demonstrated compassion and respect for the patients under their care.

Understanding and involvement of patients and those close to them

- One of the patients we spoke with said that they had been kept informed of all the details of their care prior to and throughout their stay on the unit. They said that they had been involved in decisions relating to their care.
- There were leaflets available about the cost of care and payment packages. One of the patients informed us that costs had been discussed in a clear and confidential manner. Staff advised that these discussions were always held in private with patients and their families.

Emotional support

- There was no specific counselling team in the unit, but a consultant to consultant referral could be made for counselling if appropriate. The hospital's chaplaincy service could also arrange support.
- The chaplaincy in the Hospital was Roman Catholic. However, staff told us that the hospital had connections with other faith groups.

Are critical care services responsive?

Good

Service planning and delivery to meet the needs of local people

- The CCU served private patients, either self-funding or funded by private medical insurance as well NHS patients. Most patients lived in south west London.
- We saw a service level agreement with an acute hospital for deteriorating patients whose needs could not be met in the unit, to be taken there by emergency ambulance. This had been used once since the unit reopened.
- Whilst the hospital did not provide accommodation for the families of patients, staff told us that the hospital reception would provide family members with information on local hotels.

Requires improvement

Critical care

- A visitors' waiting room was available near the unit with a water cooler and tea and coffee facilities.
- A restaurant in the hospital catered for visitors

Access and flow

- The majority of admissions to the unit were pre-planned following elective surgery. Patients were identified as requiring critical care at their pre-assessment check and if necessary a decision was taken to request a critical care bed. This allowed the unit to plan ahead in order to meet the needs of specific patients. Staff in theatres recovery told us they worked well with the Critical Care Unit.
- Patients were placed in beds according to their acuity and individual needs, to ensure that staff with the correct skillset were near to them at all times.
- We reviewed an admission to Critical Care policy dated August 2016 which was clear. This detailed roles and responsibilities of individual staff, referral processes for planned and unplanned admissions. The decision to admit to CCU was made by the consultant and anaesthetist.
- Post-elective surgery patients were collected directly from theatres (which were on the same floor as the unit) and brought in by critical care staff. We observed the critical care nursing team preparing a bed and a bay for a post-elective surgery patient, laying out all of the equipment necessary to care for the patient.
- The Unit ensured that one bed was kept free for urgent admissions of deteriorating patients from within the hospital. At the time of our inspection, the unit was not accepting critical care patients from other hospitals. The unit monitored unplanned admissions from within St Anthony's and these were reported and discussed at clinical governance meetings. In the period January to April 2017 there were 23 unplanned admissions to the unit, 11 of these were in January 2017. There was no evidence this theme had been investigated.
- There was sufficient capacity on the unit. At the time of our inspection, there were three patients on the unit, with a further patient being admitted that evening and one due to leave the unit that day. The unit was operating at half capacity, with a maximum of four patients at a time. There were plans in place to increase the capacity of the unit.
- Step down from the unit was determined by the patient's named consultant. Staff told us that there were occasionally delays in transferring patients who no longer required critical care from the unit to the ward whilst they awaited a ward bed, but that these were usually no more than a few hours. They told us that there was a good working relationship between the critical care team and ward staff.
- We noted from minutes of the Mortality meeting that some day-case patients were discharged home from CCU. This practice occurred where patients were in the unit for post cardiac procedure monitoring to ensure greater convenience and comfort for the patient rather than transferring to the ward for a short period. All other patients are stepped down to the ward prior to discharge.
- The unit manager, one of the sisters and one of the nurses acted as a critical care outreach team, visiting deteriorating patients on the wards to assess whether they needed to be stepped up to critical care. The team also visited patients who had been transferred out of the unit to the wards to monitor their recovery.
- There were clear exclusion criteria for the unit, detailed in a policy. The exclusion criteria had been agreed and reviewed by the clinical governance team. Consultants took the decision to admit patients based on the criteria.
- The unit admits bariatric patients and has necessary specialist equipment to provide adequate care and links with other providers to source additional equipment as required such as larger beds.
- No surgery had been cancelled due to a lack of capacity on the unit.

Meeting people's individual needs

- There was a provider-wide dementia clinical brief available to all staff, based on guidance from the Alzheimer's Society, and staff were aware of how to support patients with dementia.
- The critical care nursing notes included delirium assessment scores. There was a delirium care pathway in place.
- We saw posters advertising interpreter's services. Staff told us that, where required, they contacted an interpreter. A number of staff on the unit spoke other languages, which meant that they could converse with patients in their own language. They understood, however, that independent interpreters must be used for gaining consent from patients who did not have sufficient English to consent to treatment.

Requires improvement

Critical care

Learning from complaints and concerns

- There was a complaints policy for the unit which we had sight of. There was a scheme of escalation for complaints, depending on their seriousness. Senior staff on the unit told us that they always sought to deal with complaints, where possible, at a local level.
- There were no complaints in the complaints log from January 2016 relating to critical care.
- No complaints had been referred to the Parliamentary and Health Service Ombudsman.

Are critical care services well-led?

