Springfield Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Springfield Hospital is operated by Ramsay Healthcare UK Operations Limited . The hospital has 64 beds. Facilities include six operating theatres, a three-bed close observation unit, and x-ray, outpatient and diagnostic facilities.

The hospital provides surgery, medical care, services for children and young people, and outpatients and diagnostic imaging.

We carried out a focussed follow up inspection to inspect the core services which we had rated as requires improvement during our previous inspection (October 2016). We inspected surgery services and children and young people's services.

To get to the heart of patients' experiences of care and treatment, we asked the questions; are they safe and well led for surgery services and are they effective and well led for services for children and young people. We asked only these questions because, during our previous inspection (October 2016), these were the areas we rated as requires improvement. Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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

Services we rate

Our rating of this hospital improved. We rated it as **Good** overall.

We found good practice in relation to surgery services:

- Ward staff were 84% compliant with mandatory training and theatre staff were 86% compliant. This was an improvement on our previous inspection.
- Environmental cleanliness audits showed 94% compliance in theatres and 94% compliance in the ward area. This was an improvement on our previous inspection where overall compliance was 87%.
- Staff stored equipment appropriately in the clean utility rooms and the medical devices room. This was an improvement on our previous inspection.
- Theatre staff could easily access the difficult airway trolley and the latest difficult airway guidelines were also on the trolley for staff to refer to. This was an improvement on our previous inspection.
- Staff did not pre draw up drugs for use in theatre, control drugs (CD) cupboards were locked and the fluid store was tidy and organised. This was an improvement on our previous inspection.
- Medical advisory committee meetings (MAC) were now well attended and the hospital risk register had been improved to be more specific. This was an improvement on our previous inspection.

We found good practice in relation to services for children and young people:

- There were comprehensive plans in place relating to service improvement and auditing which was an improvement from our previous inspection.

Summary of findings

- Frequent resuscitation scenario training took place in theatres to ensure that staff were competent in their paediatric life support skills.
- There was a good understanding of Gillick competence and this was well recorded as part of the paediatric day case pathway.
- There was service representation throughout the hospital, from a service specific meeting, to the clinical governance and medical advisory committees.

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

- Nursing leadership for the service was still being recruited to, which meant that other staff were providing leadership in the interim.

We found areas of practice that require improvement in surgery services

- The theatre audit schedule was not up to date due to a lack of a permanent theatre manager.
- Forty nine percent of theatre staff had not completed appraisals due to lack of a permanent theatre manager.

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

Amanda Stanford

Deputy Chief Inspector of Hospitals on Behalf of the Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. Surgical services included a theatre department with six theatres, of which four had laminar airflow, six anaesthetic rooms and a six-bedded recovery area. There was also an inpatient ward consisting of 58 single bedrooms, three double bedrooms and a three-bedded close observation unit. From January 2018 to December 2018 there were 10637 inpatient and day case episodes of care recorded at the hospital; of these 60% (6419) were NHS-funded and 40% (4218) other funded. We rated this service as good because it was safe, effective, caring, responsive and well led. The hospital had addressed all the concerns which we raised during our previous inspection (October 2016). Data provided by the hospital showed ward staff were 84% compliant with mandatory training and theatre staff were 86% compliant. Environmental cleanliness audits showed 94% compliance in theatres and 94% compliance in the ward area. Staff stored equipment appropriately in the clean utility rooms and the medical devices room. Theatre staff could easily access the difficult airway trolley and the latest difficult airway guidelines were also on the trolley for staff to refer to. Staff did not pre draw up drugs for use in theatre, control drugs (CD) cupboards were locked and the fluid store was tidy and organised. Medical advisory committee meetings (MAC) were now well attended and the hospital risk register had been improved to be more specific. However, The theatre audit schedule was not up to date due to a lack of a permanent theatre manager. Forty nine percent of theatre staff had not completed appraisals due to lack of a permanent theatre manager.
Services for children and young people	Good	Children and young people's services were a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

We rated this service as good because it was safe, effective, caring and responsive, and well led although nursing leadership required strengthening.
The hospital had addressed our previous concerns around the effectiveness and the well led aspect of the service. There were now comprehensive improvement and auditing plans in place which were well managed and had oversight from the senior management team, as well as the clinical governance and medical advisory committees.
Gillick competence was now well recorded as part of the paediatric day case pathway. There was an understanding of risk and risk assessment, and service risks were noted on the hospital's risk register. The service was also well represented and received oversight at the Medical Advisory Committee.
Although the most recent staff survey results were poor, the hospital had responded and made changes to the senior leadership team which we felt had a positive impact when we inspected.

Summary of findings

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

Summary of this inspection

Background to Springfield Hospital

Springfield Hospital is operated by Ramsay Healthcare UK Operations Limited . The hospital opened in 1987 and was purchased by Ramsey Health Care in 2007 from another provider. It is a private hospital in Chelmsford, Essex. The hospital primarily serves the communities of Essex. It also accepts patient referrals from outside this area.

