Pinehill Hospital

Quality Report

Benslow Lane
Hitchin
Hertfordshire
SG4 9QZ
Tel: 01462 422822
Website: www.ramsayhealth.co.uk

Date of inspection visit: 19, 20 and 27 October 2016
Date of publication: 20/03/2017

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Pinehill Hospital is operated by Ramsay Health Care UK Operations Ltd. The hospital has 37 beds. Facilities include three operating theatres, and X-ray, outpatient and diagnostic facilities.

The hospital provides surgery and outpatients for adults, children and young people, and diagnostic imaging. We inspected surgery, outpatients and imaging and services for children and young people.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 and 20 October 2016, along with an unannounced visit to the hospital on 27 October 2016.

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.

The main services provided by this hospital were outpatients and surgery for adults. Children and young people's services were a small proportion of hospital activity. Where our findings on surgery, for example, management arrangements, also apply to other services, we do not repeat the information but cross-refer to the surgery, the main core service.

See the surgery section for main findings.

Services we rate

Safety, effective and well-led required improvement. We found caring and responsive was good. This led to a rating of **requires improvement** overall.

Main findings:

- Mandatory and safeguarding training rates were below those expected by the organisation.
- There was a high number of serious incidents and surgical site infections compared to other independent hospitals of the same type.
- There were insufficient controls in place to ensure all equipment was cleaned regularly and to prevent the misuse of medicines and prescription forms. The hospital had taken action to address our concerns following our inspection.
- Compliance with staff appraisals on the ward was low; however, staff had been booked for their appraisals at the time of inspection.
- The risk register did not have clear action plans identified against each risk or review dates. Therefore, it was unclear to see if they were on-going or old risks. However, the ward and theatres individual risk registers were clear and up to date.
- Staff turnover was higher than the average for independent hospitals. This had been recognised by the hospital and had plans in place.
- There was only one employed registered nurse (child branch) supplemented by bank and agency staff. Children were sometimes not under the direct supervision of a suitably qualified member of staff. There was no registered nurse (child branch) on duty in recovery or in outpatients when children and young people attended for appointments.
- There was not a separate children's recovery area, which meant children recovered from surgery alongside adult patients. However, children were separated from adults by a curtain.
- The outpatient department did not have a paediatric resuscitation trolley.
- Not all staff involved in caring for children had safeguarding children's level 3 training.

Summary of findings

- Children and young people's preoperative medical questionnaires were not always completed or reviewed by a registered nurse.
- Not all clinical policies referenced the most up to date national guidance available.
- There was no audit schedule for children and young people to assess patient outcomes.
- There was no strategy to fulfil the vision for expanding the paediatric service.
- Risks we identified on inspection were not on the risk register. Risk registers lacked detail and did not include actions taken to mitigate risks or what assurances the hospital had in place to minimise risks identified. No paediatric specific risk register was in place and the hospital wide risk register did not have any paediatric risks listed.

However:

- There were systems to keep patients safe, including the reporting and investigation of incidents. Learning from incidents was cascaded to all staff.
- Staffing levels were sufficient to meet the needs of patients and we observed effective multidisciplinary team working by competent staff.
- Staff were proud of the hospital and the care they provided. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received.
- Patients had access to care and treatment in a timely way. The hospital was exceeding the national referral to treatment times for NHS patients.
- Patient care and treatment was delivered in line with national guidance.
- Leadership was strong, supportive and visible. Staff felt confident to report concerns to senior managers.
- Staffing levels were sufficient to meet the needs of patients and we observed effective multidisciplinary team working by competent staff.

We found some practice that **required improvement** in relation to **outpatient care**:

- Mandatory and safeguarding training rates were below those expected by the organisation.

And some **good** practice:

- Patients had access to care and treatment in a timely way. The hospital was exceeding the national referral to treatment times.
- Patient care and treatment was delivered in line with national guidance.
- Leadership was strong, supportive and visible. Staff felt confident to report concerns to senior management.

We found areas of **good** practice in **surgery**:

- In surgery, staff worked especially hard to make the patient experience as pleasant as possible. Staff recognised and responded to the holistic needs of their patients from the first referral before admission to checks on their wellbeing after they were discharged from the hospital.

And some areas **for improvement**:

- Compliance for staff appraisals on the ward was low; however, staff had been booked for an appraisal at the time of inspection.
- The corporate risk register did not have clear action plans identified against each risk or review dates. Therefore, it was unclear to see if they were on-going or old risks. However, the ward and theatres individual risk registers were clear and up to date.

We found areas of practice that required improvement in services for **children and young people**:

Summary of findings

- Services did not meet the needs of their young patients fully because many facilities were shared inappropriately with adults, resulting in a lack of privacy and dignity for young patients.
- There was insufficient numbers of staff with the right qualifications
- There was a lack of oversight with regards to risk management and security.

And some **good** practice:

- Pain was managed well, with child friendly pain scores in use.
- Staff provided compassionate care to patients and their parents or carers.

Following this inspection, we told the provider that it must take some actions to comply with the regulations because they had been breached and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with 3 requirement notices that affected children and young people's service. Details are at the end of the report.

Edward Baker
Deputy 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. We rated this service as good because it was safe, effective, caring, responsive and well-led. • Incidents were reported, there was feedback for staff and lessons were learnt. • There were processes in place to ensure that the hospital was clean. • Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care. • There were safe systems in place to manage medicines. • Staff we spoke with were able to tell us what steps they would take if they were concerned about potential abuse to their patients or visitors. • Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. • Pain was assessed and managed pre and post operatively. Effective tools were used. • The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. • The endoscopy service was awarded the Joint Advisory Group (JAG) accreditation in April 2014. • Patient records showed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists. • Patients were treated with dignity, compassion and empathy. • Theatres managed operating lists with flexibility, to meet patient's individual needs.

Summary of findings

- There were no waiting lists and patients were seen within one to two weeks from their referral.
- Patients we spoke with confirmed they were given a choice of appointment times and were able to schedule procedures at a time convenient to them.
- There was a clear governance structure in place with committees for medicines management, infection control and health and safety.
- Staff we spoke with were motivated and positive about their work, and described all members of the senior management team as approachable and visible.

However,

- There was a high number of serious incidents and surgical site infections.
- Compliance for staff appraisals on the ward was low; however, staff had been booked for an appraisal at the time of inspection.
- The corporate risk register did not have clear action plans identified against each risk or review dates. Therefore, it was unclear to see if they were on-going or old risks. However, the ward and theatres individual risk registers were clear and up to date.
- Staff turnover was higher than the average for independent hospitals. This had been recognised by the hospital and had plans in place.

Services for children and young people

Requires improvement

Children and young people's services were a small proportion of hospital activity. Where arrangements were the same, we have reported findings in the surgery section.
We rated this service as requires improvement because safety, effective and well-led required improvement. We found caring and responsive was good.

- There was not a separate children's recovery area, which meant children recovered from surgery alongside adult patients. However, children were separated from adults by a curtain.

Summary of findings

- The outpatient department did not have a paediatric resuscitation trolley.
- Not all staff involved in caring for children had safeguarding children's level 3 training.
- Preoperative medical questionnaires were not always completed or reviewed by a registered nurse.
- There was no registered nurse (child branch) on duty in recovery or in paediatric outpatient appointments.
- Not all clinical policies referenced the most up to date national guidance available.
- There was no audit schedule for children and young people to assess patient outcomes.
- There was no strategy to fulfil the vision for expanding the paediatric service.
- No paediatric specific risk register was in place and the hospital wide risk register did not have any paediatric risks listed.
- Risks we identified on inspection were not on the risk register.

However:

- Staff understood their responsibilities to raise concerns and incidents. Lessons were learnt following incidents.
- Pain was managed well, with child friendly pain scores in use.
- Staff provided compassionate care to patients and their parents or carers.
- Parents we spoke with were very happy with the level of care their children were given.
- Saturday surgical lists had been introduced for paediatric surgeries due to increased demand.
- Children and young people had staggered admissions, to reduce the waiting time for their operation.

Outpatients and diagnostic imaging

Requires improvement

We rated this service as requires improvement because safety, and well-led required improvement. We found caring and responsive was good.
Effectiveness is not rated for outpatient and diagnostic services.

- There were insufficient controls in place to ensure all equipment was cleaned regularly and

Summary of findings

to prevent the misuse of medicines and prescription forms. The hospital had taken action to address our concerns following our inspection.
- Mandatory and safeguarding training rates were below those expected by the hospital's parent company.
- Risk registers lacked detail and did not include actions taken to mitigate risks or what assurances the hospital had in place to minimise risks identified.

However:

- There were systems to keep patients safe, including the reporting and investigation of incidents. Learning from incidents was cascaded to all staff.
- Staffing levels were sufficient to meet the needs of patients and we observed effective multidisciplinary team working by competent staff.
- Staff were proud of the hospital and the care they provided. We observed positive interactions between staff and patients. All patients spoke highly of the care they had received.
- Patients had access to care and treatment in a timely way. The hospital was exceeding the national referral to treatment times.
- Patient care and treatment was delivered in line with national guidance.
- Leadership was strong, supportive and visible. Staff felt confident to report concerns to senior management.
- There were effective governance arrangements in place to support the provision of good quality care.

Summary of findings

Contents

Requires improvement

Pinehill Hospital

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

Summary of this inspection

Background to Pinehill Hospital

Pinehill Hospital is operated by Ramsay Health Care UK Operations Ltd. Originally it was a large house, but has had numerous extensions. The hospital has 37 beds over two floors; this includes a 12 bed day ward.

It is registered to provide the following regulated activities:

- Surgical procedures
- Diagnostic and screening
- Treatment of diseases, disorder and injuries
- Family planning

There is a registered manager who has been in post since July 2016.

The matron is the accountable officer for controlled drugs.

Facilities include three operating theatres with individual anaesthetic rooms and a recovery area. There is one minor theatre used for endoscopies and local anaesthetic procedures. Other facilities include general x-ray, ultrasound, two outpatient treatment rooms and a physiotherapy gymnasium.

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

We inspected the services using our comprehensive inspection methodology. We carried out the announced part of the inspection on 19 and 20 October 2016, along with an unannounced visit to the hospital on 27 October 2016.

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.

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

Our inspection team

The team that inspected Pinehill Hospital comprised of a CQC lead inspection manager, Kim Handel, three CQC inspectors, a CQC assistant inspector and four specialist advisors; a consultant surgeon, a theatre nurse specialist, a children's nurse and a governance specialist.

Information about Pinehill Hospital

Pinehill Hospital provides an inpatient and outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, diagnostic imaging and urology. Children and young people are seen privately only.

There were 7,082 inpatient episodes between July 2015 and June 2016. 5,601 were day cases and 1,481 stayed one or more nights in hospital. In total, there were 6,923 procedures carried out during the same period. Of these, 79 were children who were cared for on a day care basis, 20 stayed overnight.

Summary of this inspection

Between July 2015 and June 2016, 48,072 people were seen in outpatients, of which 2,005 were under the age of 18.

Between July 2015 and June 2016, around 53% of the patients having day or inpatient treatment were funded by the NHS; the remaining patients were self-funding or paid for by their insurance companies. In outpatients, around 39% of patients were funded by the NHS, the rest by other means, either via insurance companies or self-pay.

Children were seen in outpatients from birth and were operated on from three years old.

The activity of the 150 doctors who had practising privileges was individually monitored. In addition, there is 109.5 whole time equivalent employed staff.

Pinehill Hospital has the following accreditations:

- BUPA accredited Breast Care Centre
- BUPA accredited Cataract Centre
- BUPA accredited Bowel Care Centre
- BUPA accredited MRI & CT Centre
- Joint Advisory Group accredited

All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day by an onsite resident medical officer. Patients are cared for and supported by registered nurses, care assistants, allied health professionals such as physiotherapists and pharmacists who are employed by the hospital.

During the inspection, we visited both wards, the day unit, outpatients and the operating theatres.

We spoke with 33 staff including; registered nurses, health care assistants, reception staff, the resident medical officer, operating department practitioners, and senior managers. In addition we spoke with six consultants who worked at the hospital under practising privileges. We spoke with 14 patients, including one young person and nine relatives. We also received 49: 'tell us about your care' comment cards which patients had completed prior to our inspection. During our inspection, we reviewed 21 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. The hospital has had two previous inspections in November 2012 and December 2013. There were no outstanding non-compliances.

Summary of this inspection

Track record on safety:

- One never event.
- Clinical incidents: 101 no harm, 46 low harm, seven moderate harm, zero severe harm, one death
- 10 serious injuries
- Zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile (C.difficle)
- One incidence of hospital acquired E-Coli
- 87 complaints.

Services provided at the hospital under service level agreement:

- Clinical and or non-clinical waste removal
- Blood transfusion
- Pathology and histology
- Maintenance of medical equipment
- Medical physics
- Interpreting services
- Laundry
- RMO provision.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- There was a high number of serious incidents and surgical site infections.
- There were insufficient controls in place to ensure all equipment was cleaned regularly.
- There were insufficient controls in place to prevent the misuse of medicines and prescription forms. The hospital had taken action to address our concerns following inspection.
- Not all staff had completed mandatory and safeguarding training and there was a risk that staff did not have up-to-date knowledge in order to protect patients, visitors and staff from potential harm.
- There was not a separate children's recovery area, which meant children recovered from surgery alongside adult patients. However, children were separated from adults by curtains.
- The outpatient department did not have a paediatric resuscitation trolley.
- Not all staff involved in caring for children had safeguarding children's level 3 training.
- Paediatric preoperative medical questionnaires were not always completed or reviewed by a registered nurse.
- There was no registered nurse (child branch) on duty in recovery or in paediatric outpatient appointments.
- Paediatric care records, such as fluid balance charts, were not always completed. There was no evidence that comorbidity checklists had been reviewed in all 10 records we reviewed.

However:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff. Incidents and lessons learned were discussed at clinical governance meetings and shared with staff.
- Staff could demonstrate their understanding of the duty of candour and provide examples of its implementation.
- There were processes in place to ensure that the hospital was clean. Ward and theatre cleaning checklists and schedules were thorough and consistently followed.
- There were sufficient numbers of nursing, radiology and support staff to meet patients' needs.
- Equipment in the radiology department was well maintained and had been screened to ensure it was fit for purpose.

Summary of this inspection

- There were robust systems in place to ensure that patients and staff were protected by adherence to national guidelines relating to ionising radiation and diagnostic imaging.
- Staff we spoke on the ward and in theatres were able to tell us what steps they would take if they were concerned about potential abuse to their patients or visitors.
- Patients were appropriately assessed prior to surgery and there were processes in place to transfer patients should they require a higher level of care.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- We found some hard copies of guidelines and policies were out of date in the hospital's seminar room, which meant there was a risk that staff were not accessing the most current policies. Guidelines available on the intranet were found to be up to date and reflected current national guidance.
- Not all paediatric clinical policies referenced the most up to date national guidance available.
- There was no audit schedule for children and young people to assess patient outcomes.
- Children and young people were at times left on the ward without supervision by a registered nurse (child branch).
- Compliance for staff appraisals on the ward was low; however, staff had been booked for an appraisal at the time of inspection.

However:

- Care and treatment was provided in line with national guidance, such as the National Institute for Health and Care Excellence.
- Audits were completed in line with the corporate audit programme and actions were taken to improve outcomes where indicated.
- Surgery had an effective system to regularly assess and monitor the quality of its services, to ensure patient outcomes were monitored and measured.
- The endoscopy service was awarded the Joint Advisory Group (JAG) accreditation in April 2014.
- The radiology department was compliant with national ionising regulations. Dose reference levels were all within the accepted range.
- There was a good multidisciplinary team approach to care and treatment. This involved a range of staff working together to meet the needs of patients using the service.

Summary of this inspection

- Staff had the right qualifications, skills, knowledge and experience to do their job. We found arrangements that ensure doctors and nurses were compliant with the revalidation requirements of their professional bodies.
- Patient records in surgery showed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.
- Staff had access to information they needed to deliver effective care and treatment.
- The hospital had external accreditation for its breast care centre, cataract centre and bowel care centre.
- Consent to care and treatment was obtained in line with legislation and national guidance.
- Comprehensive risk assessments were carried out for patients on the ward and theatres. Patients risk management plans were developed in line with national guidance.
- Pain was managed well, with child friendly pain scores in use.
- Pain was assessed and managed pre and post operatively. Effective tools were used for inpatients.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with respect and maintained patients dignity.
- Patients on the ward were treated with dignity, compassion and empathy.
- We were told by patients that staff were kind, caring and compassionate.
- Staff communicated clearly with patients to ensure care and treatment was fully understood.
- Consultants encouraged patients to be actively involved in the decision making process for their care and treatment.
- Patients we spoke with were very positive about the way they were treated.
- Staff provided compassionate care to children and their parents or carers.
- Parents we spoke with were very happy with the level of care their children were given.