Good

Leadership and culture of service

- The unit was consultant-led and there was a lead nurse, in line with the Core Standards for Intensive Care Units guidance by the faculty of intensive care medicine.
- Throughout our visit, senior staff were highly visible on the unit.
- The unit was part of the South London Critical Care Network. A senior nurse on the critical care team attended meetings of the network. She told us that she had implemented changes on the unit, in respect of mandatory training, based on learning gained at a meeting.
- Staff spoke highly of the critical care manager and of the senior team within the unit. They told us that they felt supported and that the leadership team was approachable.
- All of the staff we spoke to described a positive culture on the unit. Staff described effective team work, including MDT working.
- One of the nurses we spoke with told us that they were being supported by the hospital to undertake critical care nurse training. This course was funded by St Anthony's Hospital in conjunction with a local acute Trust who links in with the University of London.

Vision and strategy for this core service

- We did not see a written vision. However, the provider's long term vision for the service was for it to become the foremost critical care unit in the Spire group and a leading independent critical care unit in London.
- The strategy for the service was to increase the number of patients on the unit to full capacity, increasing staffing levels in line with increased bed usage.
- All of the staff we spoke with were aware of the vision and strategy and supported them. A number of staff expressed frustration that the unit was not yet operating at full capacity.
- We observed staff delivering care and demonstrating behaviours in line with the hospital and Spire Healthcare's values.

Governance, risk management and quality measurement

- The service had a plan for development.
- We reviewed an action plan, dated 15 June 2017, which set out actions to improve practice on the unit. This action plan built on an earlier action plan of September 2016. Each of the planned actions had a named responsible individual, an update on action taken and a completeness statement. Actions included the development of a Critical Care Transfer Policy including the service level agreement (SLA) with the local Trust. This action had been completed, and we had sight of the policy and signed SLA. Of 41 actions on the plan, 23 had been completed, and 16 were in progress.
- The only action which had not been started was to address the limited patient engagement on the unit by gathering feedback from patients. However, when we spoke to staff on the unit, they told us that they sought verbal feedback from patients where possible and that patients could provide feedback on their stay on the unit as part of their overall feedback to the hospital. This was a standard feature of patient follow-up.
- The unit had good links to the hospital-wide medical advisory committee (MAC). We saw the minutes of MAC meetings at which the unit was represented and discussed. At the MAC meeting of 2 March 2017, the MAC discussed the rationale for adhering to the admission and exclusion criteria for the unit and acknowledged the importance of considering each case against the criteria.
- During our inspection, we attended a hospital-wide clinical governance meeting. The critical care unit was represented at the meeting by the lead consultant.
- The unit did not submit data to the Intensive Care National Audit and Research Centre (ICNARC). However, senior staff told us that they intended to join ICNARC in

future. Further, senior staff also told us that they kept up-to-date with research and guidance from ICNARC and used the data to identify national trends and areas for improvement.

Public and staff engagement

- Patients were not routinely asked about their stay in critical care. However, senior staff had recognised this and there was an action plan in place to introduce a system for patient feedback specific to patients who spent time in critical care.
- There were two newsletters from the critical care consultants, one for staff within the unit and another for the wider hospital staff.

Workplace race equality standards

- Due to the level of NHS work undertaken at the hospital as a whole, the provider was subject to the Workplace equality standards. This was not considered as part of this inspection.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

Incidents

- Staff told us they knew how to report incidents and we saw that that there were systems to do so, and that lessons were learned and improvements made when things went wrong. They gave an example of the only incident reported in children's services, when a child fell in the outpatient waiting room and a toy broke under his weight. The incident was low harm but staff had reviewed the toys in the waiting room as a result.
- The paediatric service was very small and had only recently reopened so this was the only incident. Staff told us wider learning from incidents and complaints elsewhere in the hospital was disseminated in staff meetings, and through information on notice boards.
- There had been no serious incidents or never events.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of healthcare providers to notify patients of and provide reasonable support when something went wrong, even if someone was not harmed. Staff were aware of Spire's duty of candour policy and the sort of incident that would trigger a duty of candour response. There had not been any instances in children's services in the last year when staff had to apply duty of candour.

Cleanliness, infection control and hygiene

- There were systems and processes to ensure sound standards of hygiene to prevent cross infection.
- The hospital had a dedicated nurse for infection prevention and control (IPC) and an infection control link nurse for the children's service. The IPC lead was a member of the paediatric steering group.
- The two outpatient consulting rooms where treatment was provided to children and young people were visibly clean, tidy and free from clutter. All rooms had working facilities for handwashing, with enough paper towels and protective clothing available to use when necessary. A paediatric office adjoined the consulting rooms and the children's play area was immediately opposite.
- Housekeepers cleaned the outpatients department every evening and nursing staff cleaned all surfaces in the consulting rooms between clinics. We saw that toys in the children's play area in outpatients were easy to clean. Clinical staff cleaned the toys at the end of each clinic; we saw appropriately completed cleaning schedules for the previous month.
- The single rooms on the children's ward had en-suite bathrooms which reduced risks of infection between patients. Rooms were clean and tidy. Housekeepers employed by the hospital confirmed they cleaned rooms daily and we saw evidence of cleaning.
- Hand sanitisers were widely available in the outpatient department and in the children's ward. We saw nurses in the outpatient department and the children's ward using these before and after seeing patients. Parents we spoke with on the ward said nurses had shown them how to clean their hands to avoid cross infection, and told us they observed clinical staff washing their hands.
- The imaging department had separate records of hand hygiene audits completed with a high level of compliance.