The hospital has a 64 bed in patient facility which includes single rooms and a newly built 15 bay ambulatory care area for day case surgery.

The hospital has had a registered manager in post since 2015. At the time of inspection, an experienced new interim manager had been appointed in November 2018 and CQC registration applied for.

The hospital also offers cosmetic procedures such as dermal fillers, plastic surgery and surgical oncology services. We did not inspect these services.

Our inspection team

The team that inspected the service comprised two CQC inspectors, and a CQC inspection manager who provided offsite support. The inspection team was overseen by Fiona Allinson, Head of Hospital Inspection.

Information about Springfield Hospital

During the inspection, we visited the inpatient area, the close observation unit, the theatres and associated areas. We spoke with nine staff including registered nurses, medical staff, operating department practitioners, and senior managers. During our inspection, we reviewed eight sets of 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 (January 2018 to December 2018)

- In the reporting period January 2018 to December 2018 There were 10637 inpatient and day case episodes of care recorded at the hospital; of these 60% (6419) were NHS-funded and 40% (4218) other funded.

187 Consultants worked at the hospital under practising privileges. There were two registered medical officers (RMOs), of which one was on duty 24 hours a day seven days a week. The accountable officer for controlled drugs (CDs) was the registered manager.

Track record on safety:

- Two never events
- Clinical incidents 319 no harm, 37 low harm, 16 moderate harm, zero severe harm, zero death
- 21 serious untoward incidents

zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

zero incidences of hospital acquired Clostridium difficile (c.diff)

zero incidences of hospital acquired E-Coli

32 complaints

Services accredited by a national body:

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

Summary of this inspection

- BUPA Accredited Bowel Care Centre

Services provided at the hospital under service level agreement:

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

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe improved. We rated it as **Good** because:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and staff had received training on how to recognise and report abuse and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean.
- The service had suitable premises and equipment and looked after them well.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

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

- The service for children and young people had a comprehensive audit plan in place that was discussed and reviewed at the children and young people's meeting. The audit results had led to service improvements.
- There were processes in place to check staff competencies.
- There was a good understanding and recording of Gillick competence in young people. We saw this was now an integrated part of the paediatric day case pathway.

Are services well-led?

Requires improvement

Our rating of well-led stayed the same. We rated it as **Requires improvement** because:

Summary of this inspection

- Our well led ratings for surgery and services for children and young people improved. However, our aggregation tool took into account the ratings of other services we had previously inspected within the hospital. This meant that the overall hospital rating for well led remained requires improvement.
- The theatre audit schedule was not up to date due to a lack of a permanent theatre manager.
- Forty nine percent of theatre staff had not completed appraisals due to lack of a permanent theatre manager.

However,

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The children and young people's service was risk assessed and appropriate risks were entered on to the hospital risk register.
- The service managed information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.
- Improvement had been made for the management and leadership of the children and young people's service. The service had an actioned and monitored improvement plan and was also represented at the clinical governance and medical advisory committees.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	N/A	N/A	N/A	Good	Good
Services for children and young people	N/A	Good	N/A	N/A	Good	Good
Overall	Good	Good	N/A	N/A	Requires improvement	Good

Notes

Good

Surgery

Safe	Good
Well-led	Good

Are surgery services safe?

Good

The main service provided by this hospital was surgery.

Our rating of safe improved. We rated it as **good.**

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Mandatory training took place on an e-Learning or face to face basis.
- The hospital had a target completion rate of 85%. Data provided by the hospital showed ward staff were 84% compliant with mandatory training and theatre staff were 86% compliant. This was an improvement on our previous inspection where mandatory training compliance was 78% and 72% respectively.
- Theatre managers used bank staff to free up staff to attend mandatory training.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training on how to recognise and report abuse and they knew how to apply it.**
- Safeguarding training was included as part of the hospitals standard induction programme. Refresher safeguarding training was carried out on a three-yearly basis. We spoke with two operating department practitioners (ODP) who were able to identify what would constitute concerns around safeguarding and how they would escalate and report safeguarding concerns to the hospital named safeguarding lead.
- Hospital staff had access to online policies for the safeguarding of adults and children and guidance included information relating to female genital mutilation (FGM).

Cleanliness, infection control and hygiene

- **The hospital controlled infection risk well. Staff kept themselves, equipment and the premises clean.**
- There were no cases of meticillin resistant staphylococcus aureus (MRSA) or meticillin sensitive staphylococcus aureus (MSSA) reported between January 2018 and December 2018.
- There was no reported incident of clostridium difficile (C-diff) between January 2018 and December 2018.
- There were no incidences of hospital acquired E-Coli between January 2018 and December 2018. This was an improvement on our last inspection where the hospital had reported two cases.
- All staff had access to an infection prevention and control policy online. Infection prevention training was part of mandatory training. The policy referred to other infection control policies relating to specific circumstances such as isolation, management of patients with tuberculosis and safe handling and disposal of sharps (needles).
- Ward staff cleaned equipment after each patient contact and applied a signed and dated “I am clean” tag to ensure all staff knew it was clean and ready for use. We looked at 10 pieces of equipment and found them all to be visibly clean and labelled.
- Housekeeping staff were responsible for running taps and showers to prevent the risk of infection. Cleaning records for December 2018 showed this was completed appropriately.
- Housekeeping staff changed disposable curtains as required or at least every six months. Housekeeping staff had dated curtains to evidence they had been changed in September 2018.