However:

- The Friends and Family Test results for the hospital were varied when compared with the England average.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- Services were planned and delivered to meet the needs of patients. We saw that some services operated in the evenings and at weekends to give patients flexible access to these services.
- The hospital was exceeding national referral to treatment time standards.
- Patients were assessed prior to admission to ensure that the hospital could safely meet their needs.
- Theatres managed operating lists with flexibility, to meet patient's individual needs.
- Patients we spoke with confirmed they were given a choice of appointment times for surgical procedures and were able to schedule procedures at a time convenient to them.
- The outpatient and diagnostic imaging environment allowed for patients with physical disabilities and wheelchair users to be safely cared for.
- The hospital had a robust complaints procedure, which was well publicised and understood by staff. Complaints were investigated in a timely manner and feedback from complaints was shared with staff. There was evidence of improvements to service provision in response to complaints received.
- Saturday surgical lists had been introduced for paediatric surgeries due to increased demand.
- Children and young people had staggered admissions, to reduce the waiting time for their operation.

However:

- Despite translation services being available in OPD, staff told us they generally used relatives to act as interpreters, which is not considered best practice.
- Follow up phone calls to parents, after children had been discharged, were not routinely carried out.
- None of the leaflets available in the hospital were written in child friendly language.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The hospital had developed a vision but this had not been formally rolled out to staff at the time of our inspection. However, staff were aware of the corporate vision and values and were committed to improving patient care and experience.
- Risk registers lacked detail and did not include actions taken to mitigate risks or what assurances the hospital had in place to

Summary of this inspection

minimise risks identified. The outpatient risk register did not align with the hospital risk register and we were not assured that the hospital had full oversight of all risks identified in the outpatient department.
- Whilst the hospital participated in the national patient-led assessment of the care environment (PLACE) audit 2016. We were not assured the hospital had taken action to address any of the concerns and issues identified.
- There was no strategy to fulfil the vision for expanding the paediatric service.
- No paediatric specific risk register was in place and the hospital wide risk register did not have any paediatric risks listed.
- Paediatric risks we identified on inspection were not on the risk register.
- The corporate risk register did not have clear action plans identified against each risk or review dates. Therefore, it was unclear to see if they were ongoing or old risks. However, the ward and theatres individual risk registers were clear and up to date.
- Staff turnover was higher than the average for independent hospitals. However, this had been recognised by the hospital and had plans in place.

However:

- Staff felt that leadership was strong, with supportive and approachable managers.
- Surgery had a clear governance structure in place with committees for medicines management, infection control and health and safety.
- Staff in both theatres and on the ward, were motivated and positive about their work, and described all members of the senior management team as approachable and visible.
- Staff were overwhelmingly positive about their experience of working at the hospital and were committed to improving patient care and experience.
- The governance framework supported the delivery of good quality care.
- The hospital was committed to developing the outpatient and diagnostic imaging service. There were plans in place to expand the service, in order to meet increasing patient demand.
- A child friendly patient satisfaction survey was used to engage with children and young people.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Notes

We are currently not rating effective in outpatients and diagnostic imaging.

Good

Surgery

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

Are surgery services safe?

Good

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

We rated safe as good because:

Incidents

- Staff were aware of the process for reporting any identified risks and incidents. Incidents were logged on the hospital's electronic reporting system. Staff told us they were encouraged to report incidents. Staff were able to discuss incidents they had reported and gave examples of how they received feedback, which was provided by their line manager or matron.
- There had been 127 incidents reported from July 2015 to June 2016 by the theatre and surgery teams. Six of these were non-clinical. Each incident had been reported and investigated in accordance with the service's procedure for incident management. We saw an example of the services incident management. A procedure was cancelled due to an inconclusive pregnancy test result. This was immediately reported as an incident and escalated to the regional director. The service got new manual tests for inconclusive results and produced a standard operating plan (SOP). The SOP stated that two nurses must view the result and sign to document the result. We saw that this incident was discussed at staff meetings and lessons learnt were documented.
- Reported incidents were reviewed and investigated by the ward and theatre managers. Serious incidents were investigated by staff with the appropriate level of seniority, such as the matron.
- Staff told us that incidents and complaints were discussed during daily handovers and monthly staff meetings so shared learning could take place. We saw evidence of this in the meeting minutes. A 'lessons learnt' sheet was used by staff to stimulate discussions on specific issues.
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event. There had been no never events reported during the period from July 2015 to June 2016. However, the hospital had reported 10 serious incidents during the same reporting period, all had been investigated and the root cause analysis showed no adverse effects to the patients. We saw that for one incident, the surgeon wrote a reflective piece of work around this incident, with the full support of the clinical governance committee. The reflective account highlighted a change in clinical technique for the type of surgery that was carried out.
- Staff across all disciplines were aware of their responsibilities regarding duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities). For independent providers, the duty came into force on 1 April 2015. 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. We saw evidence demonstrating duty of candour principles were appropriately applied following the serious incident, other incidents and complaints.

- Any deaths were reported via the clinical governance committee and the MAC. There had been one death between March and June 2016. It had not been reported to the CQC, but was reported to have been expected.

Clinical Quality Dashboard

- There were effective systems in place for monitoring risk from venous thromboembolism (VTE). A VTE or thrombosis is a blood clot that forms within a vein. Safety was monitored using a risk assessment with all patients being assessed for their risk of developing VTE. Records showed that VTE screening rates were 96% from April 2016 to June 2016. There were no incidents of hospital acquired VTE or pulmonary embolisms from July 2015 to June 2016.
- We looked at 10 patient records, and they had VTE assessments completed appropriately.
- Data with regards to pressure ulcers, falls and urinary infections was collected. There had been no pressure ulcers or falls reported.

Cleanliness, infection control and hygiene

- There were systems in place to prevent and protect people from a healthcare associated infection.
- Patients were asked to complete a medical questionnaire before they attended the hospital for a procedure. The questionnaire contained a section about infection risks including identifying healthcare workers and any previous Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile infections. This meant the service could make any necessary arrangements related to infection prevention and control prior to the patient's arrival. There were no reported cases of MRSA (which is an antibiotic resistant bacteria), or Clostridium Difficile (which is a bacteria that infects the gut and causes acute diarrhoea) at the hospital from July 2015 to June 2016.
- The ward areas, theatres and clinical areas appeared visibly clean, tidy and free from clutter at the time of our inspection.
- Hand sanitiser gel dispensers were available in corridors, ward areas, bedrooms and clinical areas. Appropriate hand wash washing facilities were in place along with gel dispensers outside of the patient bedrooms. Hand hygiene posters were on display next to all sinks to remind staff of the correct procedure for hand washing. Staff were observed to be 'arms bare below the elbow' and decontaminated their hands in between patient interventions.
- Staff observed the World Health Organisation (WHO) five moments of hand hygiene guidelines for hand washing. We observed the correct use of person protective equipment (PPE) such as disposable gloves and aprons. We saw staff wore protective eye masks when carrying out procedures in endoscopy.
- The wards and day care unit were all visibly clean and in good repair and had comprehensive cleaning schedules in place.
- The operating theatre department was found to be visibly clean and tidy and the daily cleaning records were consistently completed. The service had appropriate facilities and systems to meet the National Institute for Health and Care Excellence (NICE) CG74 regarding to surgical site infection. All three main theatres had laminar air flow ventilation systems to reduce the risk of airborne contamination and exposure to chemical pollutants in surgical theatres.
- For the period from July 2015 to June 2016, there were 44 reported surgical site infections (SSIs). The rate of infections during orthopaedic and trauma, spinal, gynaecology, upper gastrointestinal and colorectal, urological and cranial procedures was above the rate of other independent hospitals. The rate of infections for breast procedures was similar to the rate of other independent hospitals and there were no SSIs resulting from primary hip arthroplasty, revision hip arthroplasty, revision knee arthroplasty or vascular procedures. We saw action plans were in place to monitor infection risks. All medical records of the patients contracting an infection post theatre were being reviewed.
- We observed in the infection prevention meeting minutes that the reported SSIs were discussed. Plans which had been implemented were, improved theatre cleaning checklists, auditing patient hygiene and the washing of the surgical site before surgery, auditing of staff wearing 'over jackets' when they leave theatres and

they were looking at best practice with regards to peri-operative temperature recordings and shaving of the surgical site. These actions all had a nominated individual to drive forward.

- The segregation and storage of clinical waste was in line with current guidelines set by the Department of Health. We observed sharps containers, clinical waste bags and municipal waste were properly maintained and were in accordance with the current guidelines.
- Storage of equipment was organised and there was a clear system in place identifying which piece of equipment had been cleaned.
- There were clear guidelines for staff about how to respond to a sharps injury (needles and sharp instruments). This complied with the Health and Safety (Sharp Instruments in Healthcare) Regulations) 2013.
- Care was provided for some patients in bedrooms with removable carpet tiles. On the first floor ward area 11 out of the 13 bedrooms had carpet. Staff said that this carpet was wipeable. Staff would wipe up spillages with water and disinfectant and then request the housekeeping staff to thoroughly clean with the appropriate and recommended cleaning products. Staff told us if there was a large spillage the carpet tiles would be removed for cleaning. The infection prevention and control policy clearly set out which cleaning and disinfectant products should be used for specific spillages. This included bodily fluids.
- Staff in theatres were observed to be wearing appropriate theatre clothing. When theatre staff left the department they applied disposable coats and changed their footwear to prevent contaminating their theatre gowns.
- We saw systems and processes were in place for the decontamination of reusable medical devices. The decontamination of reusable medical devices was carried out in line with the Department of Health: Decontamination of surgical instruments (HTM 01-01) guidance. This included separate areas for clean and dirty equipment and electronic tracking systems for use with endoscopes. Endoscopes are lighted, flexible instruments used for the examination of inside the body. The scope tracking system was audited by an external company annually and we saw evidence the department had made changes based on the previous report for example by improving the storage of the printed results.
- Staff completed mandatory training in infection prevention annually. Reports showed of the 39 staff in theatres, 23 had in date infection control training (58%) and the remaining staff were booked on courses. 90% of ward staff were compliant.
- The hospital's annual patient led assessments of the care environment (PLACE) for May 2016 scored 97% for cleanliness of the hospital.
- Staff compliance with mandatory training for hand hygiene was 95% for ward staff, and 75% for theatre staff. For aseptic non-touch technique training compliance was 95% for the wards and 80% for theatre staff. However, theatre staff were trained in the specific 'scrub technique' and the handling of surgical instruments.

Environment and equipment

- There were systems in place to ensure that the facilities were safe and equipment was maintained in line with manufacturer's recommendations.
- The hospital had three theatres, theatre one was used for revision surgery, spinal and shoulder procedures. The second theatre was used for urology, ophthalmic (eye), orthopaedic, plastic, and gynaecology procedures, and theatre three was primarily used for ear nose and throat (ENT) procedures. Other specialities including orthopaedic, plastic and gynaecology made use of this theatre too. There was a procedure room where gastroenterology procedures (endoscopies), pain injections, minor orthopaedic and plastics procedures, such as carpal tunnel and excision of small skin lesions were performed. All had the appropriate anaesthetic equipment in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. All anaesthetic equipment was checked appropriately. The checks were documented.
- There was appropriate resuscitation equipment available in the case of an emergency. Resuscitation trolleys were situated in the recovery room and the two surgical wards. They were all well-organised and had a tamper evident seal in place. We saw records indicating the trolleys and their contents were checked regularly in line with hospital policy. Theatres also had a difficult airway trolley available. We saw a comprehensive list of items which were available on the trolley and a clear checking procedure that was completed daily.
- The theatre department had a clear flow for the disposal of clinical waste and used instruments. Policies were in

place to support staff in the disposal of waste and staff we spoke with understood how to identify different types of waste and the methods which should be used to dispose of it safely.
- The storage of instruments and equipment within the theatre department was well organised.
- Equipment servicing was managed by a centralised maintenance team, who arranged for servicing to be carried out by external contractors. Equipment such as anaesthetic machines and blood pressure machines had labels showing they had been serviced and when their next service was due. Staff told us all items of equipment were readily available and any faulty equipment was repaired or replaced in a timely manner. There was a hoist available on the ward to assist with patient moving and handling when required. This had been serviced and cleaned.
- Patients who needed implants, such as breast or hip prosthesis, had this clearly recorded in their notes alongside appropriate details such as device number and size. This was to enable all implanted devices to be tracked in case any faults develop or show which patient received which type of implant and when, to allow simple tracking if needed.

Medicines

- The hospital had an onsite pharmacy. This was open Monday to Friday 9am to 6pm. Out of hours; the registered medical officer and a registered nurse would access the pharmacy, using a dual key system and code, check and sign medications out against the prescription.
- The pharmacists reviewed all medication prescriptions, including antimicrobial prescriptions, to identify and minimise the incidence of prescribing errors. Pharmacy technicians replenished medication stocks, checked expiry dates and provided guidance to staff and patients.
- There were local microbiology protocols for the administration of antibiotics, and the clinical staff were able to describe how to use them and where to find them The pharmacy manager was the hospital's official antibiotic steward. An antibiotic steward seeks to achieve the optimal clinical outcome related to antibiotic use, to minimise toxicity and other adverse events and limit the selection for antimicrobial restraint strains. This reduces the risk of antibiotics becoming less effective. The hospital had leaflets for the patients explaining this from Public Health England.
- An audit carried out for antibiotic stewardship from January 2016 to July 2016 showed the hospital was 100% compliant in prescribing antibiotics for prophylaxis (i.e. as a preventative measure) and also found 98% of antibiotics prescribed were administered on time.
- Pharmacists carried out monthly medication audits including auditing of controlled drugs (CDs). Staff told us about a documentation error which had been found in the theatre CD record book. Instead of the clinician signing each separate line for 'supplied', 'administered' and 'disposed', they had signed once across all three lines. This meant it was unclear who had supplied the controlled drug and who had administered it. We saw evidence that this had been discussed with the superintendent pharmacist at Ramsay's head office and an email confirming, whilst this is not best practice, this was adequate practice. The head pharmacist at the hospital had sent an email to all staff to reiterate the importance of best practice and maintaining it.
- Medicines, including CDs, were stored safely and securely in theatres and in the wards. Staff carried out daily checks on CDs and medication stocks to ensure medicines were reconciled appropriately.
- Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Fridge temperatures were checked daily to ensure medicines were stored at the correct temperature. Staff knew what to do if fridges were out of temperature range. We saw the standard operating procedure for this, and it was available with the temperature recording sheet.
- Emergency medications were stored in secure containers on the resuscitation trolleys. These were all in date.
- We saw good evidence of medicines management training carried out by the pharmacy department. This was delivered to all ward staff and included training on a consistent approach to advising patients and relatives of the medications they are prescribed to take home.

Records

- The hospital used paper based records and these were stored securely in order to protect confidential patient information in each area we inspected.
- We looked at 10 patient's medical records. These were structured, legible, complete and up to date. They were signed by clinicians in accordance to good practice in record keeping.
- Clear pathway documents were used throughout the patient journey. Risk assessments were used from the start of the patient's journey in pre-operative assessment through to admission on the wards. Risk assessments included VTE, nutrition, pressure care, falls, moving and handling and infection control risk.
- There were surgical pathways in place, part of the pathway included preoperative assessments. The assessments were carried out in line with NICE guidance. We saw evidence of these guidelines in use within the clinic. We reviewed a sample of these and found they were completed thoroughly.
- Staff compliance with mandatory training for information security and data protection was 90% for ward staff, and 62% for theatre staff. The theatre and ward staff also completed ISO 27001 (information security management) training, this was the international standard that describes best practice for information management. Staff on the wards, and day care unit were 91% compliant and theatre staff were 70% compliant.

Safeguarding

- The hospital had safeguarding policies and procedures available to staff on the intranet and the head of department for surgery had hard copies in a folder for staff to access if needed. The policies included details of how to manage suspected abuse and details of who to contact for further help and guidance.
- Staff we spoke with were able to tell us what steps they would take if they were concerned about potential abuse to their patients or visitors. The hospital had a named safeguarding lead for adults, who were accessible.
- Staff received mandatory training in safeguarding of vulnerable adults and children. Safeguarding is discussed in the children and young person's report.
- Staff compliance levels in safeguarding adults training was at 100% for ward staff and 90% for theatre staff.

Mandatory training

- The hospital had a mandatory training programme which included basic life support, infection control, manual handling, fire safety, information security, data protection and safeguarding. There were also specialist subjects specifically for ward and, day care unit staff and theatre staff, such as blood transfusion.
- The head of each department was responsible for ensuring the staff attended mandatory training. Status of staff compliance to training could be checked by an electronic training tracker.
- The hospital target for completion of mandatory training was 90%. This was achieved for all subjects except workplace diversity and data security for theatre staff, which was 62%. Where there was non-compliance, we observed that staff were booked onto upcoming courses. Staff were 100% compliant in adult basic life support and adult immediate life support. Staff in theatres and wards completed paediatric life support and compliance figures for this are discussed in the children and young person's report.

Assessing and responding to patient risk

- Comprehensive risk assessments were carried out for patients and risk management plans were developed in line with national guidance. Risks were managed positively.
- Every patient who was referred for surgery was asked to complete a medical questionnaire. This was undertaken at the pre-operative stage. Questions were asked about the patients past medical history, allergies, current medication and any previous anaesthetics and infection risk were included. This assessment helped to ensure patients met the criteria for having surgery at Pinehill hospital. This information and the procedure the patient was undergoing would be used to decide if the patient needed a face to face pre-operative appointment or only a telephone consultation. A telephone appointment was made for low risk patients needing minor procedures.
- The anaesthetists held clinics every Wednesday to see patients who were classed as high risk for anaesthesia or had medical conditions that deemed them at risk of developing complications after surgery.
- Staff carried out risk assessments to identify patients at risk from harm. Patients at high risk were placed on appropriate care pathways and care plans were put in place to ensure they received the right level of care.