Good

Services for children and young people

- Clinical staff complied with 'bare below the elbow' guidance to allow thorough hand washing, and appropriate protective equipment such as gloves and aprons were available when staff carried out procedures and personal care.
- Theatres were new, well designed, spacious and clean. There was an audit process for infection prevention and control in theatres. We saw a clear separation of flow between clean and dirty instruments. A central sterile services department cleaned and sterilised instruments on site.
- There were no completed infection control audits for paediatrics which had only a small number of children's clinics and theatre lists since the service reopened. However, audits were now being introduced and data would be reported quarterly.
- Domestic and clinical waste was disposed of correctly. We saw appropriate facilities for disposal of clinical waste and sharps such as needles located in the consultation and treatment rooms.

Environment and equipment

- The areas where children were treated were secure and equipment was safely maintained and appropriate for children of different ages.
- The children's ward had 11 beds and was designed with rooms appropriate for different ages and with child friendly and age appropriate bedding. The ward had been refurbished in March 2017. Staff performed a health and safety risk assessment on each room prior to each admission taking into account the age of the child.
- The ward was secure from unauthorised access. Staff accessed the ward with a swipe card and entry for visitors was by buzzer. There was a high level, no touch exit pad, out of reach of small children. Staff gave visiting parents a swipe card to enter the ward during their child's stay.
- There was specialist children's resuscitation equipment, colour coded for different age ranges/weights. There was also resuscitation equipment for adults visiting the unit. This was kept clean and tidy and records showed it was checked regularly.
- One theatre was designated a children's theatre. Children were anaesthetised in the adjoining anaesthetic room which had resuscitation drugs and equipment for children of different ages.
- We spoke with an anaesthetist and consultant who told us there was suitable and sufficient equipment available in theatres to support the type of paediatric surgery undertaken.
- There was a dedicated children's recovery room, segregated from adult recovery. There were plans to make this more child friendly by decorating one wall. Staff could take children and young people back to the ward without going through adult theatres or recovery, and it was possible for parents to visit children in recovery.
- The outpatients and diagnostic imaging department were well-maintained. Consulting rooms were of a good size, well lit, free from clutter and provided a suitable environment for treating patients.
- Emergency resuscitation equipment, for adults and children was available in the outpatients department and was easily accessed
- The imaging department had appropriate signage and lights outside the main doors to each scanning room to alert staff and patients when exposures were being undertaken. An MRI scanner in which child (and adult) patients could watch TV was being obtained. This would avoid the need to sedate children and enable them to stay still more easily while the scan was taken.
- There was a well-equipped physiotherapy gym and six physiotherapy treatment rooms. We saw an appropriate child physiotherapy policy and standard operating procedures. These followed the guidelines of the Chartered Society of Physiotherapy. There was a protocol to ensure adults did not use the gym if a child was having a physiotherapy session in that space. The area had recently been refurbished and while not specifically child-oriented was light and attractive. The hospital did not offer physiotherapy for children under six years old. Children using this service were mainly over 12 years old.

Medicines

- Medicines were well managed.
- The administration of medicines to children was covered in the hospital's local paediatric policy, which also included the paediatric pain protocol. Staff told us that as the service was small and no complex procedures were undertaken, very few paediatric medicines were administered to children, mainly simple analgesia and antibiotics.

- The same drug charts were used throughout the hospital.
- Medicines were stored securely in locked cabinets and paediatric drugs were stored separately from adult drugs.
- We saw that staff documented allergies in patients' notes.
- There was a pharmacy on site. This was not a dedicated children's pharmacy but the pharmacist had access to the Paediatric Formulary and to paediatric advice if required. The pharmacy was open while outpatient clinics were running and kept a small range of child appropriate medication for dispensing, mainly antibiotics and pain relief. Opening hours were 9am to 8pm on Monday to Friday and 9pm to 1pm on Saturday.
- Nursing staff stated they were happy with the pharmacy service received.

Records

- Records management was effective. We saw that children and young people's records were in paper files and were stored securely.
- Information held electronically included test results, reports and images.
- We reviewed four sets of patient notes. Staff had completed these appropriately and notes were in logical order, with entries legible, dated and signed. A children's nurse completed and signed pre assessment forms.
- Pain scores were recorded.

Safeguarding

- Spire had a national safeguarding policy which the hospital followed. The children's lead nurse was the named nurse for safeguarding. This nurse and the named consultant for safeguarding were both trained in child safeguarding to level four. The nurse was able to deliver level 3 child safeguarding training to other paediatric nurses.
- The safeguarding learning package contained specific relevant issues such as child sexual exploitation, domestic violence, female genital mutilation and preventing radicalisation.
- All staff involved in caring for patients under the age of 18 had completed safeguarding training to level 3 safeguarding children in line with the intercollegiate guidance. The staff we spoke with were fully aware of the signs of abuse including verbal and emotional abuse and how to report safeguarding concerns to the local safeguarding children's team.
- The named safeguarding nurse received supervision from the Sutton Local Children's Safeguarding Board, and we were told that he would provide supervision to other staff. Paediatric staff were mainly newly appointed so had not yet had supervision. However, the department was small so staff had easy access to the safeguarding lead for advice.
- Consultants working at the hospital were required to produce evidence of up to date completion of level three safeguarding children training and paediatric resuscitation. A record was kept of this on the hospital's practising privileges record. We saw evidence of this. The hospital monitored compliance with the requirement to have Level 3 safeguarding training and we were told that if doctors did not supply the information their practising privileges would be revoked. We were told of one case where this had happened.
- We saw a local policy covering the process should a child go missing, including a hospital lock down policy.