- The hospital had recently appointed a designated infection prevention and control lead nurse.
- The infection prevention and control (IPC) lead nurse carried out environmental cleanliness audits. The audit completed in September 2018 showed 94% compliance in theatres and 94% compliance in the ward area. With an overall compliance of 94%. This was an improvement on our previous inspection where overall compliance was 87%.The audit identified a lack of hand wash basins in utility rooms on the ward. The IPC lead had developed an action plan to address the issue. At the time of inspection, hand wash basins were visible in all the utility rooms.
- All staff we observed in the ward were bare below the elbow and adhering to hand hygiene techniques prior to and after patient contact.
- Theatre staff were seen to be wearing appropriate clothing and footwear for use in surgical areas. We saw the use of face masks and eye protection during surgical procedures. Gloves, aprons, footwear and theatre scrubs were available for staff use within the theatre area.
- Hand washing sinks were available with sanitising hand gel throughout all the areas we inspected. Information was available for patients and relatives to make use of hand gel when entering the department.
- The IPC lead carried out monthly hand hygiene audits. The audit dated October 2018 recorded 60% compliance. The IPC lead had drawn up an action plan to address this. The action plan included spot-checking staff, introducing IPC champions in all areas, promoting other staff to challenge staff who were not adhering to hand hygiene procedures and refresher training for all staff. The audit completed in November 2018 recorded a compliance of 90%.
- Data supplied by Public Health England (PHE) for the period July 2017 to June 20018 showed the hospital had reported three surgical site infections (SSI) during the 12 months. This was an improvement on our previous inspection where the hospital reported 34 SSI during the 12 month period.
- Single bedrooms were mostly carpet tiled. We were told that all carpets were cleaned on a three monthly rotational basis and soiled carpet tiles were removed and replaced as required. Additional cleaning was carried out when required for example, in the event of bodily fluid contamination or confirmed infection. One member of staff told us there were plans to replace all carpeted areas with wipe clean flooring as soon as finances had been agreed.
- We looked at three patient bedrooms and noted that all rooms were visibly clean and free of clutter. En-suite facilities were also clean.
- The ward area had two dirty utility rooms and two clean utility rooms. Staff checked the rooms for cleanliness on average four times per day. Staff signed and recorded the time and date on cleaning records which were displayed in each room.

Environment and equipment

- **The service had suitable premises and equipment and looked after them well.**
- Entrance to the ward and theatre area was via secure intercom. The intercom was in use throughout the day of our inspection with all patients and relatives being greeted by reception staff. Access to the theatre area was via automatic doors, which were overseen by the main reception area.
- Staff stored blood pressure machines, electrocardiogram machines, oxygen cylinders and linen trolleys appropriately in the clean utility rooms and the medical devices room. This was an improvement on our previous inspection where staff stored equipment in corridors.
- We reviewed six syringe drivers. All six had undergone portable electrical appliance testing (PAT) in February 2018. Equipment PAT records demonstrated equipment was tested appropriately by an external provider.
- We reviewed eight pieces of equipment including digital scales, patient observation units, suction equipment and beds. We found all eight had been calibrated and serviced in 2018.
- Theatre staff could easily access the difficult airway trolley. This was an improvement on our previous inspection where staff had stored equipment on top of it. Staff checked the trolley daily and records for November and December 2018 evidenced checks had been completed appropriately. The latest difficult

airway guidelines were also on the trolley for staff to refer to. This was an improvement on our previous inspection where staff kept out of date guidelines on the trolley.

- The hospital had easy access to an adult and a paediatric resuscitation trolley which was stored adjacent to the main reception area. Both trolleys contained the appropriate equipment for use in a collapse or cardiac arrest. Staff had completed daily check records for the months of October to December with no omissions. Weekly checks of this equipment revealed no omissions during the same period.
- The ward had a further adult resuscitation trolley located on the opposite side of the ward. We checked equipment on this trolley and saw that the appropriate equipment was in place. We reviewed the daily check records of this equipment for October to December and found no omissions.
- Theatre staff had easy access to a resuscitation trolley. Staff had completed daily check records for the months of October to December with no omissions.
- Staff accessed the dirty utility room and medical devices room via a key pad on the door. However, both doors were closed but not secured. We raised this with the ward manager who explained sometimes the doors did not close fully but would remind staff to take extra care when closing them.