- Staff used the national early warning score (NEWS) to recognise when a patient's condition was deteriorating. This tool ensured that any deterioration was identified early and appropriate steps were taken quickly. All nursing staff carried out routine monitoring based on the patient's individual needs and as specified by the surgeon. We saw a sample of NEWS charts and saw that they had been completed correctly. Nurses we spoke with were aware of the escalation procedure. Tis involved alerting the nurse in charge, the RMO and the consultant depending on which score had been triggered.
- We saw evidence of the sepsis six tool used. The nurses carried a laminated pocket sized handbook with the sepsis screening flow chart for quick reference. This also included the NEWS track and trigger flow chart.
- Where a patient's health deteriorated, staff were supported by medical staff and a resident medical officer (RMO). The RMO was a registrar level doctor who was on duty 24 hours a day and on site available to attend any emergencies. The hospital had a transfer agreement in place with the local acute trust, should a patient require a higher level of care.
- We observed five theatre teams undertake the World Health Organisation (WHO) 'five steps to safer surgery' procedure. Including the use of the WHO checklist. This is a core set of safety checks, identified for improving performance at safety critical time points within the patient's intraoperative care pathway. The theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the procedure. We observed good levels communication and involvement when carrying out these checklists.
- We observed the surgical safety operating list briefing was displayed on the theatre wall. This is good practice and provided information about the WHO checklists and how to carry them out appropriately.
- There was a WHO 'safer endoscopy checklist' used in the endoscopy procedure room. We observed one endoscopy procedure and looked at three endoscopy patient records and saw for all patients the WHO checklist had been carried out appropriately.
- The WHO audit report for September 2016 showed 100% compliance. We looked at medical records previous to September and saw that the checklists were completed appropriately.
- The operating list was displayed by theatre number and for each procedure in each theatre. Good practice was demonstrated by using a different coloured sheet if any changes were made to the theatre list. This meant staff could easily see any changes made.
- Ward staff telephoned patients 48 hours after they had been discharged to check on their well-being and progress post-operatively. Patients were also given a helpline telephone number to ring in the event of any issues or to ask questions. Telephone enquiries were documented in a 'patient query' record book and further appointments were then made, for example, if they needed a wound check, or the patient was worried, they could be seen in the outpatients department the next day.

Nursing and support staffing

- Staffing and skill mix was planned so that patients received safe care and treatment at all times. The service used a safer nursing care tool, this measured patient acuity and dependency. Daily activity including the number of theatre cases booked, taking into account whether they were major or minor procedures, helped to assess the correct number of nurses required for each shift.
- Heads of departments reviewed the rotas twice a day and a risk assessment was carried out for the weekends, alongside the theatre lists.
- Planned staffing for the wards during the day was three registered nurses including, one to coordinate and two health care assistants (HCA). At night two registered nurses were required and one HCA. We looked at the electronic rota system and found staffing numbers and skill mix was appropriate for the complexity of the patient caseload. The day care unit was staffed with two registered nurses and a HCA during the day.
- Theatre staffing levels were based on nationally recognised guidelines such as the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Anaesthetic Recovery Nurses Association (BARNA). Staff in theatre each day included an operating department practitioner (ODP), three 'scrub' registered nurses and a health care assistant (HCA). For the endoscopy procedure room, the planned level was two registered nurses and one HCA. In the recovery area there were two qualified nurses or ODPs. During our inspection we found that the actual staffing met the planned staffing levels.

- The vacancy rate for the theatre department as of July 2016 for nurses was 16%, meaning there were two full time equivalent (FTE) posts vacant. This was above the average of other independent healthcare providers. For theatre HCAs and ODPs, the vacancy rate was 32%, meaning there were four FTE posts vacant; this was also above the average of other independent health providers. However, in the theatre department meeting minutes, we saw evidence that 10 staff, including registered nurses, ODPs and HCAs, were due to start employment from October 2016 onwards.
- The vacancy rate for ward nurses as of July 2016 was 51%, meaning there were eight FTE posts vacant. This was above the average of other independent health providers. Up to date information gathered during out inspection showed as of October 2016 they had four FTE nurse posts vacant. The vacancy rate for HCA's was 16%, meaning there were two FTE posts vacant.
- The hospital used their own team of bank staff made up of existing staff employed by the hospital to provide cover for staff sickness or leave. Both the wards and theatres, with the exception of pre-operative clinic also used outside agencies.
- The rate of agency and bank staff for nurses in theatres was similar to other independent health providers, using an average of 12%-23% from July 2015 to June 2016. There were no agency nurses booked for theatres in the reporting period July 2015 to June 2016 when only bank staff were used. Use of bank and agency ODPs and HCAs in theatre was higher than the average rate of other independent health care providers, ranging from 30% - 50% from July 2015 to June 2016. This high level of agency and bank usage was predicted to fall following the recruitment of new staff.
- The rate of bank and agency nurses working on the wards was higher than the average rate of other independent health care providers, ranging from 15% - 44% from July 2015 to June 2016. These figures were expected to reduce from October 2016 with the recruitment of four FTE registered nurses. The rate of bank and agency HCAs working on the wards was higher than the average rate of other independent healthcare providers, ranging from 15% - 35%. However, there were no agency HCAs working on the wards in the last three months of the reporting period July 2015 to June 2016.
- Nursing handovers occurred three times a day and included discussions around patient needs, medication, present condition and the plan for discharge. If patients needed transfer to another facility, the staff would use the 'situation, background, assessment, recommendation' (SBAR) approach, and document in the patients records. No patients needed transfer during our inspection so we were unable to observe this in practice.
- The senior ward nurse met briefly with the theatre lead immediately before morning and afternoon theatre lists to share information regarding equipment and other resources required, or if there was anything specifically patient related. For example if a patient was particularly anxious.

Medical staffing

- Patient care was consultant led. Our review of patient's records showed that daily medical entries had been made by the consultants.
- There was an up to date out of hours on call list for consultants. Most consultants worked in speciality groups and provided cover for one another. Staff told us that the on call rota worked effectively and consultants were accessible when required. One member of staff told us consultants were very helpful if called out of hours, saying 'never be afraid to call us'.
- There was a procedure in place, where the consultants covered each other to ensure that there was someone, in the appropriate speciality available, should the primary consultant be unavailable. A similar process was in place for anaesthetists.
- Consultants were required, as part of their practising privileges agreement to be within 30 minutes travel from the hospital.
- Register medical officers (RMOs) were employed through an agency. They worked a one week on and three week off rota, 24 hours a day, then handed over to the next RMO. The handover took an hour and the RMO we spoke to said this was adequate time to discuss each patient in detail. The RMO had received induction training. Their duties included monitoring patients in the wards, prescribing medications, cannulation, taking blood samples and responding to emergencies. The RMO told us that they were never asked to complete procedures they did not have the skills to undertake.
- The RMO attended the evening nurse's handover to ensure that patient care and treatment was discussed for the night. The RMO said they felt supported by the

ward staff and medical teams and they could contact the consultant or anaesthetist responsible for a particular patient if further advice or support was needed.

Emergency awareness and training

- There was a major incident and business continuity plan which listed key risks that could affect the provision of care and treatment. Guidance for staff in the event of a major incident was available in the theatre and ward areas, and staff knew where to locate this.
- Each department carried out regular cardiopulmonary resuscitation (CPR) scenario training. This was unannounced and took place at weekends and out of hours. The managers would choose areas of the hospital such as the x-ray rooms, outpatients department and the basement.
- Staff completed mandatory training in fire safety and compliance with this was 95% for the ward staff, including day care unit and 72% compliance for theatre staff.

Are surgery services effective?

Good

We rated effective as good.

Evidence-based care and treatment

- We were provided with the local audit programme for Pinehill hospital. This was set corporately by the Ramsay Health Care UK Group. The programme ensured different aspects of care and treatment were checked during each monthly audit. Audits included, medical records, pre admission and discharge care, infection prevention and WHO safer surgical checklists.
- The audits were based on national guidance for benchmarking, including the Department of Health, NICE and the Royal College of Surgeons.
- The service followed guidance regarding the recording and managing of medical implants, such as breast implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database.Relevant paperwork was carried out at time of the insertion and inputted into the National Breast and Implant Register by theatre staff within 24 hours of the procedure.
- Findings from clinical audits were reviewed during routine clinical governance committee meetings and any changes to guidance and the impact it would have on their practice was discussed. These meetings were held every two months and were attended by the general manager, matron, consultants and head of departments.
- Staff on the wards and theatres used enhanced care and recovery pathways which were in line with national guidance. This included for example, integrated care pathways specific for hip or knee replacements and a day case pathway under general anaesthetic. The day case pathway included the predicted American Society of Anaesthesiologists (ASA) scoring.Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. A review of medical records and discussions with the clinicians on duty confirmed this during our inspection.
- Policies and procedures reflected current guidelines and staff told us they were easily accessible via the hospitals intranets or as hard copies if asked for.
- The endoscopy service was awarded the Joint Advisory Group (JAG) accreditation in April 2014. This is a governing body that assess the quality and standards of endoscopy services in relation to patient care. Pinehill's annual report was submitted in October 2016 and the hospital was awaiting feedback at the time of our inspection.

Pain relief

- Patients were assessed pre operatively for their preferred post-operative pain relief in the pre-assessment clinic. Staff would discuss the patient's level of pain and discomfort as part of their assessment. This assessment would continue once the patient was admitted to the ward/day care unit prior to their procedure.
- Staff used a pain assessment scoring tool to assess the level of pain both as part of their routine observations and at a suitable time after patients had received their pain relief medication. The post-operative pain management policy provided the pain assessment score and guidance for staff to follow. This assessment was part of the national early warning system that was used to monitor each patient.

- Our review of 10 patient's records found the assessment system was being used appropriately and the pain scores were recorded regularly.
- Patients told us their pain was managed effectively by staff.

Nutrition and hydration

- Patients were required to fast in preparation for their surgical procedure. Pre-operative fasting guidelines were based on the recommendations of the Royal College of Anaesthetists (RCOA) with patients on morning or afternoon lists fasted appropriately. However, compliance with this standard was not audited.
- Patients' nutrition and hydration needs were risk assessed and a specific care pathway was implemented if the patient's clinical condition required it.
- Post-operative nausea and vomiting was managed by a regime of intravenous fluid and anti-sickness medication. The balance of the patient's body fluid level was recorded until they were fit enough to eat and drink normally.
- There was a service level agreement with the local NHS trust for a dietician to visit if needed. This was routine for patients who had undergone colorectal surgery, but was available for any other advice or support.

Patient outcomes

- The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. Clinical audit and risk assessments were carried out to facilitate this. The hospital participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) programme, and the national joint registry (NJR). The PROMs score for primary knee and hip replacement and groin hernias were similar to the England average.
- The CCG (clinical commissioning group) that purchased services from Pinehill hospital had reviewed the national audits for the financial year 2016-2017 and had proposed additional audits including bowel cancer, elective surgery and the national prostate cancer audit.
- The hospital reported six unplanned readmissions within 28 days of discharge from July 2015 to July 2016. This was lower than a group of similar independent hospitals which submitted data to the CQC in the same time period.
- There were 10 cases of unplanned returns to the operating theatre in the same reporting period. The senior management team told us this was due to the increasing complexities of the procedures undertaken. All returns to theatre were entered onto their electronic reporting system and analysed for trends by the management and governance teams. Results of this analysis had resulted in additional training in the effective use of the national early warning scores (NEWS) both in theatre and on the wards.
- The hospital had 14 unplanned transfers to the local NHS trust from July 2015 to June 2016. This data was similar when compared to a group of similar independent hospitals which submitted data to the CQC. However, the hospital had taken learning from these unplanned transfers to prevent reoccurrence. In each case, the decision to transfer was made by a clinician for valid clinical reasons and the patients were transferred in accordance with the hospital's policy for transferring critically ill patients. All patients were discharged home from
- The hospital had engaged with the Private Healthcare Information Network (PHIN) so that data could be submitted in accordance with legal requirements regulated by the Competition Markets Authority.

Competent staff

- Staff were qualified and had the skills they needed to carry out their roles effectively.
- Staff were supported to deliver effective care through support from managers. However, effectiveness of care was not fully measured.
- We saw new hospital staff undertook an induction which included a corporate introduction and a local orientation. Competencies were also required for each role, and these were recorded once completed in a specific booklet. We saw evidence of these completed competencies in staff member's induction files.
- Staff underwent an annual appraisal. Compliance for the ward was 14% for registered nurses and 38% for HCAs; this was below the 75% target. Senior managers told us that due to the reporting period, not all staff appraisals had been done, however all staff who did not have a recent appraisal had been booked in for one. We saw evidence of this being discussed as a priority in the team meeting minutes. Appraisal compliance for theatre staff was 82% for registered nurses and 100% for ODPs and HCAs.

- All ward and theatre nurses were reported to have their professional registration validated, and they were supported through the revalidation process.
- Senior theatre staff had undertaken training on a recognised course to act as first assistant to the surgeon and their continued competence was reviewed as part of their annual appraisal. This training need was identified through the appraisal process and we saw six further staff were booked to attend this course.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were employed by other organisations such as the NHS. Their annual appraisals were carried out with their employer. It was the responsibility of the registered manager, with advice from medical advisory committee (MAC) to ensure consultants were skilled, competent and experienced to perform the procedures they undertook. The hospital checked registration with the General Medical Council (GMC) and the relevant specialist register. In addition, in line with the Ramsay practising privileges policy, checked that consultants had no criminal record through the disclosing and barring service (DBS) checks and that they had up to date indemnity insurance. DBS is a criminal record check and indemnity insurance is designed to protect professionals when they are found to be at fault for a specific event. We saw evidence that this was discussed and reviewed in the MAC meeting minutes.
- Practising privileges for consultants were reviewed every other year. The review included all aspects of a consultant's performance. The review included an assessment of their annual appraisal, volume and scope of practice, plus any related incidents and complaints. In addition, the MAC advised the hospital about continuation of practising privileges. The hospital used an electronic system to check when privileges were due to expire.

Multidisciplinary working

- We saw evidence of robust multidisciplinary working, and communication between the staff in theatres and wards. Staff told us they had a good working relationship with consultants and the RMO.
- Ward and theatre staff carried out 'safety huddles' on a daily basis to ensure all staff had up to date information about patient risks and concerns.
- We saw evidence of team communication across all services. The hospital had set up a '10 at 10' meeting. This took place at 10am every morning and all the heads of the departments attended and discussed the daily activity and any concerns across the service for 10 minutes. This had received very positive feedback from the staff.
- Patient records showed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.
- Information about all of the treatment a patient had received during their stay in the hospital was communicated to the referring GP when they were discharged from the service.
- The hospital hosted GP training meetings which were presented by consultants. This allowed a multidisciplinary approach to sharing best practice.

Seven-day services

- Consultants were on call seven days a week for patients under their care. Patients were seen daily by their consultant, including weekends.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed.
- The ward accommodated overnight patients seven days a week and ward staffing levels were suitably maintained during out of hours and weekends. The RMO provided out of hours medical cover for the wards 24 hours a day, seven days a week.
- The pharmacy was open Monday to Friday from 9am to 6pm. This was under review due to an increase in evening and Saturday theatre lists. In the event of patients requiring medications out of hours, the RMO and a registered nurse went to the pharmacy department and checked out the medications in accordance with the hospital medications policy.
- There was a small pathology laboratory onsite which enabled enable basic blood testing to be carried out seven days a week.
- There was access to all key clinical services, radiology and physiotherapy on an on call basis out of normal working hours.

Access to information

- Patient information that was needed to deliver effective care and treatment was available to the relevant staff in a timely and accessible way.
- Staff could access information needed about a patient at any time, through their medical records. Medical

records contained detailed information from admission and surgery through to discharge. There was appropriate information when the patient was referred to the hospital and this enabled clinicians to have all relevant information, including test results, prior to their first appointment.
- Staff could access policies and procedures through the hospital's intranet. Computers were available in the ward and theatre areas.
- Care summaries, such as discharge plans, were sent to the patient's GP at point of discharge, to ensure continuity of care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients.
- There was an effective consent policy for staff to follow. This outlined that consultants should seek consent from patients undergoing surgery during the initial consultation process and again on the ward during admission before the procedure. We saw from patient records that this had been obtained in agreement with the policy. However, we observed one surgeon gaining consent from a patient whilst they were in the operating theatre. This was against hospital policy, it had happened previously, but had not been challenged by ward or theatre staff. We raised this immediately to the hospitals senior management team (SMT). They wrote a formal letter to the surgeon during our inspection outlining that this was a breach of hospital policy and against GMC guidance with regards to gaining consent. The SMT then had a meeting with the consultant to discuss further. We were told the outcome of this meeting included the consultant understanding what they did was against hospital policy and they would refrain from practising in this way in future. We spoke with the matron during the unannounced inspection and they confirmed that the consultant's practice was now in line with the policy.
- We saw that patients who were booked for cosmetic surgery were given a two week cooling off period before undergoing the procedure in case they wanted to change their mind.
- We observed the consent process was part of the local audit programme. Results from an audit carried out in September 2016 showed a compliance of 86%.
- Staff were aware of the legal requirements of the Mental Capacity Act (MCA) 2005 and Deprivation of Liberties Safeguards (DoLS).
- In both the ward and theatre, staff had access to an 'essential documents' folder. This contained a practical guide on identifying and implementing DoLS. There were no patients identified during our inspection that had a DoLS in place.
- Staff told us the majority of admitted patients had the capacity to make their decisions. Patients that lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Where patients could not provide informed consent, the staff would make decisions in the best interests of the patients, involving the patient's representatives and other healthcare professionals.