Mandatory training

- Most mandatory training was delivered online through the Spire Healthcare electronic system, which staff could access in the hospital or at home. Training was also provided in classroom settings. The training included infection control, fire safety, equality and diversity, information governance and health and safety.
- All staff in the paediatric team had completed their mandatory training, either at this hospital or the hospital they had previously worked at.
- All paediatric staff were trained in life support. On inspection we saw that there was always a member of staff trained in European Advanced Life Support (EPALS) or Advanced Paediatric Life Support (APLS) in recovery, on the ward and in outpatients when children were being seen, This was in line with national guidance (Royal College of Nursing- Safer Staffing 2013),. All four paediatric nurses and recovery staff had advanced life support training.
- Paediatric intermediate life support training (PILS) was being rolled out to staff outside the paediatric service who worked in areas where children were cared for, such as outpatients and diagnostic imaging. 79% of staff had been trained. This training would be repeated annually.

Assessing and responding to patient risk

- The hospital local paediatric policy had set strict eligibility criteria for patient selection for surgery to

minimise risk. Children were only accepted for day surgery. They did not accept children with known behavioural issues, mental health concerns, chronic illness or complex medical needs. The hospital was not staffed to manage children or young people under the age of 16 who required overnight care or critical care support. This meant surgery was only carried out on low risk patients aged 3-18 years.

- The pre admission consultation ensured staff excluded any child assessed as a surgical risk. The policy was to assess children face to face. Only one child (of the 27 children admitted for day case surgery) had had a telephone pre-assessment because there had been a problem attending the clinic. The pre assessment was to check that the child or young person was clinically fit, to identify any risks and to explain the arrangements for admission. All children were weighed at pre assessment to allow accurate calculation of drug doses. A standard Spire pre assessment form was used and we saw these were completed appropriately.
- Pregnancy tests were carried out on girls over 12 years old before surgery to exclude the risk to a foetus. We saw evidence of this.
- The hospital used a paediatric emergency care system (PECS). On admission, they were given a coloured wristband indicating their weight range (noted at pre-assessment), which correlated to the colour scheme of the paediatric emergency care system. This enabled staff to respond quickly with the correct equipment in an emergency, for example red packaged emergency drugs and equipment for a child wearing a red wristband.
- Children's nurses met before each surgical list to ensure all staff knew about the ages and conditions of the children on the list.
- The hospital used the Paediatric Early Warning System (PEWS) formulated for different age ranges, to identify deteriorating patients. Staff were awaiting new charts from Spire at the time of the inspection.
- Parents were given details of who to contact if there was a concern after they left the ward.
- Staff considered the risks to children using the simple play equipment in outpatients to be minimal. Parents and carers were responsible for supervising children. No adults used the paediatric outpatient area when children were present.
- Risks in radiology were understood and managed. Radiation protection monitoring was in line with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).
- We saw that theatre staff used the World Health Organisation's surgical safety checklist.

Nursing staffing

- Nurse staffing was at their full complement to meet the currently expected planned admissions for surgery and to cover the outpatient department. The ratio of nurses to children in the two areas of activity was enough to protect children from avoidable harm. The lead paediatric nurse worked half time clinically and half management time. There were four nurses in all, 2.7 working time equivalent (WTE). There was one healthcare assistant.
- The staffing complied with the Royal College of Nursing (RCN) guidance on safe staffing (2013) which recommends ' there should be a minimum of two registered children's nurses at all time in inpatient and day case areas'.
- A registered children's nurse was always in outpatients when a doctor held consultations with children and would be present for any interventional procedure. This was achieved by not scheduling paediatric clinics when an operating list was running.
- There was one bank paediatric nurse.
- Staff in recovery were not children's nurses but had paediatric competencies.
- Young people between 16 and 18 years would be booked and pre-assessed by a paediatric nurse. As part of the assessment a decision would be reached about whether an adult or child pathway was more appropriate, taking account of risk. A children's nurse was required to be available for advice and support. A 16-18 year old could be monitored using the National Early Warning Score (NEWS) rather than PEWS.

Medical staffing

- In the paediatric outpatient service 34 consultants had paediatric practising privileges. These were surgeons and physicians with a range of specialties. Some ran general paediatric clinics and some attended for specific specialities. ENT practitioners who treated both adults and children, held outpatient appointments for children and young people.
- There were 18 consultants with practising privileges related to surgery. The application process for practising

privileges required consultants to show evidence of paediatric work as part of their NHS practice, the number of paediatric patients seen in the previous year, and their qualifications and training, including level three safeguarding training and training in paediatric life support. Approval for practice was authorised by the paediatric lead, consultant paediatric lead and the Medical Advisory Committee (MAC). All paediatricians also worked in the NHS.