Assessing and responding to patient risk

- Adjacent to the nurses' station was a three bedded room for patients requiring close observation. This area was specifically for patients requiring one to one care with higher needs for example; patients at risk of deterioration, breathing complications and post bariatric surgery.
- The hospital had a service level agreement (SLA) in place with the local NHS trust to enable the transfer of critically unwell patients should the need arise.
- The hospital used the national early warning score (NEWS) tool to identify deteriorating patients in the theatre, recovery and ward areas. NEWS is based on a simple scoring system in which a score is allocated to physiological measurements (including blood pressure and pulse) to enable timely detection of patient deterioration.
- Four sets of medical records we reviewed revealed that the use of NEWS had been accurately calculated and completed. Nursing staff used a national communication tool (SBAR)when contacting a consultant or the resident medical officer (RMO) if a patient gave rise for concern. SBAR is an acronym for situation, background, assessment and recommendation which ensures nursing staff communicate the relevant information when seeking medical advice.
- All staff had access to a sepsis screening tool. Sepsis is a potentially life-threatening condition triggered by an infection or injury. We reviewed this tool, which provided clear directions of the actions to take if sepsis was suspected, including treatment and the need to escalate the patient to a senior clinician immediately, with transfer to the local NHS trust if required.
- Patients were not accepted into the theatre area unless they had been marked identifying the site where surgery was planned. A consultant explained how patients were not anaesthetised until they had confirmed the correct site of surgery. This process was in place to prevent the occurrence of wrong site surgery.
- Theatre staff identified those members of staff who had received training in paediatric life support and immediate life support at the start of each day using an asterix on the staffing white board. This meant that, in an emergency, staff knew who to call upon quickly.
- Theatre staff identified which staff member was the list safety officer for each theatre. This staff member wore a red hat and was responsible for overseeing the World Health Organisation (WHO) 'Five Steps to Safer Surgery' checklists were completed correctly.
- We reviewed four sets of medical records, which all contained completed WHO 'Five Steps to Safer Surgery' checklists. This included notes on debrief for each procedure.

Nursing and support staffing

- A senior nurse reported that the standard number of staff on the ward consisted of six or seven registered nurses (RN) and four healthcare assistants. Ward staff levels were calculated based on theatre lists with staff being planned four days in advance using a tool to calculate safe staffing levels.

- At the time of inspection, the ward had vacancies for four RNs. The theatre had seven vacancies. The hospital had a continuous recruitment programme ongoing.
- Both theatres and the ward used regular agency staff regularly to address any staff shortages and ensure appropriate numbers on each shift. Agency staff were required to complete an induction prior to commencement of work at the hospital. We saw five completed induction forms. At the time of inspection, the ward was using three agency staff.

Medical staffing

- The hospital had 187 doctors on practising privileges (PP's) at the time of our inspection.
- The surgical department had access to the hospital's Resident Medical Officer (RMO) who provided continuous medical cover and conducted regular ward rounds to ensure that all patients were appropriately treated and safe.
- The hospital had two RMO's who worked one weeks on, one week off. Standby doctors were available in the event of the resident RMO being unavailable through either private reasons or when excessive night time working had occurred.
- Medical staffing cover out of hours was provided by the on-site RMO. In addition, consultants visited their patients at least once in a 24 hour period and were contactable out of hours by telephone. They provided advice over the telephone or attended the hospital should the need arise. We were told that consultants were supportive when contacted for advice.

Records

- **Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.**
- All patient records were in paper format and staff stored them securely onsite. We reviewed four sets of patient medical records. Notes were neat and tidy, legible and clearly detailed who had completed each entry on the records for ease of traceability.
- All records contained a venous thromboembolism (VTE) risk assessment and World Health Organisation (WHO) surgical checklist and prescription drug chart along with a correctly completed national early warning score (NEWS).Staff had recorded next of kin, patient allergies and patient weight in all records we reviewed.

Medicines

- **The hospital followed best practice when prescribing, giving, recording and storing medicines.**
- Ward staff monitored daily fridge temperatures of the medicines fridge. Records showed staff took action and reset the fridge if the temperature was outside of acceptable limits.
- The on-site pharmacy department provided all prescribed medications for use in theatre and ward areas.
- Staff stored controlled drugs (CD) securely in the ward area. Two registered nurses (RN) completed daily checks of CD's and drugs were stored in line with legislation. One nominated staff member held the keys for this store at all times.
- Staff stored general ward medications in locked cupboards or in drug trolleys which were locked and secured to the wall in the clean utility room. The pharmacy department were responsible for the checking and stocking of this area.
- Controlled drugs within the theatre area were accessible via one of five keys. More keys were required in this area due to the number of theatre lists that were carried out at any one time to enable clinicians to access to patient drugs in a timely manner. At the end of the day, all five keys were secured in a central cupboard once operating lists had finished.
- We visited three operating theatres and their respective anaesthetic areas. Staff had locked all CD cupboards. This was an improvement on our previous inspection where two controlled drug cupboards had been left unlocked in the anaesthetic room areas.
- We checked two drugs within the controlled drugs cupboard, both were all in date and correctly reconciled with the CDs record book.
- In the three anaesthetic rooms we visited staff had not inappropriately left pre- drawn up drugs on the work

top. This was an improvement on our previous inspection where we found staff prepared drugs used for the induction of anaesthesia in advance and left them on the side.