Are surgery services caring?

Good

We rated caring as good.

Compassionate care

- Patients were treated with dignity, compassion and empathy. We observed staff providing and communicating care and treatment in a respectful manner.
- Staff spoke with patients discreetly to maintain confidentiality. Patients were given gowns and slippers to maintain their dignity when being transferred between wards and theatres. Once patients were in the recovery room curtains were closed to ensure privacy and dignity.
- We spoke with eight patients. All the patients thought staff were kind and caring and said they could not fault the service. Two patients told us that they had received fantastic care and had had a positive experience during their stay at the hospital and would recommend it to any of their friends or family.
- In theatres we observed an older patient express their concerns about transferring onto the operating table. We saw, the surgeon and ODP immediately went to the patient's side to support and assist them onto the table and, maintained the patient's dignity throughout.

Good

Surgery

- We observed several operations during our inspection and saw that staff maintained patients' dignity whist they were under anaesthetic and only exposed the skin and body areas when it was absolutely necessary.
- The hospital submitted data to the Friends and Family Test (FFT). This was a method used to capture patient's perceptions of the care they received and how likely they were to recommend the service to their friends and family. The hospital had a response rate of between 25% to 78% from January 2016 to June 2016. Scores were between 65% and 99%, of patients recommending the hospital.
- CQC patient feedback gained prior to our inspection was positive. Comments included, staff were caring, friendly and professional, they maintained patients' dignity and privacy and were approachable.
- Staff undertook a customer care course as part of their mandatory training and compliance was 90%.

Understanding and involvement of patients and those close to them

- Patient records included pre-admission and pre-operative assessments that took into account individual patient needs and preferences. For example, if the patient required an interpreter to help them understand or support with their mobility.
- Costs were explained during the booking process and through to discharge and patients were given a copy of their treatment options and associated costs.
- Patients told us that staff spoke with them about their care and treatment in a manner they understood and included their families or friends when required.
- Patients also spoke positively about the information they received in the form of written materials, for example, the information regarding the surgical procedure they had.
- We observed the pharmacy technician providing advice to relatives on how and when a patient should take their medications when they were discharged from hospital. This was carried out in a manner that they all understood, as they were asked to relay the information they had been told and if they understood the instructions given.

Emotional support

- We observed patients in theatre and endoscopy and saw staff were supportive to patients with any anxieties. Staff were reassuring and maintained a calm environment.
- Patients had a named nurse who looked after them during each shift. The named nurse ensured they were available for their patients to voice any concerns or anxieties.
- Patients told us staff listened to any of their concerns and provided signposting to other services if needed, for example, counselling or Macmillan services.
- The hospital had Wi-Fi so that patients could keep in contact with their friends and relatives.

Are surgery services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- The services provided reflected the needs of the population they served and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including cosmetic surgery, general surgery and endoscopy.
- The hospital had a commitment to private patients as well as working in partnership with the NHS, and it ensured that services commissioned from them were safe and of high quality. To achieve this, the senior management team listened to patient feedback, acted on audit results, observed national guidance and accepted recommendations from various hospital committees.
- Investment had been approved to purchase additional spinal instruments to enable the expansion of spinal surgery services in order to meet the needs of local people.
- An orthopaedic consultant surgeon had commenced hip arthroscopies and another was starting a new technique for rotator cuff tears of the shoulder, this would increase the services offered to patients.

Good

Surgery

- The theatres were mainly open Monday to Friday 8am to 6pm, however we were told the service could be expanded and operate until 9pm during the week and also open on Saturday mornings which provided patients and consultants with increased flexibility.
- Patients we spoke with confirmed they were given a choice of appointment times and were able to schedule procedures at a time convenient to them.
- The heads of department for theatres and the ward had regular meetings with the matron to discuss the numbers of expected patients to ensure there were sufficient bed spaces and staff allocated.
- There were 23 inpatient bedrooms and a separate day care unit. The hospital had three main theatres, all with laminar flow and a minor procedure/endoscopy suite; this ensured that planned services could be delivered to patients.

Access and flow

- Patients had timely access to initial assessment and treatment.
- The referral time to treatment (RTT) was used for tracking times to treatment for NHS patients. From July 2015 to June 2016, the hospital was achieving RTT times in excess of 90%, with RTT times of 93% to 100% of patients being treated within 18 weeks from their original referral date. This is better than the England average for NHS patients.
- There was no formal mechanism similar to the RTT for the private patients, however, we saw that were no waiting lists and patients were seen within one to two weeks from their referral.
- The majority of patients were referred to the hospital by their GP via the NHS referrals system. Patients were given a choice of dates for their procedures and those we spoke with did not highlight any concerns with this process.
- The hospital's admission policy ensured that patients received a pre-operative assessment. All patients were assessed which meant patients could be identified as being safe for surgery, which helped to avoid any unnecessary cancellations. Patients with co-existing conditions were identified during this process and then given further tests, for example blood tests, or diagnostic imaging.
- Patients with multiple comorbidities were assessed by a consultant anaesthetist and if they were deemed unsuitable for surgery their admission was deferred. Exclusion criteria was used following NICE guidelines.
- Patient's procedures were only cancelled or delayed when necessary. The service cancelled 27 procedures for non-clinical reasons within the last 12 months. All were offered another appointment within 28 days of the cancellation. The hospital did not submit data as to the formal reasons why these procedures were cancelled, however staff told us some of them were cancelled by patients, or patient did not attend for their planned surgery. There were 7,082 inpatient and day case episodes meaning the cancellation rate was 1%. This was similar to other independent hospitals.
- Discharge planning started at the pre-operative assessment stage. Length of the patient's expected stay was discussed and this helped patients plan for any additional support required at home.
- Patient's records showed staff had completed discharge checklists, which covered areas such as medication, communication provided to the patient and other healthcare professionals, for example, GPs. This ensured patients were discharged in a planned and organised manner.
- If there was need for patients to return to theatre for a further procedure, the hospital had an on call theatre team.

Meeting people's individual needs

- Services were planned and delivered to take into account the individual needs of its patients. For example, age, disability, gender, religion or belief.
- Patients living with dementia were identified during the pre-operative assessment stage. All patients who were screened positive for dementia followed a dementia care pathway. Staff had received training in looking after patients living with dementia.

Good

Surgery

- One member of staff, who was the lead nurse for dementia and learning disabilities, had made a 'memory box' for the patients who were living with dementia. Carers and relatives were encouraged to stay with patients living with dementia, overnight if required.
- There was a designated folder for advice and ways to support patients with a learning disability. Carers or relatives were allowed into the anaesthetic room if required, and to stay overnight.
- Patients who required translation services would be identified at the pre-operative assessment stage and the hospital could access language line for interpreters and translation.
- The service had a range of leaflets and bespoke information regarding certain procedures. For example, certain consultants had specific guidelines on the patient's post-operative care, so there were specific patient advice leaflets.
- The patient led assessment of the care environment (PLACE) audit from February 2016 to June 2016 scored 71% for patients living with dementia and 70% for patients with a disability. Staff told us that this score should now improve since the recent introduction of the lead for dementia and learning disabilities.
- Patients and staff told us there was a variety of food and drinks available. Halal or gluten free diets could be catered for. One patient told us the chef from the kitchen came onto the ward to ask specifically what they would like, as they did not like anything on the menu.

Learning from complaints and concerns

- Information on how to raise complaints and concerns was displayed in the areas we inspected.
- The service had reported 87 complaints in the reporting period of July 2015 to June 2016. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). We saw evidence that all complaints had been logged and investigated in accordance with the hospitals complaints policy
- The hospitals general manager had overall responsibility for the management of complaints. Complaints were logged on the electronic incident reporting system and investigations were carried out by the head of the department. All staff involved were sent copy of the complaint and gave a statement if required.
- The complaints policy stated complaints would be acknowledged within two working days and investigated and responded to within 20 working days for routine complaints. Where the complaint investigation took longer than 20 working days, a holding letter was sent to the patient, explaining why the response was delayed. Almost all complaints had been resolved within these timescales. There were several that we saw, that due to their complexity, had not been resolved within 20 days. However, we did see evidence that the complainant had been kept up to date regularly with progress.
- The general manager and the matron were very willing to speak with patients immediately following a concern being raised. The staff were aware of this and told us that they were willing to call them if they thought that they could resolve the problem. When we spoke with the general manager and the matron, we were given several examples of when this had happened.
- Staff told us information about complaints was discussed at team meetings to raise awareness and aid future learning. We saw evidence of this in the meeting minutes.
- The matron had recently started holding complaints scenario workshops. This was time solely given to discussing and working through individual complaints with staff from different areas, to see how they could have done things differently. We spoke with a member of staff who had attended one of these workshops and they told us it was very informative and productive in their learning process.

Are surgery services well-led?

Good

We rated well-led as good.

Leadership/culture of service related to this core service

Good

Surgery

- The overall lead for surgical services at the hospital was the matron who had been in post for some years. The ward and day care unit were led by a head of department, as were theatres. Both managers were established and had been in post for longer than 12 months. The medical advisory committee (MAC) chairman was the lead for the medical services for surgery.
- Staff we spoke with were motivated and positive about their work, and described all members of the senior management team as approachable and visible. They told us there was a friendly and open culture.
- The overall staff sickness rates from July 2015 to June 2016 were from 0% to 40% for ward staff and from 0% to 10% for theatre staff. The sickness rate for ward and theatre staff was similar to the average of other independent healthcare providers.
- The overall staff turnover rate for staff in theatres and the wards was above the average of other independent healthcare providers for the period of July 2015 to June 2016. For ward registered nurses it was approximately 40%, against an industry average of 10% for other independent healthcare providers and approximately 20% for theatre nurses. HCA turnover was higher, at approximately 60% and the average was 10% for theatres and 8% for wards.
- Senior managers told us that retention had been an issue within the last year but turnover had been reducing. Some staff had retired and overseas nurses had returned home or to left for other opportunities. The service had planned to focus on clinical recruitment and leadership in the next 12 months in order to reduce turnover and sickness. In addition, there was a plan to develop a clinical strategy to identify training and development needs and ensure staff training took place, which it was hoped, would improve staff retention.

Vision and strategy for this this core service

- Staff were clear about the corporate vision and values called the 'Ramsay Way'. The hospital had recently introduced their own specific values but at the time of our inspection we saw that these had not been fully embedded with staff. Senior management told us a meeting was planned with staff to talk about the new values and get feedback on how to tailor them individually to their departments. The new hospital specific values were displayed in all areas we inspected.
- The service did not have a defined strategy relating to surgery but the service was included in the hospital's overall strategy which outlined the composition and function of the service.
- The heads of theatres and wards had outlined key objectives for their departments and these had been based on the 'Ramsay Way' values.
- Staff we spoke with understood their role and what was expected from them. They were enthusiastic about the service and the future development of their own values.

Governance, risk management and quality measurement

- There was a clear governance structure in place with committees for medicines management, infection control and health and safety which fed into the clinical governance committee. In addition, the medical advisory committee (MAC) which had separate meetings to discuss the consultant's professional registrations and appraisals.
- The heads of theatre and wards had recorded identified risks onto a local department risk register and we saw that these were up to date. Key risks were placed onto the hospital wide corporate risk register. However, the corporate risk register did not have clear action plans identified against each risk or review dates. Therefore, it was unclear to see if they were ongoing or old risks. Also, there had been no clinical risk identified, for example the high rate of surgical site infections (SSIs) or staffing issues, such as sickness and vacancies. The heads of departments were aware of these risks and they were discussed at meetings with clear action plans in place.
- There was a plan in place for local safety standards for invasive procedures using the national guidelines. However, staff were unable to tell us the progress the service was making with this.
- Routine audit and monitoring of key processes took place across ward and theatre areas to monitor performance against objectives. The quality improvement lead coordinated audit activity and maintained the hospital's audit schedule.

Good

Surgery

Public and staff engagement

- Patient's views and experiences were gathered and acted on to shape and improve services and the culture.
- The service used the friends and family survey and the patient led assessment of the care environment (PLACE) audits to gain feedback on patients' experiences.
- All patients were asked their consent to receive an electronic survey or phone call after they left the hospital. The results from the questions were used to influence the way the hospital could improve their service. Any text comments, both positive and negative, made by patients on the survey were sent as 'hot alerts' to the general manager within 48 hours so that a response could be sent to the patient as soon as possible.
- There were ad hoc patient focus groups which were used to gain feedback on specific things such as the patient's experience of their endoscopy.
- Staff told us they received good communication from their managers. Staff routinely went to staff meetings across wards and theatres.
- The hospital told us they were involved in the community and their staff participated in community activities such as Macmillan coffee mornings, golf challenges, and raffles.

Innovation, improvement and sustainability

- Staff we spoke to were confident in the sustainability of the surgical services. They felt that they all worked well together to provide a good standard of care and treatment.
- The hospital had a robust financial planning and surgery services were a key part in the future strategy.
- The hospitals five year plan included, a business case to extend and refurbish the inpatient wards, which would give an additional 15 to 20 beds.

Requires improvement

Services for children and young people

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

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and reported them internally and externally. During the reporting period; July 2015 to June 2016 there had been no incidents, serious incidents or never events involving children or young people. See the surgical report for the definition of a never event.
- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations is the regulation that introduced the statutory duty of candour. For independent providers, the duty came into force in April 2015. 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.
- We were told patients and parents would be informed if they were affected by something that went wrong, given an apology and informed of any actions taken as a result. However, as no incidents involving children where the duty of candour should have been applied had happened during the reporting period, we were unable to see evidence to demonstrate this. Staff we spoke with were able to explain the duty of candour and give examples of how this would be implemented, if an incident occurred involving a child or young person.
- Lessons were learnt and were shared to make sure action was taken to improve safety beyond the affected team or service. Staff described lessons being shared with them through team meetings and in notifications within their payslips.

Clinical Quality Dashboard or equivalent (how does the service monitor safety and use results)

- The hospital did not use a clinical quality dashboard to monitor safety and results with regards to children and young people. Clinical quality dashboards are used to monitor improvements in quality indicators. This meant there was no evidence that any quality indicators had been set, or that these indicators were being performance monitored.

Cleanliness, infection control and hygiene

- The main findings regarding cleanliness, infection control and hygiene can be found in the surgery and outpatient sections of this report.
- Paediatric patients were given themed printed gowns to wear to theatres, to reduce the risk of infection.
- Children and their parents were instructed on the use of hand sanitiser.

Environment and equipment

- At our initial inspection, the design and use of facilities and premises were not appropriate to ensure children and young people were always kept safe. Children and young people were admitted to rooms on one side of

the second floor ward at the hospital. Adult surgical patients were admitted to the other side of the second floor ward. There was no division between the two sections and no security measures in place to ensure that adults could not access children on the ward. We also noted that there was no CCTV on the ward, to record who was accessing the children's rooms.

- We raised this concern with the hospital immediately, and we were informed that the senior managers were in the process of gathering quotations for works to install a key card access pad.
- When we returned on our unannounced inspection we saw that children and young people had been moved to the day case area, which was separated from adult patients. The keypad lock had been ordered and had arrived, and the hospital management team were liaising with maintenance engineers regarding installation.
- Children and young people were also kept in recovery with adult patients, as there was no separate paediatric recovery. Beds in recovery were separated by curtains; however, this did not provide much privacy and children and young people might have been distressed by hostile noises from adult patients recovering next to them.
- During our announced inspection we found the electrical cupboard unlocked on the second floor ward. This cupboard contained high voltages which could have been dangerous to patients or visitors. We escalated this immediately to staff on the ward. None of the staff on the ward had access to the key to secure the cupboard and had to call the hospital maintenance team to lock it. During our unannounced inspection we found that children and young people were no longer being nursed on this floor and had been moved to the day case unit, which did not have an electrical cupboard within it. We checked the cupboard during our unannounced inspection and found it was locked.
- Equipment was maintained according to manufacturer's instructions. A paediatric resuscitation trolley was available where children and young people were nursed. We checked this and found that all daily checks were completed, all medications were in date and all equipment was maintained in sterile packaging.
- An adult resuscitation trolley was available in outpatients. A separate grab box with paediatric airways equipment was available next to the adult trolley. A defibrillator was also available. However, if a child or young person was to require further resuscitation support in the outpatients department, staff would have to go to the second floor to obtain the necessary medicines and equipment. This could have caused delays in emergency treatment. This was escalated during our inspection; however, resuscitation medications were still not present in outpatients when we returned for our unannounced inspection.

Medicines

- There were arrangements in place for managing medicines and medical gases. Staff showed us that they used a copy of the paediatric British National Formulary (BNF) to check correct doses of medicines were being administered. All medicines administered to children and young people were double checked by two members of staff to ensure the correct doses were being given. For detail on the storage of medications please refer to the surgical and outpatients section of the report.
- We reviewed 10 sets of surgical paediatric notes and found that all had allergies listed were appropriate and that drug charts were clear and legible, with all entries signed appropriately. Children were weighed on admission to ensure that drug doses were calculated correctly.