- A paediatric anaesthetist remained at the hospital until the child was stable after their procedure, and was required to be able to return to the hospital within 30 minutes in the event of an emergency. Staff told us they would contact the responsible consultant directly if they had any concerns about a child.
- The hospital arranged a paediatric anaesthetist for every paediatric theatre list. Five paediatric anaesthetists worked on a rota and lists were planned six weeks in advance. The anaesthetist visited all children before surgery to explain their procedure. A lead anaesthetist oversaw the anaesthetic services for children.
- The Resident Medical Officer (RMO) on site was trained in EPALS or equivalent and required to have paediatric experience in line with the local policy. In practice staff said that with the current low volume of paediatric activity, the RMO was unlikely to see or treat any children. This was because children seen as day patients, or in outpatients, were under the sole care of the admitting consultant or anaesthetist.
- All consultants were required to have paediatric resuscitation training. We noted that on the list of consultants with paediatric practising privileges, five consultants were due to update their resuscitation training, and in four cases the doctors had not supplied evidence of such training. We were assured that managers were seeking to obtain the information and would not allow consultants to practice without the assurance their training was up to date.

Other staffing

- Two members of Spire's central staff who were each in the hospital two days a week were managing theatres on a temporary basis. A new theatre manager had been recruited but was not yet in post at the time of the inspection. A paediatric operating department practitioner had been appointed to be Deputy Team leader for anaesthetics.
- There were two paediatric radiologists in outpatients.
- Physiotherapy was available for children from a paediatric physiotherapist with appropriate paediatric training.

Emergency awareness and training

- The hospital had procedures in the event of an incident on site and there were departmental action cards explaining what to do in the event of for example, fire, electrical failure or flooding.
- Staff had practiced evacuation of the hospital within the last year and fire safety training was part of mandatory training.
- We saw the hospital's policies and protocols for the emergency transfer of children to the local NHS hospital in the case of complications which required critical care or an overnight stay. There had been no emergency transfers of children since the service opened.

Are services for children and young people effective?

Not sufficient evidence to rate

We did not have enough evidence to rate effective. The children's day surgery service had been running for only three months on a very small scale, and insufficient outcome evidence was available.

Evidence-based care and treatment

- Staff followed policies developed in line with up to date national guidance. There were corporate Spire policies and local guidance for the care of children and young people within St Anthony's hospital. The local paediatric policy, dated May 2017, was based on the Royal College of Anaesthetists Guidance on the provision of a paediatric anaesthesia service (2015); the Royal College of Anaesthetists Accreditation Standards 2015 and the Royal College Surgeons, Standard for children's surgery (2013). It linked with the Spire Clinical Policy 11. Guidelines for the care of children in Spire Healthcare, and the St Anthony's Hospital Safeguarding policy.
- Consultants were responsible for ensuring that they complied with Spire's policies and worked within their

scope of practice with children in the three specified age bands: 4-5 years, 5-12 years and 12 to 16 years. All paediatric staff were aware of the scope of practice of consultants.
- Policies and protocols in radiography were up to date and reflected national institute for health care excellence guidance (NICE).
- National toolkits such as Paediatric Sepsis were available and staff understood the pathways.
- Care pathways contained patient risk assessments.

Pain relief

- The hospital had an appropriate policy for the management of pain in children.
- Nurses assessed children's pain using age-appropriate methods based on observation (the FLACC scale based on observation of a child's face, legs, activity, crying and consolability) for children who could not report pain verbally, and nurses told us they spoke to older patients and to their parents about pain levels. Staff could also use the Wong Baker FACES pain rating scale.
- Staff offered appropriate methods of reducing pain, including pain relief prescribed by the paediatric anaesthetist. Feedback from children showed they were happy with pain relief. We spoke with parents who said the hospital was good at managing pain.

Nutrition and hydration

- The hospital followed the standard pre-operation fasting guidelines and advised parents and older young people at the pre-admission assessment, that they should fast for a period of six hours for food and two hours for clear fluids before their procedure. Parents told us they had received this information verbally at pre-assessment and in writing.
- Staff gave parents fasting guidelines in writing before the child's admission. The operating list during our inspection was an afternoon list and neither child had eaten since the previous day, although they had had drinks. Parents said they had not wanted to wake children early to give them something to eat. The children themselves did not seem concerned about the time without food. The hospital did not specifically advise parents to give children an early breakfast if they were on an afternoon operating list to make them more comfortable throughout the day.
- Patient's meals were prepared on site. Children and young people were encouraged to order food and drinks to have when they returned to the ward. We saw a menu for a range of age appropriate food. The catering service could also provide for dietary needs such as dairy or gluten free.
- There was a visitor's restaurant. Parents could also have a meal in their child's room.

Patient outcomes

- Staff told us patient outcomes were good. A paediatric clinical scorecard was centrally managed by Spire and covered compliance with aspects of national guidance grouped under each of the CQC domains, such as paediatric early warning scores (PEWS), pain relief, temperature recording, fasting guidelines and staff training. Measures of clinical outcomes recorded on this were limited to infection rates, re-admissions, unplanned returns to theatre and transfers to other hospitals.
- The information provided indicated that in quarter two 2017/18 there had been no unplanned returns to theatre for children, no re-admissions within 31 days of discharge or transfers to other hospitals and no surgical site infections within 31 days. These indicated good outcomes. As a private hospital, St Anthony's Hospital did not have access to participate in the majority of national audits undertaken by the NHS although paediatric staff were familiar with the audits done by other paediatric departments. There were currently no plans to benchmark the hospital's performance outside the Spire group locally although there was a national steering group in place looking at opportunities for this.
- Only 27 patients had had surgery since the children's day surgery unit opened. A programme of audit had been set up, to include safeguarding, infection control, health and safety and surgical practice.
- We were told there was an intention, in line with national Spire policy, to produce an annual report of CYP activity, compliance with quality standards and clinical outcomes.
- We were concerned that staff did not always record children's temperature in the intraoperative period. This is important because children lose heat differently from adults under anaesthesia, and in adults there is clear evidence that even mild intra-operative hypothermia is associated with adverse outcomes. We saw an action plan to improve the measurement of temperature.
- A generic child day care pathway covered all surgical interventions on children and young people.