- Theatre staff stored intravenous fluids in a locked and temperature monitored cupboard. Fluids were stored in labelled drawers, were neat and easily accessible. This was an improvement on our previous inspection where the fluid storage area was disorganised.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- The hospital had introduced a "Stand up for Safety" initiative which gave all staff the power to stop other people and challenge them if they felt their actions were potentially unsafe. Two members of staff told us they felt empowered by this.
- The hospital reported two never events in surgical services from January 2018 to December 2018. One involved a retained swab and the other was a wrong side prosthesis. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The medical advisory committee (MAC), the heads of department (HoDs) and senior leadership team (SLT) investigated the incidents and developed appropriate actions plans to address issues identified and ensure the sharing of learning with all staff.
- Three RNs we spoke to about the duty of candour regulation (DoC) were able to talk confidently and knowledgeably about it and had received update training. This was an improvement on our previous inspection. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The ward manager shared learning from local and national incidents in the monthly newsletter and at team meetings. Meeting minutes dated 10 October 2018 evidenced this.
- Team meeting minutes displayed on a white board in the theatre area evidenced staff shared learning from incidents.

Safety Thermometer

- The hospital utilised an electronic dashboard to monitor safety within the hospital. This gave an overview of the number of episodes harm free care, falls, urinary tract infections (UTI), and looked at data such as emergency returns to theatre and unplanned transfers.
- Information from the dashboard was fed to the heads of departments and shared with ward and theatre staff at team meetings.
- Safety dashboard data from November 2018 showed zero patients with VTE, 100% of patients had received harm free care, zero patients with pressure ulcers and 100% of patients had received a VTE risk assessment.
- Ward team meeting minutes dated 10 October 2018 evidenced discussions around the safety thermometer and learnings from incidents identified.

Are surgery services well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The senior leadership team consisted of the interim hospital director who was also the registered manager,

operations manager and the head of clinical services (matron). All three were experienced in health care. The hospital director had only been in post four weeks at the time of inspection.

- The surgery service was being managed by two acting theatre managers and the inpatient manager. The leads reported to the head of clinical services.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups**.
- The hospital vision was 'to make Springfield the hospital of choice for all stakeholders'. This was underpinned with three strategies; to make the hospital a great place to work. To ensure the hospital was the first choice for customers, including patients, consultants and GP's who refer or those who commission services at the hospital.
- The ward vision was "excellence all of the time" and this was discussed at ward team meetings.
- The senior leadership team discussed the strategy for surgery as part of the SLT meeting dated November 2018 and agreed actions to implement it.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- Staff spoke positively about the local senior leadership team (SLT). One member of staff said the hospital director was very visible and approachable and showed us a list of concerns they were about to raise with them in the confidence action would be taken and there would be no reprisals.
- One member of staff told us "I love it here" another said local managers were visible and supportive.
- Fifty one percent of theatre staff had received appraisal and 90% of ward staff. The SLT told us appraisal rates for theatre staff were lower than desired because the theatre manager had recently left. The SLT were looking to appoint a new manager before the end of 2018 who would address this.
- Three members of staff told us the head of clinical services was very visible and approachable.

Governance

- The hospital governance issues were addressed through various meetings including the medical advisory committee (MAC) meeting, heads of department (HoD) meeting, SLT meetings and the clinical governance committee.
- The MAC met on a three monthly basis. Reports from the clinical governance meeting, SLT and HoD meeting were sent through the MAC. We reviewed the minutes of MAC meetings held in April, August and November 2018, which were comprehensive in detailing discussions of the meeting agenda items.
- The MAC meeting had a regular agenda for discussion. The meeting minutes provided to us for April, August and November 2018, showed the MAC had oversight of hospital risks, agency usage, staffing levels and training among other things.
- The MAC meetings were well attended with an average of four doctors sending apologies per meeting. This was an improvement on our previous inspection where minutes of the meetings provided showed that attendance did not represent all specialties. There were doctors who regularly sent apologies. The MAC chair and clinical governance lead explained attendance had improved by opening up the invitation to the meeting to other doctors within a specialty and having a rolling programme of meeting dates established well in advance.
- The hospital director showed us letters evidencing how doctors with practicing privileges (PP) were requested to provide details of their recent appraisal, disclosure and barring service (DBS) certificate and medical indemnity insurance in order to maintain their PP with the hospital.
- The hospital had a meeting structure which allowed communication from ward to board and back again. The clinical governance team met quarterly and produced a hospital wide report which was shared with the MAC and the SLT.
- The SLT met weekly, which was more regular than usual, at the time of inspection as part of the settling in process for the interim hospital director. Meeting minutes dated 26 November and 10 December 2018

demonstrated the SLT held discussions around feedback from the MAC, HoDs and ward meetings. This ensured the SLT had oversight of issues around staffing, audits and risks among other things.