Records

- Patients' individual care records were not always written and managed effectively. We reviewed 10 sets of notes during the inspection and saw that these were not always completed. In all 10 sets of notes a comorbidity checklist was present in the child's file; however, none of these had been completed, or signed to evidence that these had been reviewed or checked. Four of the 10 records we reviewed had fluid balance charts in them, of these one was complete, two were half completed with details of fluid intake but no details of fluid output and one chart was blank. The rest of the records did not have a fluid balance chart present. This was escalated to the senior team during our feedback session.

- We also saw on the announced inspection that the records trolley which contained patients' confidential medical notes was unlocked. During our unannounced inspection we checked the trolley again and found it to be locked securely.

Safeguarding

- Arrangements were in place to safeguard children and young people from abuse that reflected relevant legislation and local requirements. We reviewed the hospital's safeguarding children and young people policy. This was in date and referenced the 2015 statutory guidance on safeguarding children.
- Staff understood their responsibilities and adhered to safeguarding policies and procedures. Staff described the process for escalating safeguarding concerns and gave examples of concerns that they had escalated.
- The hospital's registered nurse (child branch) was familiar with guidance on female genital mutilation and discussed an incident involving this which had occurred at another place of employment. This nurse, in conjunction with the hospital's lead nurse for children's safeguarding, provided all safeguarding children's training to staff.
- Not all staff that cared for children and young people had level 3 children's safeguarding training. The hospital confirmed that 79 staff members required the training. Out of these, the hospital confirmed 44 members of staff had received safeguarding level 3 training. This was 56% of the staff. However, we were informed that four members of staff were on maternity leave and three members of staff had only recently joined the hospital. Within wards 77% of staff members had safeguarding level 3. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 in safeguarding.
- The hospital's aim was to get all required staff to have safeguarding level 3 training by June 2017. We saw evidence of training sessions being organised in order to meet this target.
- The hospital had a standard operating procedure (SOP) covering an abduction of a child or young person from the hospital. The SOP set out the process for identifying who had parental responsibility (the legal rights and responsibilities for the child, which does not occur if the father was not listed on the birth certificate and was not married to the child's mother) and set out the lockdown process if a child or young person were to go missing.

Mandatory training

- Please see the section on surgery and outpatients for mandatory training information for each department.

Assessing and responding to patient risk

- Comprehensive risk assessments were not always carried out for children and young people. We reviewed 10 sets of paediatric surgical notes and in all of them the preoperative assessment sheet had not been completed. We raised this with the hospital during our unannounced inspection and we were told that this assessment was completed through a medical questionnaire, instead of the preoperative assessment form.
- We reviewed a further seven sets of notes during our unannounced inspection to consider the preoperative assessment forms and found that three were completed and had been signed by a registered nurse, to confirm they had been reviewed. Two of the records we reviewed did not have a medical questionnaire present, therefore, there was no evidence that the risk assessment had been carried out. The remaining two records had copies of the medical questionnaires completed; however, they had not been signed by a registered nurse to confirm that they had been reviewed. This meant that there was a possibility that any co-exiting conditions may not have been taken into account.
- During our announced inspection we found that there was limited paediatric resuscitation equipment available in outpatients. We escalated this as a concern and the hospital took immediate action to reduce the risk and assured us that they would mitigate the risk.
- Staff generally identified and responded appropriately to changing risks to patients, including deteriorating health and wellbeing and medical emergencies. The hospital used the paediatric early warning score (PEWS). This was a hospital wide standardised approach to the

detection of a deteriorating young patient and had a clearly documented escalation response. On the PEWS chart staff recorded oxygen saturations, blood pressure and temperature and collated a total score. At various score points, which indicated the young person's condition, different types of escalation were required. Guidance was available on the back of the PEWS charts about what escalation was required for each trigger score.

- We reviewed 10 PEWS charts and found that eight of these were completed appropriately. One of the PEWS charts had no evidence of physiological observations being carried out for 50 minutes following admission to the ward from recovery. However, when observations were next documented there was no evidence the patient had deteriorated in that period. The other set of medical records we reviewed did not have a PEWS chart included.
- In the event of a paediatric day case patient not recovering quickly enough to be discharged the same day, a process was in place to get an agency registered nurse (child branch) in, to cover the night shift, and the child or young person would stay in the hospital overnight.
- If the child or young patient deteriorated beyond the hospital's ability to treat, and required specialist medical care, a service level arrangement was in place for the child to be transferred by the Children's Acute Transport Service (a paediatric intensive care retrieval service) to an NHS hospital with appropriate facilities.
- All parents were given details of the hospital's phone number, which was managed 24 hours a day. Parents were encouraged to call this number if they had any concerns following their child's discharge. A senior nurse on call would always speak to the parents and escalate the concerns to the consultant if necessary.
- The service did not at the time of our inspection routinely call parents following a child's discharge. We were told this had recently been implemented for adult patients and that plans were in place for this to be extended to paediatric patients.

Nursing staffing

- Paediatric surgical lists were planned in conjunction with the availability of the hospital's registered nurse (child branch). The hospital's paediatric nurse had worked for the hospital for seven years on an agency basis, and had at the time of our inspection, recently been given part time contracted hours.
- The hospital did not have sufficient levels of nurse staffing for children and young people. The hospital did not have a registered nurse (child branch) on duty in recovery during paediatric surgical lists, did not have a paediatric nurse on duty during outpatient appointments and only had one paediatric nurse on duty for paediatric lists of up to four patients. This was in breach of Royal College of Nursing standards 'Defining staffing levels for children and young people's services' (2013) which states that there should be a minimum of two registered children's nurses at all times in all inpatient and day care areas, that there should be a minimum of one registered children's nurse on duty in recovery areas at all times and that a minimum of one registered children's nurse must be available at all times to assist, supervise, support and chaperone children in outpatient clinics. We escalated this to the hospital senior managers, who informed us that they had taken action to recruit another registered nurse (child branch). We were told informal discussions had taken place with a potential candidate and that they were waiting to receive a formal application from them.
- Bank or agency staff were used to care for children and young people in the hospital, when the main registered nurse (child branch) was unable to cover the surgical list. Agency or bank staff were also used when a child or young person needed to stay overnight following their procedure, to relieve the main registered nurse (child branch).
- Verbal handovers between the hospital's registered nurse (child branch) and the agency or bank staff took place, with the nurse explaining the layout of the hospital, the bleep process and the resuscitation trolley, as well as any relevant information regarding the patient.
- The hospital did not complete an agency induction checklist, to confirm that agency staff working in the hospital had received an induction to the ward area. However, we saw that most agency staff the hospital used were employed regularly, who were familiar with the hospital and its protocols.

Requires improvement

Services for children and young people

Medical staffing

- Children and young people who were due to undergo surgery, remained under the care of their admitting consultant. Out of hours cover was provided by the resident medical officer who was trained in paediatric advanced life support (PALS).
- Within outpatients there were four paediatrician consultants, three ear, nose and throat consultants and two dermatologist consultants who treated children and young people.
- Within surgery there were three ear, nose and throat surgeons, two urology surgeons and three plastic surgeons that operated on children and young people.
- Before consultants were permitted to operate or anaesthetise children the medical advisory committee (MAC) checked their scope of practice. All these surgeons and the associated anaesthetists undertook paediatric surgery within their NHS practice.

Emergency awareness and training

- A paediatric emergency training scenario occurred within the outpatient department in April 2016. We reviewed the scenario report, which highlighted areas of good practice and areas to improve. We saw actions were identified to improve any areas of concern.
- We reviewed the hospital's 'management of children's medical emergencies' policy and saw that it was in date and contained appropriate guidance for such scenarios.

Are services for children and young people effective?

Requires improvement

We rated effective as requires improvement.

Evidence-based care and treatment

- Relevant evidence-based guidance, standards, best practice and legislation were identified and used to develop how services, care and treatment were delivered.
- Policies were based on professional guidelines, for example, National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- Not all policies we reviewed referenced the most up to date guidelines. For example, the 'Care of the child policy' referenced 2011 Royal College of Nursing guidelines, which had been superseded by 2013 guidance. The 'Management of paediatric resuscitation' policy was not due for update until October 2017, however, new guidance was issued by the Resuscitation Council UK in October 2015, and the policy had not been reviewed to incorporate this.
- Policies were available on the intranet and in hard copy in the hospital's meeting room so that they were accessible to all.
- Patients had their needs assessed and their care planned and delivered in line with evidence-based, guidance, standards and best practice. However, this was not monitored to ensure compliance as there was no audit schedule for the paediatric department.
- The service followed guidance regarding the recording and traceability of medical implants, such as grommets. All implant serial numbers were recorded in the patient's physical records.
- Equipment was not always used to enhance the delivery of effective care and treatment. The hospital did not have any Starlight distraction boxes, which are used to distract children undergoing medical procedures.

Pain relief

- Children and young persons' pain levels were assessed during observations and recorded on the paediatric early warning score (PEWS) chart.
- Pain was assessed through use of a paediatric pain rating scale, which is a pictorial graph with different smiley or sad faces, designed specifically to assess pain in children. There was no access to a specialist pain team, specifically for children and young people.
- The charts we reviewed showed evidence of pain relief being administered where required.
- We reviewed the hospital's 'Pain assessment for children' policy. The policy was in date and included guidance on assessing pain in children with cognitive impairments.

- We spoke with three parents and they told us that their child was given adequate pain relief in a timely fashion. The hospital did not audit any of its activities with children and young people; therefore, there were no audits available on the effectiveness of their pain relief.

Nutrition and hydration

- Children and young people undergoing surgery were fasted before the operation according to current guidelines. As children and young people were prioritised on the surgical lists, their fasting time was reduced to the minimum length of time needed. Information regarding fasting was provided to parents by the booking team by letter in advance of the procedure.

Patient outcomes

- Information about the outcomes of children and young people's care and treatment was not collected and monitored. There was no audit schedule to monitor paediatric performance and the hospital did not benchmark its paediatric performance with other hospitals within the Ramsay group.
- One child underwent an unplanned return to theatre from July 2015 to June 2016. This was due to the child needing to be re-sutured.
- During the same reporting period two children were transferred to the local NHS trust for treatment following surgery at the hospital. One child was transferred due to a post-operative complication and the second was due to the child needing an extended recovery time prior to discharge. On both occasions they were transferred as the hospital was unable to provide paediatric nursing care cover.

Competent staff

- The hospital employed one registered nurse (child branch) to care for children and young people in the hospital. The nurse kept up to date with their competencies through corporate competency workbooks and was trained in paediatric intermediate life support (PILS) and level 3 safeguarding training. The registered nurse (child branch) had also been sent on training courses in adult safeguarding and adult intermediate life support, to ensure ongoing competencies in all areas of nursing.
- The registered nurse (child branch) accompanied children and young people, alongside their parents, to theatre and from recovery. During this time there was no registered nurse (child branch) on the ward. A registered adult nurse was on the ward during these times; however, this nurse was not trained in PILS and was not trained to level 3 in children's safeguarding. The registered adult nurse we spoke to who was responsible for these children and young people's care during the time the registered nurse (child branch) was off the ward had limited experience with caring for children.
- However, children were not often left on the ward with a registered adult nurse. Although the hospital would admit up to four children at a time, they did not always have a full list. For example, on our unannounced inspection two children were planned for admission, and one was then evaluated as not needing to have surgery. As a result, there was only one child present on the ward.
- Within the wards 95% of staff had basic life support (PBLS) and 55% of staff had paediatric intermediate life support (PILS). Within theatres 44% of staff had PBLS and 40% had PILS.
- The resident medical officer (RMO) was trained in advanced paediatric life support (APLS) and the only person in the hospital who was on duty 24 hours per day. Some anaesthetists had this qualification, but were not always present in the hospital. However, several other staff members told us they were planning to complete this training in the future. One senior anaesthetic nurse we spoke with had completed competencies in PILS, Children Acute Transport Service (CATS) retrieval and managing the acutely unwell child.
- All of the surgeons and anaesthetists who operated and cared for children and young people at the hospital also operated on children and young people within their NHS practice. This ensured that they were up to date with any clinical developments and were conducting these procedures routinely, to ensure ongoing competency.

Multidisciplinary working

Requires improvement

Services for children and young people

- The hospital saw children and young people in ear, nose and throat, urology, physiotherapy, surgery, plastic surgery and general paediatrics and worked together to provide a multidisciplinary service to children and young people.
- Staff confirmed that there was good multidisciplinary working between the registered nurse (child branch), the theatre and recovery staff and the RMO. Paediatric surgical lists were planned by the booking team in conjunction with the registered nurse (child branch) rota, to ensure paediatric nursing cover was available.
- At the time of our inspection the hospital did not have a play specialist. However, the service was small and intermittent.
- Children and young people were seen postoperatively in the outpatients department, to ensure the procedure was successful. This appointment was made by the registered nurse (child branch) before the patient was discharged from the ward, to ensure that the appointments were booked.

Seven-day services

- The hospital had recently begun Saturday surgical lists, to extend the flexibility for both patients and consultants.
- Other information about seven day services is contained within the surgical report.

Access to information

- The hospital was a small environment and staff were easily able to seek advice or support from other professionals around the building.
- The registered nurse (child branch) who cared for the paediatric patients had telephone access to another qualified nurse at a nearby Ramsay hospital if advice was required. However, we were informed this not needed due to the experience of the registered nurse (child branch) the hospital employed.
- There was no evidence that the hospital ensured the use of the Personal Child Health Record (referred to as red books) to each hospital appointment or at admission for a surgical procedure in order to facilitate information sharing.
- Please refer to the surgical section of the report for evidence on information sharing with GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children's Acts 1989 and 2004.
- We reviewed 10 sets of medical notes. All of these had completed parental consent forms with the parent's signature and details of all associated risks and benefits of the procedure. The records we reviewed were for younger children and therefore, parental consent was the appropriate form of consent required.
- Young people were engaged during the consent process and a section was available on the form for them to sign to say they were aware of their procedure and were in agreement with it. One of the forms we reviewed of a young person had this section completed.
- We also reviewed the hospital's consent policy, which had a specific section regarding consent for children and young people. This included guidance on assessing Gillick competency (where a child under 16 can consent to a procedure, without parental knowledge or consent, if they meet the criteria of sufficient maturity).
- Staff were familiar with Gillick competency and explained how this operated in practice for young people under 16. Staff confirmed that young people aged 17 and 18 consented to their procedures in accordance with the Mental Capacity Act 2005.

Are services for children and young people caring?

Good

We rated caring as good.

Compassionate care

- Parents we spoke with told us that staff members had been kind and considerate to them and their children, and that they were happy with the service they had been provided.

Requires improvement

Services for children and young people

- We saw the registered nurse (child branch) comforting children if they were upset or scared.
- Parents accompanied their children to the anaesthetic room, alongside the registered nurse (child branch) to reassure their child as they went under anaesthetic. Parents also came with the registered nurse (child branch) to recovery to pick up their child following their operation.
- The registered nurse (child branch) had bought a flashing disco ball to distract children during procedures and had a box of toys and colouring materials to entertain them whilst they were on the ward. However, there were no toys for children to use as a distraction in outpatients, with staff citing infection control measures as the reason for this.
- Staff ensured that children and young people's privacy and dignity was always respected, including during physical or intimate care. Children and young people were nursed in private en-suite bedrooms and chaperones were offered during any examination or procedure, in line with the hospital chaperone policy.
- The parents we spoke with all had positive experiences with the treatment their children were provided with. They spoke of the compassionate and kind care they were given. We were given examples of their children exhibiting challenging behaviour as a result of their fears over their forthcoming surgery, and told us that the staff handled this well and sympathetically.
- One parent we spoke with told us that they felt the hospital was 'outstanding' and that it had been 'such a positive experience for their child'.
- The hospital participated in the Friends and Family Test (FFT). The hospital did not differentiate the results between adults and children and young people. Therefore, we were unable to comment specifically on the results for the paediatric service. The details of the results can be found in the surgery section of the report.
- The hospital also invited children and young people, with their parents, to complete patient satisfaction surveys. These showed positive results, with all patients recording that they were happy with the care and treatment they received.

Understanding and involvement of patients and those close to them

- Children and young people and their parents were invited in to hospital prior to their procedure in order to familiarise themselves with the environment and process.
- We observed a paediatric outpatient clinic appointment and saw that the consultant engaged with the young child well, talking to them in understandable language, while also ensuring the parent was made aware of all the necessary information.
- The parents we spoke with told us that the staff spoke directly to their child and engaged them in the decision making process, which gave the children a sense of control over what was happening. They also confirmed that they were always given sufficient information so that they knew what would be happening to their child.

Emotional support

- We observed nursing staff and health care assistants who were caring for children and young people, providing emotional support and reassurances to children and their parents who were anxious or worried.
- The registered nurse (child branch) we spoke with was very passionate about their role and took time to make sure children and young people were well cared for. The registered nurse (child branch) had implemented a kangaroo trail to theatre, where children followed signs for kangaroos to get to the theatre department. This form of distraction made the journey more enjoyable for children, who otherwise might have been upset.
- Staff alerted patients to the free Wi-Fi available within the hospital so young people could access internet facilities on their mobile phones or electronic devices. This allowed children and young people to access social media and remain in touch with their friends and support groups whilst in the hospital.
- One of the parents we spoke with specifically commented on the reassurance and support the nursing staff gave to the parents when their child was undergoing a procedure.