Good

Services for children and young people

Competent staff

- The hospital provided opportunities for staff induction, learning development and appraisal. The hospital used e-learning supplemented with face to face learning. We spoke to a new nurse who said she had a comprehensive induction and was still supernumerary while learning the job.
- All four nurses were registered children's nurses. Managers recognised the restricted scope of nursing practice at present because of the limited range of procedures and complexities of children they admitted. The intention was for staff to rotate between the ward and recovery to maintain skills in immediate post-operative care. As the service developed staff expected to increase their skills and knowledge.
- Theatre nurses working with children obtained paediatric competences through attending a paediatrics acute illness management (PAIM) course, for which they obtained signed certificates. Training had started in May 2017 and 13 nurses had completed and passed the course at the time of the inspection. This training would be an ongoing rolling programme. The recovery team leader and two recovery nurses had completed the course as well as the paediatric nurses.
- Staff had an annual appraisal covering a review of their individual performance and also a formal review of mandatory training completion. The paediatric staff had been in post for less than a year so had not had appraisals yet.
- The role of the MAC included ensuring that consultants were skilled, competent and experienced to perform the treatments undertaken. We reviewed the practising privileges documentation. We were told the hospital director was responsible for undertaking routine reviews of each clinician's practising privileges which included reviewing the clinicians whole practice appraisal, incidents, general activity and complaint data and that this process was supported and signed off by the MAC. We reviewed the practising privileges files of three consultants which showed evidence that the hospital's requirements were met.
- All phlebotomy staff had specific training for carrying out blood tests for children and were able to talk us through the process they would follow.

Multidisciplinary working

- Patient records contained details of all the multi-disciplinary input in treatment which included the medical, nursing and anaesthetic teams and recovery staff input.
- On discharge from hospital staff sent a letter to the child's GP and health visitor to ensure continuity of care. They were not able to send information to GPs electronically because of system incompatibility.
- We saw a signed service level agreement (SLA) for transfer of a child or young person to another hospital if this was necessary for a child's clinical needs. No children stayed overnight at the hospital or used the hospital's adult critical care unit. There was a protocol for transfer. The consultant in charge of the child was responsible for providing advice to the receiving hospital.
- Some children were seen in the physiotherapy department. Two physiotherapists had paediatric competences.

Seven-day services

- Outpatient paediatric clinics were held on most weekdays. Children could also have appointments with individual doctors with paediatric privileges on any day they worked at the hospital. There was a children's clinic until 12.30 on some Saturdays.
- Operating lists were one or two days a week at the time of our inspection.

Access to information

- Staff could view the Spire policies and local guidelines on the hospital's intranet which were easy to access.
- Staff had access to care notes, test results and risk assessments in relation to treatment at this hospital. Children and young people's test results and images were easily available to the relevant staff through electronic reporting systems.
- Children attending for surgical procedures would have been referred by the GP who might include a health summary with the referral. Parents were not asked to bring their child's health record in the form of the Red book.
- A separate register of all patients aged between 12 and 18 years was held by the physiotherapy department to monitor all children who had received physiotherapy treatment since January 2016. Records for physiotherapy patients were stored securely in the physiotherapy department.

Good

Services for children and young people

- Consultants told us that they could obtain copies of medical notes from the patient's GP if needed.
- There was evidence that guidelines and protocols were accessible to clinical staff, including the local antibiotic policy
- There was information about children's services on the hospital's website. This provided information to parents about the range of services as well as costs and methods of payment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The records we looked at all demonstrated appropriate signed consent for children attending for elective surgery. Staff were aware of and able to describe how consent issues changed as children became older and were more able to make their own choices. There was a standard operating procedure on confidentiality and consent.
- Staff used consent form 2 for young people under 16. This form, "Parental agreement to investigation, treatment or procedure for a child or young person" offered the young person to sign as well if they wished. This was a two stage process, with a final confirmation of consent just before the procedure.
- There was a joint consent process for older children. At the pre-admission consultation before surgery a children's nurse assessed whether a child was mature enough to make decisions about their care and treatment, using the test of 'Gillick competence'. This ensured children could make their own decisions when they had sufficient understanding and intelligence to be capable of making an informed decision
- The nurses were aware of the rights of young people aged 16 and 17 years regarding care and treatment on adult wards.

Are services for children and young people caring?

Not sufficient evidence to rate

We did not rate caring because we only saw a small number of children using the service on inspection.

Compassionate care

- Only a small number of children and parents were present during our inspection, but we observed positive interactions between nurses and families in outpatients where four young children were attending a paediatric clinic. We also spoke with three parents of children on the day case operating list. We saw friendly and age appropriate interactions with children as well as staff giving reassurance to parents.
- We spoke with their parents who told us that the nurses and consultant were friendly and approachable.
- Children and young people were cared for in single en-suite rooms which helped ensure their privacy and dignity.