- HoDs met on a monthly basis and used a standing agenda. We reviewed meeting minutes dated 26 September, 17 October and 21 November 2018 and saw the agenda items included feedback from SLT and ward team meetings.
- Ward team met on a bi monthly basis and meetings were attended by a member of the SLT. Meeting minutes dated October 2018 evidenced discussions around risks, staffing and audits among other things and feedback from the HoD and SLT meetings.

Managing risks, issues and performance

- The hospital had a risk register. The risk register covered all services in the hospital. There were 22 risks on the risk register dating back to February 2018. The descriptions of the risks were specific, each risk had a named owner, a review date and was rated red, amber or green. This was an improvement on our previous inspection where the risks recorded were generic and related more to operational management than service specific risks.
- The entries on the risk register were descriptive and reflected current service risk, for example usage of agency staff and the emergency call bell system. There were clearly defined control measures in place to mitigate the risks in their current form or long terms plans to mitigate, reduce or eliminate the risk of impact. This was an improvement on our previous inspection. All the risks had been reviewed 3 November 2018.
- The hospital took part in Ramsay group wide audits, national audits and local audits. For example, the patient-led assessments of the care environment (PLACE) audits, notes audits, venous thromboembolism (VTE) risk assessment audits and hand hygiene audits among others.
- Audits were completed by all staff with support from seniors and the inpatient manager. Staff were allocated time for completion of audits. Staff developed action plans to address findings if compliance was less than 95%. This demonstrated using audits to improve services.
- The hospital had comprehensive audit schedule for all areas of the ward and theatre. Theatre audits were two months behind schedule. This was because the theatre manager had recently left. The SLT were looking to appoint a new manager before the end of 2018 who would address this.
- SLT meeting minutes dated 26 November and 10 December 2018 demonstrated the SLT had oversight of audits and their outcomes and of risks. The SLT reviewed the risk register as part of a standing agenda item.
- HoD meeting minutes dated 26 September 2018 demonstrated the HoDs discussed and acted on audit findings in order to improve services.

Managing information

- **The service collected, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- The hospital used an electronic clinical governance dashboard to monitor quality and performance.
- All staff could access policies through the hospitals internet using their unique secure log in details. Staff reported that they had access to these. One member of staff told us that printed copies of new policies or updated policies were left in the rest room for staff to read.
- Senior leaders and the MAC discussed quality and sustainability in meetings. This was evidence by the MAC meeting minutes dated November 2018 and the SLT meeting minutes dated 26 September 2018.
- Theatre staff stuck the barcodes of any implants used during surgery into the patient's records for future reference if required.

Engagement

- **The hospital sought patient feedback via a number of methods.** Patients were able to submit feedback via the hospital website or using complaints and compliments forms.
- During our inspection we saw feedback forms on display in the reception area. These were aimed at both staff and patients and named 'customer service excellence

recommendation'. The aim of the forms was to highlight anyone who had provided a good service, either a patient recommending, or, a staff member recognising excellence in another member of staff.

- The reception desk had a supply of 'would you recommend us' cards on display for patient use with contact numbers to provide feedback.
- Data provided by the hospital showed the recent patient satisfaction survey results, published for December 2018, were overall positive with 95% of patients likely to recommend to family and friends.
- The Hospital Director told us the staff survey, undertaken in July 2018, contained disappointing results for the SLT**.** The SLT had developed an action plan to address the issues identified and there had also been a change in leadership. The next staff survey results were not yet due but five members of staff we spoke with spoke positively about working at the hospital.

Learning, continuous improvement and innovation

- The hospital was introducing a standardised call bell system to replace the two systems currently in place. This would simplify the emergency call system for staff.
- Since our previous inspection (October 2016) the SLT had developed a 26 point, RAG (red, amber, green) rated, action plan to address all the concerns we raised and ensure improvement. Twenty three of these points were now rated green and three were amber and ongoing.
- The hospital was preparing for major building works (February 2019) to expand and refurbish the reception area to allow all service receptionists to be located in one area of the hospital.

Good

Services for children and young people

Effective	Good
Well-led	Good

Are services for children and young people effective?

Good

Our rating of effective improved. We rated it as **good.**

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- The policies used by the hospital for children and young people were developed by Ramsay Health Care UK Operations Limited.The policies were written in line with national guidance. We reviewed three policies relating to the care of children and young people. All of the policies referenced relevant guidelines and legislation and were up-to-date with review dates on them. For example, the nutrition and hydration policy contained guidance from Ramsay corporate policies and guidance, the National Patient Safety Agency, and the National Institute of Health and Care Excellence (NICE).
- The paediatric day case care pathway was evidence based. The pathway was underpinned throughout by Resuscitation Council, the Nursing and Midwifery Council, NICE guidance, National Patient Safety Agency (NPSA) guidelines, The Marsden Manual 2015, and two published, reviewed, independent research projects. The pathway included checks of paediatric early warning scoring and relevant risk assessments throughout the pathway.
- The service did not participate in national audits for the care of children and young people. The service would be informed by their head office if they qualified for any national audit participation.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.**
- The service provided a separate menu for children, with age appropriate meal choices. Feedback from patients led to a review of the menu to reflect meal choices for adolescents.
- Patients, where they were able to consent or their parents, were provided with information regarding fasting prior to procedures in the outpatient setting. We saw the nutrition and hydration policy which was evidenced based and included Ramsay guidelines on pre-operative starvation.
- Fasting could be staggered throughout the day and changed dependent on where a patient was on the operating list.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.**
- The service used the Baker-Wong pain assessment tool to help children identify their levels of pain.
- Children's heights and weights were recorded in their notes. This was audited along with the recording of pain assessments and whether children's pain was controlled or not.
- The service had access to paediatric pharmacy advice and support, between 9am and 5pm Monday to Friday, with an on call pharmacist available at all other times.