Are services for children and young people responsive?

Requires improvement

Services for children and young people

Good

We rated responsive as good.

Service planning and delivery to meet the needs of local people

- Information about the needs of the local population was used to direct how services were planned and delivered. The hospital had recently introduced Saturday surgical lists to meet increased demand for paediatric surgeries. Outpatient appointments for children and young people were planned, so far as possible, for after school hours to avoid disruption to their education.
- The hospital had planned, in conjunction with Healthwatch (a consumer champion for health and social care) for a group of young people from a local college to visit and inspect the hospital in November 2016. This was planned to determine young people's perspectives on how services for children and young people were planned and delivered.
- The services provided generally reflected the needs of the population they served and ensured flexibility, choice and continuity of care. Parents were able to choose outpatient appointment times that were convenient for them. However, there were limited paediatric surgical lists each month, with lists occurring one Thursday a month and one Saturday morning a month. Lists were put on occasionally on extra Thursdays in cases of extra demand; however, paediatric surgery did not happen on other days of the week. This was because the registered nurse (child branch) was not employed full time and only worked certain shifts at the hospital.
- There was no separate waiting room for children or young people waiting for outpatient appointments.
- Facilities were available for parents to stay with their child overnight following their operation. Drinks were also offered to parents and hot food was available in the hospital restaurant.

Access and flow

- The hospital had a paediatric day care pathway, which covered the child or young person's journey from pre-admission to discharge.
- Children and young people's surgical lists were prioritised on the day of surgery, so they were operated on first, before any adult lists began. This reduced their waiting time and meant they had longer to recover before discharge, to reduce the likelihood of an overnight stay being necessary.
- Children and young people's admissions were staggered, to reduce the amount of time they had to wait in the hospital for their procedure.
- Appointments for outpatient clinics were booked either directly through the consultant's secretary or through the hospital booking office. We saw evidence that patients were seen quickly and appointments were scheduled easily. During our inspection we saw that physiotherapy appointments were available each day, to enable quick access to a physiotherapist.
- Three procedures had been cancelled in between July 2015 and June 2016. One was cancelled as the patient was underage, one was cancelled by the child's parents and the third was cancelled due to a lack of anaesthetic cover. Three procedures had been delayed during the same reporting period; two due to incomplete admission documentation and the third due to medication not arriving in time for the surgery.

Meeting people's individual needs

- Information was provided in leaflets for parents. These covered a variety of procedures which were carried out in the hospital, including tonsillectomy and circumcision. None of the leaflets available were written in child-friendly language.
- The hospital did not offer any other formalised arrangements for children with additional needs such as sensory needs or with a learning disability.
- Children and young people who were due for admission were subjected to admission criteria; in order that those with additional medical needs were not operated on at Pinehill hospital.

Requires improvement

Services for children and young people

- Reasonable adjustments were made for children who struggled with the hospital environment. Themed duvet covers were used to make the bedroom more homely and laminated story cards were used as distraction techniques.
- Information regarding translation services is available in the surgical report.
- Catering was provided on site and children and young people were offered age appropriate meals. Due to the catering being on site, the service was flexible and children could request meals that were not on the menu if they preferred.

Learning from complaints and concerns

- Complaints that were received at ward level were dealt with locally by the registered nurse (child branch). All complaints were entered onto the hospital's electronic reporting system. All complaints were escalated to the matron. Staff told us that there had been one complaint regarding a child or young person in the past 12 months. The registered nurse (child branch) explained this had related to the agency nurse's attitude and a lack of clear communication from the surgical team regarding discharge.
- We asked parents if they knew how to complain if they needed to regarding their child's care. The parents we spoke with told us although they were not aware of the complaints process, that they would have felt comfortable raising any concerns with the hospital staff.
- Although complaints leaflets were available within the hospital, they had not been adapted for children or young people to understand.

Are services for children and young people well-led?

Requires improvement

We rated well-led as requires improvement.

Leadership / culture of service

- The children's and young people's department was run by the matron, in conjunction with the hospital's registered nurse (child branch). A consultant paediatrician was utilised in an advisory capacity. Both the matron and the registered nurse (child branch) had worked in the hospital for several years, and were well known throughout the hospital.
- All staff we spoke with spoke positively of the culture of the department and mentioned the good teamwork between colleagues.

Vision and strategy for this this core service

- The hospital had a vision to expand the children and young people's service. At the time of our announced inspection, there was a vision to move the paediatric surgical inpatient area which was on the second floor and shared with adult inpatients, to the ground floor day care area. This would have allowed children and young people to be nursed separately from adults and increase security. This would also allow more children and young people to be treated, as there were six rooms within the day care area, compared to the four used on the ward. When we returned for our unannounced inspection we saw that the move had been completed.
- All staff we spoke to were aware of this vision and viewed it as a positive improvement for the hospital.
- There was no formal strategy to fulfil the vision of expanding the service and the management team told us they were waiting for our inspection outcome before deciding whether to proceed with increasing the numbers of paediatric patients admitted.
- There were no specific values for the children and young people's service. Staff and senior managers told us that new hospital wide values had been released the week prior to our inspection; however, due to the newness of the values, these had not yet had time to be embedded with staff.

Governance, risk management and quality measurement for this core service

- There were very limited risk management and governance procedures in place for the children's and young people's service.
- There was no risk register specifically for children and young people. We reviewed the hospital wide risk register and there were no risks entered onto this which specifically related to children and young people. The

risks regarding lack of security for children and young people whilst they were ward patients and low numbers of registered nurses (child branch) were not recorded on the risk register.

- Senior staff we spoke with were unaware of the main clinical and operational risks relating to the children's and young people's service when asked and displayed no oversight of the risks facing this patient group.
- The hospital did not hold specific children and young people clinical governance meetings. Children and young people's services were discussed during the hospital wide bi-monthly clinical governance meetings. We reviewed the minutes of these meetings and saw that the paediatric service had become a standing agenda item in June 2016.
- A paediatric working group was formed by the hospital in July 2016 and an initial meeting had been held. The function of the group was to integrate clinical governance in paediatric patients and ensure adherence to guidelines. The group was chaired by a consultant paediatrician. By the time of our inspection one further meeting had been held, in September 2016. We saw from the minutes that discussions with regards to the vision to move the children and young people who required admission to the ward, to the day care area. In addition there were discussions with regards to the introduction of Saturday operating lists. However, the minutes we reviewed did not evidence discussion of clinical effectiveness or risk management.
- The minutes from the September 2016 meeting also showed that it had been decided that all anaesthetists caring for children required level 2 safeguarding training. However, this does not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding. This indicated that the working group did not have a good knowledge of the governance procedures relating to the safeguarding of children and young people. The anaesthetists we spoke to during the inspection had level 3 safeguarding training.
- Not all records we reviewed were complete. We reviewed 10 sets of notes during the inspection and saw that these were not always completed. In all 10 sets of notes a comorbidity checklist was present in the child's file; however, none of these had been completed, or signed to evidence that these had been reviewed or checked. Four of the 10 records we reviewed had fluid balance charts in them, of these one was complete, two were half completed with details of fluid intake but no details of fluid output and one chart was blank. The rest of the records did not have a fluid balance chart present. As senior managers did not audit the children's and young people's service the senior managers were not aware of these omissions.
- The matron represented the paediatric service at the Medical Advisory Committee (MAC) meetings. We reviewed the minutes of four MAC meetings and saw that three of the meetings did not mention children or young people's services. We saw from the minutes of the meeting held in June 2016 alluded to the hospital's exclusion providing diagnostic imaging for children. This had led to a proposal to discuss the possibility of a service level agreement with the local NHS trust to provide this.

Public and staff engagement

- The hospital participated in a patient satisfaction survey. The survey was adapted for children and young people, which allowed them to engage and give their views. We reviewed these and saw many positive comments about the hospital and the care provided by the registered nurse (child branch).The hospital did not run any patient forums involving children and young people.
- As the hospital only employed one registered nurse (child branch), they were heavily engaged with the development and expansion of the service.

Innovation, improvement and sustainability

- The registered nurse (child branch) and matron both confirmed that there had been no times when financial pressures had compromised patient care.
- The hospital was considering expanding the service to treat more children and young people. Staff were aware of the impact this would have and explained how if this went ahead, more paediatric nurses would need to be employed.

Requires improvement

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Requires improvement

We rated safe as requires improvement.

Incidents

- There had been no never events reported for the outpatient and diagnostic imaging department from July 2015 to June 2016. 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. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- All staff we spoke with knew how to report incidents through the hospital's electronic incident reporting system. Staff were aware of the type of incidents they needed to escalate and report. Some staff we spoke with were able to give examples of recently reported incidents. For example, staff in radiology told us about an incident where a patient had been given a compact disc containing another patient's diagnostic images. We saw evidence that the hospital had taken actions to minimise the risk of this incident reoccurring, lessons learned had been shared in the department and the duty of candour was applied. The patient was informed of the incident and received a written apology, which included details of what had gone wrong.
- Incidents were discussed at clinical governance committee meetings which took place every other month. We saw four sets of meeting minutes. The heads of department meetings also discussed 'significant events/complaints' and we saw four sets of minutes from these meetings.
- A total of 10 clinical incidents and one non-clinical incident were reported between July 2015 and June 2016. This was lower than the number of incidents reported for other comparable independent acute hospitals. We requested details of the incidents reported but were not provided with this information. Therefore, we were unable to determine if thorough and robust reviews of all incidents were carried out.
- Senior managers told us that learning from incidents was fed back to staff in a variety of ways, such as following the heads of department daily 'huddle,' known as the 10@10, email, the communications book and departmental team meetings. Staff we spoke with confirmed this happened and some were able to give us examples of lessons learned. For example, one incident related to mislabelled histology samples. Staff told us that since this incident had happened, the consultant who had taken the sample was responsible for checking all information with a nurse, to ensure they were completed accurately before samples were sent for testing.
- The provider, Ramsay Health Care UK published a quarterly radiology lessons learned report. We reviewed one report, which contained details of lessons learned following the review and feedback from incidents, complaints and audits that had happened across radiology services within the Ramsay Health Care UK group of hospitals.

- The Ionising radiation (Medical Exposure) Regulations, or IR(ME)R, are a framework which deals with the safe and effective use of ionising radiation when exposing patients and are designed to minimise the risk of unintended, excessive or incorrect medical exposure. The service had not reported any incidents related to radiation between July 2015 and June 2016.
- The Ionising Radiation Regulations 1999 (IRR99) aim to protect staff working with ionising radiation. This legislation requires radiology services to produce 'local rules', which is a set of rules describing what systems and processes are in place in individual services to protect staff. The radiology service had developed their 'local rules' and these were displayed in relevant areas of the department.

Duty of Candour

- See the Surgery section for main findings.
- Staff were aware of the importance of being open and honest with patients and relatives when something went wrong. Staff were familiar with the duty of candour regulation and were aware of their roles and responsibilities in relation to duty of candour.
- We saw evidence that patients were told when things went wrong and they had received an apology. There had been an information governance incident in radiology. We saw that duty of candour principles had been applied.

Cleanliness, infection control and hygiene

- All areas visited, including clinical and waiting areas, were visibly clean and tidy.
- We saw the service level agreement for the provision of housekeeping services, which included daily, weekly and monthly cleaning schedules. We saw completed cleaning schedules during October 2016, which confirmed areas had been cleaned.
- Nursing and/or healthcare assistants were responsible for cleaning rooms and equipment after each clinic. Housekeeping staff cleaned all consultation and treatment rooms in the evening, when the department was closed
- The outpatient department had trolleys, which were used to store equipment for specific clinics, such as ophthalmology, vascular and dermatology. The local procedure was that any trolley used for a specific clinic would be cleaned prior to clinic use, between procedures and at the end of each clinic session. All trolleys were also cleaned on a weekly basis. The weekly cleaning of these trolleys was allocated to specific nursing staff. We reviewed the cleaning schedules for September and October 2016 and saw there was three occasions when two trolleys had not been cleaned because the designated member of staff was on annual leave and the cleaning duty had not been allocated to another member of staff during their absence. We also found a trolley in the physiotherapy department that was covered in dust. Therefore, we were not assured there was an effective system in place to ensure that all equipment was cleaned regularly.
- The hospital carried out quarterly infection prevention and control environmental audits. Compliance was audited against eight standards; infection control management, general environment, clinical equipment, decontamination, clinical practices, sharps handling and disposal, waste disposal and hand washing. We saw the results of audits carried out between November 2015 and August 2016 and overall compliance with the eight standards was high at 90% and above. We saw evidence that actions were taken to address areas of non-compliance. For example, the audit carried out in May 2016 reported that sharps bins were not left with temporary closures in place. We observed temporary closures were in place during our inspection.
- Flexible nasal endoscopes were cleaned in line with Department of Health guidance (Health Technical Memorandum 01-06: Decontamination of flexible endoscopes. Part A: Policy and management, March 2016). Only staff that had completed training and competency assessment cleaned the flexible endoscopes. We saw evidence of this during inspection.
- Hand sanitiser gel dispensers were available in waiting areas, corridors and consultation and treatment rooms. We observed reception staff asking patients and visitors to apply the hand gel when they booked in at the main outpatient waiting area. We also saw staff using the hand sanitiser gel dispensers when they entered outpatient department.
- We saw consultants wash their hands following consultations with patients.

Requires improvement

Outpatients and diagnostic imaging

- Hand hygiene audits for the hospital from July 2015 to April 2016 showed compliance was at 98% and above. We saw evidence that actions were taken to address areas of non-compliance. For example, results of the audit carried out in April 2016 reported that a student nurse was wearing clear nail varnish. The student nurse was advised this was not in line with hospital policy and was told to remove it.
- All clinical rooms had appropriate facilities for the disposal of clinical waste and sharps. All sharps boxes were clean, were not overfilled and had temporary closures in place to minimise the risk of needle stick injuries.
- There was access to hand washing facilities and a supply of personal protective equipment (PPE), which included gloves and aprons. However, we did not observe any procedure, so did not see if these were used appropriately.
- Staff told us that if a patient was known to have a communicable disease, such as influenza or tuberculosis, they would seek advice from the infection control lead to ensure appropriate precautions and actions were taken to minimise the risk of cross-infection.
- The hospital's patient-led assessment of the care environment (PLACE) audit for 2016 showed they scored slightly worse than the England average for cleanliness. The hospital scored 97%, whilst the England average was 98%. We requested details of actions taken in response to findings from the PLACE audit but the hospital did not provide us with this evidence. Therefore, we were unable to determine whether the hospital had taken any action to improve.

Environment and equipment

- See children and young people section for main findings on the environment and equipment for children and young people.
- There was both carpeted and vinyl areas on the floor in the consultation rooms. The patients' examination couch was situated on the vinyl area. The Department of Health (2013) Health Building Note 00-10 Part A: Flooring states that the use of carpets in consultation rooms should be risk assessed, with clearly defined maintenance and cleaning programmes in place. The service level agreement showed that carpets were cleaned every three months. Spillage of any bodily fluids was cleaned in the first instance by outpatient staff, followed by a deep clean from housekeeping staff. We asked a member of staff on how spillages on carpets would be cleaned; they told us they had never known anything other than coffee being spilt and they would contact housekeeping staff. Spillage kits were available in the hospital.
- Adult resuscitation equipment was available in case of an emergency in the outpatient department. We examined the resuscitation trolley and saw that regular checks had been completed and documented to ensure the equipment was fit for use. The oxygen cylinder stored on the resuscitation trolley was in-date.
- The consultation and treatment rooms had emergency alarms that could be used to summon assistance when needed.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps. Bins were not overfilled.
- The maintenance of equipment was completed via service level agreements with the manufacturer or the hospital's estates department. A schedule of work was in place and equipment was assessed annually as safe for use. All equipment we saw had been annually checked and appeared fit for use.
- Equipment was visibly clean and "I am clean" stickers were used to indicate when equipment had been cleaned and was ready for use.
- We saw access to appropriate PPE, including lead gowns and thyroid shields in the radiology department. A thyroid shield protects the neck area from radiation. The radiology department had clear guidelines on which specialised PPE should be used for specific procedures. All PPE we saw had been regularly checked and was found to be in good order. An external audit carried out in October 2015 reported that excellent PPE was available.
- The physiotherapy department gymnasium was equipped with a cross-trainer, exercise bike, rowing machine, treadmill and step machine. The physiotherapy department also had height adjustable chairs, which could be modified for patients as needed.

Requires improvement

Outpatients and diagnostic imaging

- The hospital's PLACE audit for 2016 showed they scored worse than the England average for the condition, appearance and maintenance of premises. The hospital scored 87%, whilst the England average was 93%. We requested details of actions taken in response to findings from the PLACE audit but the hospital did not provide us with this evidence. Therefore, we were unable to determine whether the hospital had taken any action to improve.
- One patient, who had been attending the hospital for nine years, told us; "The environment was very clean, bright and hygienic" and another patient said; "It has always been a well-kept and clean environment."