Understanding and involvement of patients and those close to them

- We observed nurses communicating clearly with child patients and their parents so they both understood the care and treatment that staff were giving.
- We observed staff speaking to children before they spoke to parents, listening to children and taking their views into account.
- We reviewed patient (14 children) and parent feedback (9 parents). All comments were positive: 'Care has been fantastic"; "I could not fault the care given; good explanations about treatment and reassurances along the way". All the parents we spoke with said that staff had been helpful, informative and supportive to them and their child.
- The hospital had a chaperone policy. This could also allow a young person to speak with a doctor without their parent or guardian present. Chaperone presence was documented in patient notes, and the hospital policy required the presence of a chaperone for examinations and invasive procedures.

Emotional support

- Children and young people were able to visit the children's ward where they would stay for their procedure, when they had their pre-assessment appointment, and were able to choose their room.
- Wi-Fi was available so children could keep in touch with friends and family from their hospital bed, and play familiar games. Children were encouraged to bring tablets or game stations as well as favourite toys.

Good

Services for children and young people

- Parents were able to be with their children all the time up until their anaesthetic, and could visit their child in recovery once the child had safely regained consciousness.

Are services for children and young people responsive?

Good

Service planning and delivery to meet the needs of local people

- There were enough rooms for the number of children currently using the service in en-suite rooms in a designated and newly decorated children's ward.
- The outpatient area had a designated room with toys where parents could wait with their young children.
- Parents and their children could choose the timing of their appointments and procedures, for example timing these for school holidays if they preferred and if this was clinically appropriate. Appointments were half an hour for an initial appointment and 20 minutes for a follow up. Children could usually have tests on the same day as their appointment.
- Parents or other adults could spend time with child on the ward. Parents accompanied their child to the anaesthetic room.
- Children having a theatre procedure would not see adult patients in the theatre area, or in recovery.
- We saw two comprehensive booklets in plain language about preparing to come to hospital for surgery, one for children and a parallel booklet for parents with suggestions about how to prepare their child for a hospital admission.
- The hospital had developed a standard price list for self-pay patients. To date, costs for all children except one had been covered by their parents' medical insurance.

Access and flow

- Children's outpatient clinics were available several days a week and individual consultant appointments took place both in the day time and the evening. Not all clinics ran weekly because of the small numbers of children attending.
- Waiting times were short. There was some flexibility to extend a clinic to accommodate a late booking patient and we saw an example of this on our inspection.
- The hospital's 72 hour booking rule was extended to seven days for children's services and any request for an earlier day surgery admission would be scrutinised by the theatre manager and lead paediatric nurse before authorisation was given to accept. This extension was so a full pre-assessment could be completed and paediatric staffing arranged before an admission.
- A named consultant with paediatric practising privileges was responsible for the care of every child they admitted. Children only had surgery on a designated children's operating list, with a paediatric anaesthetist.
- As surgery was elective and planned in advance registered children's nurses were always available. There were no instances of unplanned surgical interventions.
- There had been no surgical cancellations by the hospital although some parents had cancelled their child's planned surgery.
- Staff helped parents make a follow up appointment in outpatients before they discharged children home.
- Parents we spoke with said they were happy with the time to assessment, diagnosis and treatment. Staff told us that there were no delays in accessing paediatric intervention once the patient was booked in.
- Outpatient staff told us there was very little wait for consultant appointments and most parents we spoke with confirmed this. We saw a nurse explain to a parent who had booked late that there would be a delay until the end of the clinic.

Meeting people's individual needs

- Within the outpatients area there was a small room with toys where young children could wait with their parents. Older children could sit in the main outpatient area if they preferred.
- The bedrooms on the children's ward were decorated and equipped in age appropriate ways. Some had more adult decoration to suit adolescent needs. Wi-Fi was available to meet the recreational needs of older children
- Translation was available for people who did not speak English and we saw leaflets about this, but we did not see this used.

Good

Services for children and young people

- Parents could often make outpatient appointments to see a paediatrician at short notice. We saw an example on our inspection where a consultant stayed late to see a family.
- Parents said test results were available quickly and they received results by email which they found helpful.
- We saw clear written information about care at home for parents of children discharged after ENT procedures: removal of adenoids, tonsils and insertion of grommets. This supplemented information that nurses explained before the parent and child left hospital.
- Staff gave parents a telephone number to ring if they had any concerns about their child after surgery. Paediatric nurses who worked on a rota system to receive calls answered calls. In case of a serious post-operative emergency, staff would advise parents to take the child to an Emergency Department.
- The service did not have a play therapist to support the play needs of children but paediatric nurses had training in distraction techniques that they could use when needed.

Learning from complaints and concerns

- There was a hospital wide complaints policy and procedure. We saw information on display about how to raise concerns. There had been no complaints about children's services since the service had re-opened. We saw very positive feedback from the parents and children that had used the service
- We saw leaflets available in all waiting areas entitled 'please talk to us'. These outlined the complaints procedure to patients and advised them on how they could provide feedback.
- Children were able to provide feedback using a child-friendly patient survey.

Are services for children and young people well-led?