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.**
- There were no national audits undertaken by the hospital involving children and young people.

- The service had a formal audit plan in place. The plan included, but was not limited to, audits on resuscitation, staffing, theatres, safeguarding, documentation, paediatric information leaflets and risk assessments. One nurse was able to discuss action plans to specific audits. This was an improvement from our previous inspection where we found that there were no specific audits undertaken locally on the care or treatment of children or young people.
- The audit plan was managed and well actioned. We saw an audit that showed only 60% of sampled staff had taken part in a paediatric resuscitation training scenario. As a result of this, three of these scenarios had been conducted between August and November 2018 to capture more staff, with a re-audit planned.
- There was a pathway in place for the care of children attending for day surgery.
- The hospital had no unplanned transfers to local NHS trust in the period January 2018 to December 2018 for children and young people.

Competent staff

- **The service made sure staff were competent for their roles**.
- The service had two registered nurses (child branch) in post. One had been in post for three months at the time of our inspection and the other was on long term leave from their role. Another registered nurse (child branch) had accepted an offer of employment and was due to commence their post imminently after our inspection. Another post, for a childrens' service nursing lead, was out to advert at the time of our inspection. Due to these staffing arrangements we were unable to gain a view of the effectiveness of appraisal arrangements.
- There was one regular agency nurse (child branch) used to support the service on night shifts when children were required to stay overnight.
- The ward had three health care assistants who had completed some paediatric competencies to support in caring for children admitted to the ward.
- Staff had clinical competency booklets to work through, alongside an induction process when new in post. All new starters were allocated a buddy to support them through their induction period.
- The ward manager kept competency folders in their office. This was a new system they had created, to measure which staff were competent in particular skills. The paediatric competency file was in process at the time of our inspection.
- All theatre staff had received Paediatric Immediate Life Support training and 55 registered nurses out of 88 had completed Paediatric Immediate Life Support training annually. Six members of theatre staff had received Advanced Paediatric Life Support training, which was sufficient for the number and size of theatre lists with children on them. All theatre staff had received safeguarding children level three training. Medical staff had their competencies checked by the MAC, as a condition of their practicing privileges.
- Theatre staff had undertaken three separate paediatric cardiac arrest scenarios. We saw debrief information with learning points, in theatres. This meant that staff were able to practice their skills in cardiac arrest.

Multidisciplinary working

- **Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**
- Nursing staff told us of a senior paediatrician who was the service lead, however they were not available for us to speak to at the time of our inspection. One nurse told us they felt well supported and well-led by this lead.
- All childrens' admissions were arranged between the surgeon and the member of nursing staff (child branch) who was the only registered nurse in post and present at the time of our inspection. This meant that all children had the same named nurse, and the nurse was able to limit admission numbers to keep the nurse to patient ratio within safe limits. The clinical governance chair, a paediatric anaesthetist, stated that known complex cases were not accepted at this service. This assured us that the service ensured staff were not expected to provide care for children with complex needs outside of their competency.
- The service had a pathway in place with a local NHS trust for the transfer of deteriorating children. This was supported by a working arrangement with the Children's Acute Transport Service (CATS).

Good

Services for children and young people

Seven-day services

- Surgery for children and young people was carried out on selected days. Provision for their care was planned around these admissions and around the shifts of the registered nurse (child branch) who was operational at the time of our inspection.

Health promotion

- **The service promoted health, wellbeing and personal safety to patients and their families.**
- We saw display board in the corridor dedicated for children's beds. The board included information on staying safe, sun protection, hand hygiene, mental health, physical activity and signs and symptoms of meningitis.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.**
- The hospital had an up-to-date consent policy, which outlined the process for gaining valid consent from children and young people for examination and treatment.
- The policy described, 'Gillick competence', which is a legal requirement to determine whether a child had sufficient understanding and intelligence to enable them to understand fully the proposed procedure. One member of staff explained how Gillick competence was assessed in children and young people. We saw four sets of records, all of which showed appropriate recording of the Gillick competence assessment. All entries were signed and dated by the nurse carrying out the assessment. This was an improvement from our previous report where this was not recorded formally as to whether it was or was not considered.

Are services for children and young people well-led?