Medicines

- The outpatients and radiology department had appropriate lockable storage facilities for medicines. Medicines that needed to be kept below a certain temperature were stored in a locked fridge. No controlled drugs (medicines subject to additional security measures) were stored in the outpatients and radiology department. However, the keys to medicine cupboards were not stored in accordance with national guidance. The keys to the medicine cupboards in outpatients were stored in a cupboard, which contained other keys for the department and patient records. Whilst we observed this cupboard was kept locked when not in use, we were told that all members of staff had access to this cupboard, which meant unauthorised members of staff could access the medicine cupboards.
- There was a similar situation in the radiology department; the keys for medicine cupboards were stored with other keys for the department. This also meant that unauthorised persons could access the medicine cupboards. We raised our concerns at the time of inspection and when we revisited the hospital on our unannounced inspection we saw that some action had been taken by the hospital to address our concerns. For example, a safe had been fitted to store the medicines keys in the outpatient department. We were told that only nursing staff had access to the safe. The hospital also planned to fit a safe for the storage of medicines keys in the radiology department. We saw evidence that a safe key had been installed in the radiology department following our unannounced inspection.
- Blank prescription pads were not stored securely and robust monitoring systems were not in place to ensure that all prescriptions were accounted for. Prescription pads were stored in the same cupboard as the outpatient department keys and patient records. This meant that unauthorised members of staff could access blank prescriptions. The prescriptions record book detailed all prescriptions issued from outpatients and included the name of the consultant who issued the prescription, the date it was issued and the prescription number. The Department of Health Security of prescription form guidance (August 2015) states that best practice includes the recording of serial numbers daily and an audit trail that shows the serial number of prescriptions from issue to prescription. However, from the records we reviewed we found six entries where no information, other than the prescription number, had been provided. This meant there was a risk that missing prescriptions had not been noticed and could have been used inappropriately. We raised our concerns at the time of inspection and when we revisited on our unannounced inspection we saw the hospital had taken action to address our concerns. Prescription pads were stored securely and could only be accessed by authorised staff. Furthermore, the hospital had introduced a monitoring system to ensure all prescriptions were accounted for.
- There was an established system for the temperature management of medicines to ensure they were safe to use. The ambient and room temperatures were checked daily by staff, in line with hospital policy. We reviewed the temperature records for September and October 2016 and found they were completed and contained minimum and maximum temperatures, which alerted staff when they not within the required range. Staff we spoke with were aware of the procedure to follow if temperatures were not within the required range.
- Outpatient prescriptions were dispensed by the on-site pharmacy department, which provided daily cover between 8am and 4 to 6pm depending on hospital activity, Monday to Friday. Nursing staff told us that the pharmacy team were available to offer support and advice to both staff and patients as needed. An on-call pharmacist was available for advice 24 hours a day, seven days a week.

- Some diagnostic scans required the patient to be injected with a chemical contrast agent to improve the clarity and diagnostic accuracy of the scan. There was an up to date policy for the administration of contrast agents and medicines for diagnostic imaging. Radiologists were responsible for prescribing and administering all contrast agents.

Records

- Records of patients who attended outpatient clinics were stored securely in a locked cupboard, in line with legislation. We did not find this cupboard unlocked during our inspection.
- Records of patients that had attended the hospital since 2015 were stored on site in the medical records office, which was situated in the basement of the main hospital building. This office was locked and was accessed by a key code. Patient records prior to 2015 were stored off site by an external provider. Staff told us that patient records stored off site were delivered to the hospital within one day of request. Patient records were generally prepared a few days ahead of the clinic by the medical records team. This included the records of patients who returned to the hospital for wound checks and/or dressings. These records would then be brought to outpatients and stored in a locked cupboard in front of the nursing desk.
- Patient records were managed in line with the corporate medical records policy. As part of their practising rights at the hospital, consultants had to meet the regulatory requirements for keeping private patient records and were also required to register with the Registered Commissioners Office (RCO). Senior managers told us that some consultants stored the records of private patients at the hospital and some consultants stored the records of private patients under their own arrangements. Duplicate clinical paper was available in all clinical areas, which enabled consultants to take a copy of their consultation notes with them and keep a copy on site. NHS patient records were retained by the hospital.
- All staff we spoke with told us there were no problems with accessing patients' records for clinic appointments. If patient records were not available temporary sets of records would be made up. For first appointments, copies of referral letters and medical history would be obtained from the GP or referring hospital. For follow up appointments, copies of clinic letters would be obtained from medical secretaries or the NHS office. The hospital told us their monitoring showed less than 5% of appointments occurred without all relevant patient records being available. Therefore, we were assured that clinicians could make informed decisions about the care and treatment of patients based on current patient information.
- We reviewed the records of five patients attending an outpatient appointment. Referral letters, care plans and risk assessments were available, where applicable.

Safeguarding

- See the children and young people section for main findings on the safeguarding of children and young people.
- There had been no safeguarding concerns reported to the Care Quality Commission in the reporting period from July 2015 to June 2016.
- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- Safeguarding adult policies were in date and were accessible to staff via the hospital intranet.
- The hospital had named safeguarding leads for adults and children. Safeguarding information, escalation flowcharts for adults and children and relevant contact numbers were displayed on noticeboards in the outpatient and radiology departments.
- Staff we spoke with had not had to make a safeguarding referral but could explain the process if a concern was identified.
- Staff had some awareness of female genital mutilation (FGM) but had not received any specific training on this topic.
- As of November 2016, training records for outpatients, physiotherapy and radiology showed 70% of staff had completed level two safeguarding children training. The

hospital target for completing safeguarding training was 100%. Therefore, we were not assured that all staff had received the appropriate level of safeguarding children training.

- The hospital was not able to provide safeguarding adults training by department. As of November 2016, training compliance data for all hospital staff showed 94% of staff had completed safeguarding adults level two training.

Mandatory training

- Mandatory training covered a range of topics, which included fire safety, manual handling, information governance and adult basic life support. All staff within the outpatient and diagnostic imaging service were aware of the need to complete mandatory training.
- Training was completed as e-learning modules or face-to-face sessions. Staff could access e-learning courses at work or home.
- Senior managers maintained oversight of training requirements via a tracker, which detailed when each member of staff had completed specific training modules. We were told that the hospital had recently introduced a new system, which meant the tracker was no longer automatically updated when staff completed training. Staff were now required to present the certificates they received on completion of training modules to departmental managers, who would then update the tracker accordingly.
- The hospital target for completing mandatory training was 100%. Hospital data provided at the time of inspection showed completed mandatory training did not meet the hospital target. The compliance figures for contracted staff amongst outpatients, radiology and physiotherapy were 50%, 43% and 75% respectively. The compliance figures for bank staff were 50%, 67% and 57% respectively. Therefore, we were not assured that all staff had completed mandatory training. Senior staff told us that training compliance was discussed at department meetings and we saw evidence of this in meeting minutes. Non-compliant staff were emailed by their head of department and told to arrange required training. Staff who had not achieved 100% completion of their annual training may forfeit their annual pay review until they had completed all training requirements. However, based on training figures provided, we were not assured effective action was taken to address non-completion of mandatory training.

Assessing and responding to patient risk

- The outpatient and diagnostic service had systems in place to assess risks to patients and monitor and maintain patients' safety.
- The hospital had a standard acceptance criteria for NHS admissions, to ensure only patients who met this criteria were seen and treated at the hospital. The exclusions included any patient who would require a planned admission to an intensive treatment unit (ITU) post-surgery and who had a high body mass index. Patients with co-morbidities (such as high blood pressure, diabetes or asthma) would be assessed by medical staff, including an anaesthetist, for their suitability for treatment at the hospital. Patients who were unsuitable for treatment would be referred to the local NHS trust.
- All patients were required to complete a medical history questionnaire prior to their appointment, which included whether they had any known allergies, infection risks and what medications they were currently taking. The information was reviewed by nursing staff, consultants and/or anaesthetists to ensure potential risks were identified prior to treatment. We reviewed five patient records and saw care plans and risk assessments had been completed, where appropriate.
- Staff were aware of what actions they would take if a patient became unwell in the outpatient and radiology department. This included a call for urgent medical assistance, which meant that staff holding the emergency bleeps would be alerted to attend the department. The hospital had a registered medical officer on site 24 hours a day, seven days a week to support the clinical team in the event of emergencies or with patients who required additional medical support.
- There were policies and processes in place in the event of a patient's condition deteriorating and necessitating their transfer to an appropriate NHS unit. The hospital had a service level agreement with a local NHS trust for the transfer of acutely ill patients.

Requires improvement

Outpatients and diagnostic imaging

- We were told that regular impromptu emergency scenarios were carried out to maintain and improve the skills needed in the event of an emergency. The most recent emergency scenario in the outpatient department had been undertaken in August 2016. We reviewed the evaluation record and saw areas of good practice; areas for improvement and learning from the incident were detailed and shared within the whole hospital.
- There was an emergency trolley and automatic external defibrillator (AED) situated in the outpatient department. The radiology and physiotherapy departments did not have their own emergency trolleys but could easily access the one in the outpatient department, as all departments were situated on the ground floor, in close proximity to one another. The radiology department had an anaphylaxis kit (emergency equipment and medicines used to treat life-threatening allergic reactions), which was in date.
- The world health organisations (WHO) checklist, designed to prevent avoidable harm, was completed for patients undergoing radiological interventions. We reviewed three checklists and found the patient's allergy status had not been documented on two occasions; all other information was complete. We raised this with the radiology manager at the time of inspection, who suggested that the omissions were probably due to the question not being applicable (i.e. those patients did not have any known allergies) rather than the question not having been asked. The radiology manager told us they would remind staff to ensure all sections of the checklist were completed.

Nursing staffing

- See the children and young people section for nursing staffing for children and young people.
- There is no national baseline acuity tool for nursing staffing in outpatients. The manager reviewed staffing requirements in advance of clinic sessions held per week. Staff confirmed there was sufficient nursing staff to deliver care safely within outpatients. We reviewed the staffing rotas for September 2016 and observed that planned staffing requirements were met for all shifts. Information provided by the hospital showed there were no unfilled shifts from April to June 2016. Where additional staffing was required to cover sickness or annual leave, this was generally covered by contracted or bank staff.
- Information provided by the hospital showed no agency nurses were used in outpatients from April to July 2016. The use of bank and agency nurses in outpatients was similar to the average use of agency staff in other independent acute hospitals during the reporting period from July 2015 to June 2016.
- There were no nursing vacancies in outpatients at the time of our inspection. The sickness rate, during the reporting period, for nurses working in outpatients was similar to the average sickness rate for other independent acute hospitals. Staff turnover rate was below the average for other independent acute hospitals during the reporting period.
- Contracted and bank staff underwent a formal hospital and local induction process prior to the commencement of clinical duties.
- The hospital had been unable to recruit a head for the radiology department since May 2015; this department was being managed in the interim, by the head of physiotherapy. The hospital had recruited a senior radiographer in May 2015 to supervise the technical requirements. At the time of inspection we were told that the radiology department was advertising for two radiographers; one full-time and one part-time, in order to facilitate development and growth in the department.
- We saw evidence of a competency and induction checklist for new, bank and agency staff. All new starters underwent an induction process and worked supernumerary for a minimum of two weeks, to ensure they received adequate support and supervision. The induction process included the completion of competencies and training requirements, such as health and safety procedures, the use of specialised PPE, radiation protection and the hospital's 'local rules'.

Medical staffing

- There were 150 consultants who had been granted practising privileges at the hospital; none were employed directly by the hospital. Practising privileges

is a term used when doctors have been granted the right to practise in an independent hospital. The majority of consultants at the hospital were employed at the local NHS trust.

- Consultants and radiologists had planned clinics and attended the department on set days and set times. This meant that appropriate staffing could be arranged in advance.
- Consultants were responsible for ensuring arrangements were in place to cover planned leave and any other circumstances.
- Consultants could be contacted by telephone, email or via their secretaries to provide advice to staff when they were not in attendance at the hospital.
- An RMO was on site 24 hours a day, seven days a week. They could be contacted for medical advice, in the event of an emergency and for patients who required additional medical support.
- The radiology department provided a consultant on-call service 24 hours a day, seven days a week.

Emergency awareness and training

- The hospital had a business continuity plan, which included flowcharts of actions staff should take in the event of a fire, medical emergency, chemical emergency, explosion, bomb threat or loss of power. Staff could access this via the hospital intranet.
- Within radiology there were effective arrangements in place in the event of a major incident happening within the department. This included the 'local rules', which provided guidance on what to do in the event of a radiation incident. The 'local rules' were clearly displayed in the department.
- There were emergency call alarms in the consulting and treatment rooms in the outpatient, radiology and physiotherapy departments. Staff told us the emergency bleep holders were automatically alerted when an alarm call was raised. Staff would use the emergency call alarms to summon assistance as needed, although we were told that this did not happen very often.
- The hospital target for completing basic life support (BLS) training was 100%. As of November 2016, 65% of outpatient staff, 38% of radiology staff and 46% of physiotherapy staff had completed BLS training.

Furthermore, the manager for outpatients told us that all qualified staff were required to complete annual adult intermediate life support (ILS) training. However, according to information provided to us at the time of inspection, no registered nurses (out of a potential seven identified from the data we were given) had completed ILS training within the last 12 months. The last dates recorded for three qualified staff dated back to 2013 and one dated back to 2012. Data provided following our inspection showed that 25% of qualified staff had completed ILS training. Therefore, we were not assured that staff could assist in an emergency situation as they had not attended the appropriate training.

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate the service for effectiveness.

Evidence based care and treatment

- Policies followed the National Institute for Health and Care Excellence (NICE) guidance, royal college's guidance, best practice and legislation, where appropriate. For example, the radiology department had a policy for the prevention of contrast induced neuropathy in line with national guidance.
- Staff told us they were able to access policies and procedures on the hospital intranet. We saw evidence of this during our inspection. Hard copies of policies were also available in the hospital's meeting room, near to the management offices. However, we reviewed the hard copies of radiology policies and found the majority of them were out of date. We raised this with senior managers at the time of our inspection, who were unaware that the hard copies of policies had not been updated to reflect current guidance. We reviewed the radiology policies on the hospital intranet and saw they were in date. Therefore, we were not reassured that staff were always accessing the most up to date policies.
- Outpatient procedure and specific care pathways, such as the cataract care pathway under local anaesthesia, were in use within the outpatient department.
- The imaging department used diagnostic reference levels (DRLs) as an aid to optimisation in medical exposure. The radiation protection advisor (RPA) was responsible for ensuring that DRLs were displayed in

each appropriate area and regular audits were carried out with action taken when necessary. DRLs should be set in line with the Ionising Radiation (Medical Exposure) Regulations, or IR(ME)R, guidelines to ensure that patients received the minimum exposure as was reasonably practicable. We reviewed the DRLs in the main x-ray room for September and October 2016 and all were within the accepted range.

- An external audit of DRLs had been undertaken in October 2015. The audit concluded that DRLs were a fraction of the national DRLs, especially for plain film radiography carried out in the main x-ray room.
- Staff working with ionising radiation at the hospital were required to wear a dosimeter, in line with the Ionising Radiation Regulations (IRR). A dosimeter is used to detect and measure the quality of ionising radiation that a person may have absorbed or been exposed to. Staff told us that dosimeters were replaced every two months. We saw evidence that audits were carried out to ensure that effective measurements were in place to protect staff.
- The hospital had external accreditation for its breast care centre, cataract centre and bowel care centre. This meant these services had been assessed as meeting the standards set by an external health and care provider.
- Patients considering cosmetic surgery were given a mandatory two week cooling off period between the initial consultation and follow up. This allowed patients time to consider the information given to them before they made any final decision about whether to go ahead with cosmetic surgery.

Nutrition and hydration

- Patients who attended clinic or diagnostic appointments were not generally in the department for long periods of time, therefore beverages and food were not provided.
- Water dispensers were available for patients and visitors in all areas of the service.
- The hospital's patient-led assessment of the care environment (PLACE) audit for 2016 showed they scored better than the England average for food and hydration. The hospital scored 90%, whilst the England average was 88%.

Pain relief

- Pain relief could be prescribed within the outpatient department and subsequently dispensed by the pharmacy department as required.
- The hospital provided pain management clinics for patients referred with musculoskeletal based pain. The pain management clinics were run by three consultants who had achieved competencies and experience in advanced pain medicine, as defined by the Faculty of Pain Medicine of the Royal college of Anaesthetists. Consultants could refer patients for physiotherapy services, as needed. Patients who required psychological support to manage their pain were not seen at the hospital; they would be referred to the local NHS trust.
- Pain levels were assessed by use of a recognised pain score. Care pathways used at the hospital included specific reference to pain assessment and management. For example, patients who had a procedure in outpatients were assessed for their level of pain following the procedure. They were also asked if they had suitable pain relief to take at home. Patients were reassessed for their level of pain within 24 hours of discharge. We reviewed five patient medical records and saw that pain was assessed and managed appropriately, where needed.
- None of the patients we spoke with required pain relief at the time of our inspection. Staff told us they would escalate any concerns regarding pain relief to the appropriate consultant, if available, or to the resident medical officer (RMO).

Patient outcomes

- See surgery section for main findings.
- The follow-up to new appointment rate at the hospital was 2:8 for NHS patients, which is in line with national averages and 1:8 for privately funded patients from July 2015 to June 2016.
- The physiotherapy department participated in regular audits to ensure care was provided in accordance with the Quality Assurance Standards for physiotherapy service delivery (Chartered Society of Physiotherapy, 2012). We reviewed the results of audits carried out in

March, April and November 2016 and saw compliance was high (90%, 95% and 99% respectively). We saw evidence that action was taken to address any areas of non-compliance.