Good

Leadership and culture of service

- The paediatric nursing lead and deputy matron led the children and young people's service and had recruited the staff and set up governance and risk management arrangements. The lead paediatrician was also the paediatric lead anaesthetist.
- Staff were enthusiastic about working in the service. It was clear that the team worked well together in an open and honest culture, with respect for the leadership. All staff said they would have no hesitation in raising concerns, although to date there had been none.
- The team were keen to learn from other hospitals from within the Spire Group, and to share their knowledge with others.
- Staff were positive about working at the hospital. They told us management were supportive and there was a culture of openness. They told us there was a good working relationship between the consultants and the nursing staff, and with senior managers.

Vision and strategy for this core service

- The vision of the service was for children and their families to receive the best care they could for children, young people and families. Staff were proud of the service they were delivering. The service aimed to be, in time, the main independent provider of children's services in the area and to be a flagship for children's services in the Spire group.
- We saw a written strategy document from 2016 identifying the paediatric service as an area for development and growth. Now that the service had opened, staff were developing a marketing plan and beginning to run events to help raise awareness of the new service among GPs and consultants, and among local people.
- The service was small but had plans for growth, through expanding the number of paediatricians and services. The outpatient service had recently started providing minor invasive procedures such as allergy testing, nasal endoscopy and infant tongue tie release.
- Spire centrally was developing children's services in its hospitals on a hub and spoke model. Paediatric staff at St Anthony's were giving advice to other Spire hospitals about services for children and young people.
- There was currently no plan to take NHS funded child patients.

Governance, risk management and quality measurement

- Governance had been set up on a firm footing. Consultants were involved in and supportive of the paediatric service. The paediatric lead for the hospital was a paediatric anaesthetist, and would become a member of the medical advisory committee (MAC) at their next meeting.

Good

Services for children and young people

- An ENT consultant who carried out surgery on both children and adults was the chair of the MAC. The minutes for the last meeting of the MAC showed paediatric issues were raised in this forum. This demonstrated that governance issues were discussed including practising privileges. There was a system to review practising privileges annually and remove the privileges of those who did not meet required standards.
- The lead paediatric nurse chaired a Steering Committee for Children and Young People. This had met every two to three months during the planning phase and would meet quarterly in future to review and develop paediatric services. This body was responsible for clinical governance of paediatric services. The Paediatric Steering group reported to the Clinical Governance committee, which in turn reported to the MAC. We reviewed the notes of the meetings in December 2016 and February 2017 which took place before the opening of children's surgery. The meetings were comprehensive in their approach.
- There was a corporate risk register which contained some paediatric risks. The risks we saw identified had appropriate mitigations ensuring the risk after mitigation was low. We did not identify other risks with the service. We also saw a risk register for children attending the physiotherapy outpatient department. There was single risk register specific to all the services for children. We saw that risks were discussed at the Paediatric Steering Committee.
- The hospital had a clinical governance lead responsible for risk management, audit, incident investigations, RCA investigation reports and local policies. There was a place on the agenda for a paediatric update. The group produced a quarterly clinical governance report which we reviewed. The report included the results of hospital audits, clinical scorecard audits, clinical incidents, complaints and the risk register. Lessons learnt from incidents were also recorded.
- The first paediatric team meeting took place in April and staff took minutes at these meetings. Meetings were monthly. We saw that the most recent meeting had covered the incoming Spire led paediatric scorecard, an update on recruitment, numbers of children being seen at the hospital and policies in development, for example on colonoscopy. However, the team met together regularly on operating list days.

Public and staff engagement

- The paediatric services undertook a satisfaction survey both from children and young people and adults which they planned to use to inform future planning. We saw survey forms for children under 6 with six simple questions who were also invited to draw answers to what they liked or disliked about being in hospital. There was a longer set of questions for older children and parents were asked to complete a longer survey.
- Patient satisfaction was 100% since the service reopened in November 2016.

Workplace race equality standards

- Due to the level of NHS work undertaken at the hospital as a whole, the provider was subject to the Workplace equality standards. This was not considered as part of this inspection.

Innovation, improvement and sustainability

- The aim of the new service was to be safe, effective and financially viable.
- There were plans to increase the range of paediatric services at the hospital in the future.

Good

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

For detailed findings, please see report previously published.

Are outpatients and diagnostic imaging services responsive?

Good

For detailed findings, please see report previously published.

Are outpatients and diagnostic imaging services effective?

Not sufficient evidence to rate

For detailed findings, please see report previously published.

Are outpatients and diagnostic imaging services well-led?

Good

For detailed findings, please see report previously published.

Are outpatients and diagnostic imaging services caring?

Good

For detailed findings, please see report previously published.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Managers must review the trigger threshold for activating a duty of candour response, even when no or low harm results from sub optimal care.

Action the provider SHOULD take to improve

- Managers should review processes in the hospital external to, but impacting on critical care, such as pre-assessing surgical patients and ensuring bookings for relevant cardiac procedures include critical care are tightened so that sufficient staff are available to care for high dependency patients.
- Staff should ensure patients are reviewed by a doctor twice a day and that evidence of updates to treatment plans is recorded daily.
- The hospital should ensure that all children have their temperature recorded intra-operatively to ensure they maintain a normal body temperature.

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 20 HSCA (RA) Regulations 2014 Duty of candour **The provider did not always act in an open and transparent way because:** **The duty of candour had not been activated in any relevant reported incidents, including after a death where a lesson learned had been about response to sepsis.** Regulation 20 (2), (3), (4)