Good

Our rating of well-led improved. We rated it as **good.**

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The service had a consultant medical lead. Recruitment was ongoing for a nursing lead for the service. The current infection prevention and control lead was also a registered nurse (child branch) with a senior nursing background, and had taken an informal leadership role in relation to the children and young people's meeting, audit plan, and improvement plan, supported by the senior leadership team.
- There was representation of the children and young people's service at the Medical Advisory Committee.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff, patients, and local community groups.**
- The service was committed to an annual plan. This plan aimed to improve and strengthen the service. The children and young people's meeting had regular oversight of this plan. We reviewed the plan and saw the majority of aims for the service had been achieved. Outstanding actions included creating a separate children's area in the outpatients' department, continued recruitment into the service to support service expansion, and the formalisation of an on-call plan for consultant anaesthetists and surgeons.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- On the day we inspected the service there were no children admitted to the hospital so we were unable to

talk to many staff in children's and young people's services. However, we spoke with staff in departments throughout the hospital about children's and young people's services who spoke positively about working at the hospital, and the priority that children's services was given.

- Staff surveys were completed annually. The results from the last survey completed in July 2018 showed that the hospital was performing worse than the Ramsay Health Care average in 51 questions, out of a total of 53 questions. These questions cover topics such as culture, staffing, management and leadership, and work-life balance. This was worse than we found in our previous inspection where the hospital performed worse in 11 questions.
- However, the poor survey results had led to a change in hospital leadership. Staff we spoke with on our inspection were very positive about the service which indicates a positive change in culture since this survey.
- The service had a positive culture towards providing a safe and effective service to children and their families. This was evident as they had voluntarily suspended the service completely between April 2018 and September 2018 in order to make improvements.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- The service had a meeting structure in place. There was a children and young persons meeting that met quarterly. This meeting fed in to the hospital's clinical governance committee to advise the committee on the performance and safety of the children and young people's service. Representation at this meeting included representation from the ward, theatres, the head of clinical services, the hospital director and several consultants. We saw minutes that showed issues such as progress of the paediatric action plan, staffing, safeguarding and training were covered in these meetings.
- The chair of the clinical governance committee was a paediatric anaesthetist. The service governance processes were the same throughout the hospital. We have reported about the governance processes under the surgery service within this report.
- The risk register for the hospital included oversight of the children's service. The risk was reviewed and updated regularly and included a named ownership of the risk, a designated oversight committee (in this case, the MAC with escalation to the clinical governance committee), and set actions for improvement. This was an improvement from our previous inspection where we found no items on the risk register relating to the children's and young people's service.
- A paediatric consultant represented the children and young people service on the medical advisory committee (MAC). We saw reference to the children and young people's service in MAC minutes from April, August and November 2018. This was an improvement from our last inspection where we were not assured that there was sufficient MAC oversight of the service.
- The discussion of children's services was a standard agenda item at the clinical governance meeting agenda. A paediatric anaesthetist chaired the committee and a registered nurse (child branch) was on the committee. We reviewed four clinical governance meeting minutes and saw that the service was represented, although discussion of the service only took place in two of the meetings.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- We saw a completed risk assessment for children being treated on the ward where adult patients were. The risk assessment included risk scoring, controls, and dated actions. We saw the outcome of the actions with the children's corridor completed at the time of our inspection.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**

Good

Services for children and young people

- All staff could access policies through the hospitals internet. Staff reported, and we saw that they had access to these. One member of staff told us that printed copies of new policies or updated policies were left in the rest room for staff to read.
- Children's discharge was nurse led. Patients and their carers were provided with leaflets containing details about postoperative care for different procedures, pain medication, and the telephone number of the ward to call with any questions or concerns. Auditing took place of these leaflets, and action from these audits led to all information being Ramsay approved and written for different age ranges.

Engagement

- **The service engaged well with patients and staff to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- There was a feedback board located in the corridor dedicated to children's beds. The board showed how patients and their families were engaged with to gain their views for the purpose of service improvement.
- Service level agreements in place with local NHS trusts and the Children's Acute Transport Service, for paediatric advice and support ensured a safe, effective and well supported service.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.**
- One nurse told us they were proud of the way the service had worked on smaller improvements for children, such as matching bed linen with children's likes, improving the play room and the provision of a new teddy bear for all admitted children.
- In our previous inspection we saw that building work was being undertaken to create a separate area of the ward for children. During this inspection we saw a 10 bedded corridor on the ward that was dedicated to children. This included a paediatric emergency trolley, and three double rooms, to sleep parents too, with age appropriate decoration and bed linen.
- In our previous inspection we saw that building work was being undertaken to create a dedicated children's recovery area. During this inspection we saw this completed area. The children's recovery area was a two bedded glass room. Privacy was protected with frosted glass and the area had age appropriate decoration.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that it has a substantive service lead to provide nursing leadership.
- The provider should ensure that the theatre audit schedule is up to date.
- The provider should ensure that all theatre staff have an annual appraisal.