- The hospital had a local annual audit programme, which included the audit of medical records, consent and radiology referral forms, in line with the Ionising Radiation (Medical Exposure) Regulations 2000. For example, results from the radiology referral forms audit for October 2017 showed compliance with completion was 100%. The results of the non-radiologist reported imaging audit also showed 100% compliance.
- The hospital did not participate in the imaging services accreditation scheme (ISAS) or improving quality in physiological services (IQIPS).

Competent staff

- All staff were required to have an annual appraisal. Information provided by the hospital showed 90% of nursing staff and 100% of health care assistants had received an appraisal during the reporting period from July 2015 to June 2016. Staff we spoke with told us it was a useful process for identifying any training and development needs.
- Medical revalidation was introduced in 2012 with the aim to ensure that all doctors were up to date and remain 'fit to practise'. The hospital reported that all consultants working under practising privileges had revalidated. Therefore, we were assured that the hospital had appropriate measures in place to monitor medical revalidation and to ensure that all doctors were up to date and remained 'fit to practise'.
- Revalidation was introduced by the nursing and midwifery council (NMC) in April 2016 and is the process that all nurses and midwives must follow every three years to maintain their registration. Only one member of nursing staff had been required to revalidate in 2016 and had successfully done so.
- The hospital supported in house training and development. For example, we were told that one healthcare assistant had recently started an apprenticeship scheme, which could lead to registration as a qualified nurse.
- The physiotherapy department had a formal supervision process in place to support and develop staff. Some physiotherapists had achieved competency in the use of acupuncture; one physiotherapist working at the hospital had a master's degree in acupuncture. Several physiotherapists had master's degrees in neuromusculoskeletal physiotherapy and manual therapy.
- We saw evidence that the radiation protection supervisor had achieved competency in 'radiation protection for radiation protection supervisors and quality assurance in radiology'.
- Staff who administered radiation were appropriately trained to do so.
- New members of staff were required to complete a comprehensive induction programme and competencies, which were appropriate to their role.
- The nurse responsible for laser hair removal had undertaken appropriate training and competency assessment. We saw this had been updated annually.
- The urology nurse specialist had attained additional competencies specific to her role, such as male catheterisation.

Multidisciplinary working

- We observed collaborative working and communication amongst all staff in the department. Staff told us they worked well as a team.
- Medical and nursing staff reported good working arrangements and relationships with the local NHS hospital.
- The hospital had some specialist nurses, such as a urology nurse specialist and laser hair removal nurse specialist. Staff and patients could access them for support and advice as needed.
- We saw evidence that some specialities worked collaboratively with the radiology department to deliver effective care and treatment. For example, the hospital offered a consultant led 'one stop' breast clinic, where patients could undergo diagnostic testing, which included imaging, pathology and consultation in one visit.
- Consultants from the pain management service met weekly at the local NHS trust to discuss case histories and share best practice.

Requires improvement

Outpatients and diagnostic imaging

- Physiotherapists worked collaboratively with the radiology department and clinical specialities, such as orthopaedics, rheumatology and pain management, to provide outpatient services. For example, patients could be referred for post-operative rehabilitation following hip and knee replacement surgery.
- Staff told us that radiologists checked or protocolled scan requests to ensure any exposure to radiation was justified. Patients were asked if they had undergone similar diagnostic imaging at any other hospital. If they had the hospital would request the images, which would be reviewed by a radiologist who would then decide whether further imaging was justified.

Seven-day services

- Outpatient clinics were available from 8am to 9pm Monday to Friday, and 8am to 1pm on Saturdays. This enabled patients to attend the hospital at a time that suited them.
- The radiology department was available 8am to 6pm Monday to Friday, with additional evening services provided on alternate Mondays until 9pm. Radiographers were also available to support orthopaedic clinics and theatre lists out of these scheduled hours, as needed. A radiologist on-call service was available 24 hours a day, seven days a week.
- Physiotherapists were available from 8am to 9pm Monday to Thursday, 8am to 6pm on Fridays and 8.30am to 12pm on Saturdays.
- When the outpatient department was closed, patients could phone the ward staff for advice.
- There was an out of hours on-call list for consultants. Most consultants worked in speciality groups and provided cover for one another.

Access to information

- Staff had the information they needed to deliver effective care and treatment to people who attended the outpatient and diagnostic imaging service.
- All staff we spoke with told us there were no problems with accessing patients' records for clinic appointments. If patient records were not available temporary sets would be made up. The hospital told us their monitoring showed less than 5% of appointments occurred without all relevant patient records being available.
- Patient records were managed in line with the corporate medical records policy. As part of their practising rights at the hospital, consultants had to meet the regulatory requirements for keeping private patient records and were also required to register with the Registered Commissioners Office (RCO). Senior managers told us that some consultants stored the records of private patients at the hospital and some consultants stored the records of private patients under their own arrangements. Duplicate clinical paper was available in all clinical areas, which enabled consultants to take a copy with them and keep a copy on site. NHS patient records were retained by the hospital.
- The hospital generally received medical information for NHS patients from their GP as part of their referral process via the NHS e-referral system. E-referral is a national electronic referral service, formerly called choose and book, which gives patients a choice of place, date and time for their first appointment in a hospital or clinic.
- NHS patients were given a copy of the discharge letter sent to their GP. Private patients were given copies of all letters sent to their GP. The hospital did not monitor the time it took for discharge letters to be sent to GPs and/or patients. We were told that letters were produced directly by consultants and their secretaries and the usual turnaround time was between one and two weeks.
- Diagnostic images were initially reported on the hospital's radiology information system (RIS). Once the images were saved on RIS this system interfaced with the patient archive communication system (PACS) and enabled appropriate staff to view patient's diagnostic imaging results electronically. The hospital reported no backlog of unreported images at the time of our inspection.
- Patients could request a copy of their diagnostic images on compact disc. Following an incident, whereby the images of one patient were given to another patient in error, the hospital had acquired a compact disc burner, which encrypted the disc to maintain patient

confidentiality. The password for the disc would be sent separately to the patient via the post. If a patient required the password when they collected the disc they had to provide photographic evidence to evidence their identification.

- All consultation and treatment rooms had computer terminals, which enabled staff to access patient information such as x-rays and blood results via the electronic reporting system.
- Staff had access to the hospital intranet to obtain information relating to hospital policies, procedures and national guidance.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital had an up to date policy regarding consent, which staff could access via the hospital intranet.
- Staff we spoke with understood their roles and responsibilities with regards to consent, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff told us if they had any concerns regarding a patient's capacity to consent they would refer to the consultant and/or matron.
- The hospital had four nationally recognised consent forms in use. These included a consent form for patients who were able to consent and one for patients who were not able to give consent for their operation or procedure.
- The hospital audit plan for July 2016 to June 2017 included a quarterly consent audit. According to information provided by the hospital the compliance for September 2016 was 86%. We saw evidence that the results of this audit were discussed at the clinical governance committee meeting held in October 2016 and actions were identified to improve compliance.
- We reviewed five sets of patient records and saw consent forms were fully completed, signed and dated by the consultant and patient. The forms included the planned treatment and associated risks and benefits.
- The radiology department used consent form three (patient agreement to investigation or treatment where consciousness not impaired). We reviewed the records of three patients who had undergone radiological intervention and saw consent forms were fully completed, signed and dated by the radiologist and patient. The forms included the risks associated with the investigation and/or treatment.
- Verbal consent was gained as a minimum prior to any diagnostic procedures. We observed this during inspection.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good.

Compassionate care

- Patients were treated with compassion, kindness, dignity and respect.
- We observed reception staff greet patients in a courteous and friendly manner and direct them to the appropriate waiting area. Patients were able to speak to reception staff without being overheard. Staff told us they obtained patient feedback about their services in a variety of ways, such as the NHS Choices website.
- The hospital took part in the friends and family test (FFT), a survey that asks patients whether they would recommend the service they have received to friends and family who need similar treatment or care. The hospital did not collect FFT results per service. Therefore, we were unable to determine FFT results for the outpatient and diagnostic imaging service. The overall hospital FFT scores for January to June 2016 were varied when compared with the England average. The percentage of patients who would recommend the service to friends and/or family ranged from 65% in June to 100% in February 2016; the average score for this period was 88%. The percentage of patients who responded to the FFT survey during this period ranged from 25% in February to 78% in January 2016. The average response rate for this period was 53%, which was better than the England average of 40%.

Requires improvement

Outpatients and diagnostic imaging

- We observed good examples of caring, considerate staff throughout all areas of outpatient and diagnostic imaging departments. We saw a radiographer give a patient extra pillows to ensure they were comfortable during their imaging procedure.
- Staff knocked on doors before entering consultation and treatment rooms. There were disposable curtains in consultation and treatment rooms to protect patient's privacy and dignity during examinations and/or treatment. However, the hospital's patient-led assessment of the care environment (PLACE) audit for 2016 showed they scored worse than the England average for how the environment supports the delivery of care with regards to the patient's privacy, dignity and wellbeing. The hospital scored 63%, whilst the England average was 84%. We requested details of actions taken in response to findings from the PLACE audit but the hospital did not provide us with this evidence. Therefore, we were unable to determine whether the hospital had taken any action to improve.
- Patients told us the service was excellent. One patient told us the; "Care was brilliant, felt fully informed and privacy and dignity was maintained".
- We observed posters in the public areas around the outpatient department and inside consultation rooms informing patients that they could request a chaperone if they wanted one. Staff told us that same sex chaperones would be provided upon request.

Understanding the involvement of patients and those close to them

- Patients we spoke with felt well informed about their care and treatment. One patient told us; "All my questions were answered and I felt fully informed. I would make no changes".
- Patients understood when they would need to attend the hospital for investigations or when to expect a follow up outpatient appointment. Patients told us they were given a choice of appointments to suit their needs and that it was easy to change appointments.
- We observed reception staff checked that patients knew which clinic they were attending and which consultant they were going to see.
- Consultants introduced themselves and shook patients' hands when they were called in for their appointment.
- Staff were available to discuss the full or partial cost of care and treatment with patients.
- Patients were asked if the hospital could contact them by phone and/or leave a message if they were not available. Patients were also asked if there was anyone they did not wish the hospital to discuss their care with. This information was documented on the patient's medical questionnaire.
- Patients could contact the department and speak with nursing staff if they had any questions or concerns.

Emotional support

- Patients could request a chaperone or be accompanied by a relative or friend during their appointment. This service was clearly promoted within both departments.
- Staff showed an understanding of emotional needs and had access to chaplaincy services, which provided spiritual care and religious support for patients and those close to them, as needed.

Are outpatients and diagnostic imaging services responsive?

Good

We rated responsive as good.

Service planning and delivery to meet needs of local people

- The outpatient department was open 8am until 9pm Monday to Friday and also on a Saturday morning. The radiology department was open 8am to 6pm Monday to Friday, with additional evening appointments provided on alternate Mondays until 9pm. The physiotherapy department was open from 8am to 9pm Monday to Thursday, 8am to 6pm on Fridays and also on a Saturday morning. Evening and weekend appointments allowed patients access to healthcare that suited their circumstances.
- The radiology department carried out x-rays and ultrasound scans. The hospital also provided more complex tests, such as magnetic resonance imaging (MRI) and multi-slice computerised tomography (CT) via a mobile scanner unit. However, the hospital did report

that MRI was only available two to three times a week and because of an increase in patient demand for this service, some patients occasionally had to be referred to other healthcare providers.

- We observed the outpatient, radiology and physiotherapy environment were appropriate and patient centred. The main outpatient area was spacious and comfortable. Each department also had its own waiting and reception areas. There was adequate seating for patients and visitors throughout the departments.
- There were sufficient toilets within the department. Disabled toilets and baby changing facilities were also provided.
- The outpatient, radiology and physiotherapy departments were clearly signposted.
- Free car parking was available at the hospital, which was a short distance from the outpatient department. However, patients told us that it was sometimes difficult to find a parking space.
- T

Access and flow

- Patients had access to care and treatment in a timely way.
- The referral to treatment time (RTT) of patients on incomplete pathways who were seen within 18 weeks was better than the England average. Between July 2015 and June 2016, 99% of patients waited 18 weeks or less to be seen; this exceeded the hospital target of 92%.
- The hospital also exceeded the national target of 95% of non-admitted patients beginning treatment within 18 weeks of referral for each month in the reporting period from July 2015 to June 2016; an average of 99% of patients commenced treatment within 18 weeks of referral.
- Two patients waited more than six weeks for a colonoscopy; one in December 2015 and one in February 2016. No patients waited six weeks or more for all other diagnostic assessments and/or treatments, from April 2015 to March 2016; this included magnetic resonance imaging (MRI) multi-slice computerised tomography (CT), x-ray and non-obstetric ultrasound.
- Patients accessed NHS services via a GP referral through the NHS e-referral system, or via direct referral for private/self-funding patients or via their health care insurer. Patients could rearrange their appointment by contacting the hospital directly or, for NHS patients, via e-referral.
- Staff told us they would inform patients if clinics were running late. Patients we spoke with told us they didn't have to wait long to be seen. One patient said they usually waited five minutes to be seen. Another patient said they didn't have to wait and was actually seen before their scheduled appointment time.
- The hospital did not monitor the number of patients who did not attend their appointment. If an NHS patient did not attend their appointment the hospital would telephone them to establish why they did not attend and would rebook the appointment, if appropriate. If a private patient did not attend their appointment the hospital would telephone them and rebook the appointment, if directed by the consultant. Nursing staff would follow-up any patients who did not attend a clinical treatment appointment.
- The hospital did not monitor the number of clinics that were cancelled. Therefore, we were unable to determine the impact of cancelled clinics on service provision. In the event of a clinic being cancelled at short notice, patients were contacted and rescheduled on the next available clinic. Where notification for cancellation of a clinic was given, such as due to annual leave, patients were sent a letter which detailed the new appointment date and time.

Meeting people's individual needs

- Services were planned to take account of the needs of different people. There was an interpreting service available via a dedicated telephone translation service. However, staff told us they would generally use a relative to act as interpreter. The use of relatives and/or friends is strongly discouraged in national guidance and is not considered best practice (NHS England, Principles for High Quality Interpreting and Translation Services).
- A hearing loop was available within the outpatient and diagnostic imaging service.

Requires improvement

Outpatients and diagnostic imaging

- The outpatient and diagnostic imaging service was accessible to patients living with physical disabilities and wheelchair users.
- Transport to and from the hospital could be arranged for NHS patients with mobility difficulties.
- We saw a wide range of information leaflets for patients in the outpatient department. All leaflets had been produced by Ramsay Health Care UK. However, the leaflets we saw were all in English. We were told that information leaflets could be provided in other languages upon request.
- There were arrangements to ensure self-funding patients were aware of fees payable. We spoke with a member of staff who told us they were available to discuss the cost of care and treatment with patients and ensure they understood all costs quoted. Patients were provided with a written quotation of costs and were given time to consider whether they wished to proceed with the care and/or treatment. Quotations were kept on the system for two years. Lists of fees were openly displayed in consultation and treatment rooms. Leaflets were available which gave an explanation to the pricing structure for self-funding and insured patients and advice for whom to contact if patients had any questions.
- Reading material was available for patients and their relatives in all waiting areas whilst they waited for their appointment. There was also music playing on low volume in the main outpatient waiting area, which was in place to promote a relaxed environment and helped maintain patient confidentiality as it prevented patients being overheard when they booked in at reception.
- Whilst there were no specific chairs in the outpatient waiting area for overweight patients, there were sofas available which could be used by those who found it difficult to fit into a standard chair.
- The radiology department had three changing cubicles, which included a safe where patients could store valuables. Designated male and female changing cubicles were not available. Patients were required to change into a hospital gown for certain diagnostic imaging procedures and were provided with a towelling robe, which they could wear when seated in the waiting area to help maintain their dignity.
- We reviewed the clinic schedule and saw new patients were given a longer appointment time than patients attending follow-up appointments. Appointment times varied, depending on the speciality. For example, neurology and orthopaedic patients were given 40 minute appointment slots for first appointments and 30 minutes for follow-up appointments. This meant new patients had more time to ask questions and for follow-up tests to be arranged.
- Staff we spoke with had awareness of patients with complex needs and those patients who may require additional support. Staff told us that patients with complex needs, learning difficulties and dementia did not attend the hospital very often.
- There were water dispensers in all waiting areas in the outpatient and diagnostic imaging service. Hot drinks and food could be purchased from the hospital restaurant.
- Information was displayed in the radiology department to remind patients of the importance of notifying the radiologist if they were or could be pregnant.

Learning from complaints and concerns

- See Surgery section for main findings.
- The hospital reported a total of 87 complaints for the reporting period from July 2015 and June 2016. The main themes included nursing staff (25%), medical staff (23%) and radiology (17%). Information regarding complaints received solely for the outpatient and diagnostic imaging service was not available. No complaints had been referred to the ombudsman or independent healthcare sector complaints adjudication service (ISCAS).
- Staff told us that, where possible, complaints were resolved locally and at the time of the complaint. The general manager undertook overall responsibility for responding to all written complaints. The hospital aimed to provide written acknowledgement within two working days of receipt of a complaint and provide a full written response within 20 working days when the outcome of the investigation was known. Regular contact would be kept with patients if their complaint took longer than 20 days to conclude. At the time of our inspection, the outpatient and diagnostic service had no outstanding complaints.

Requires improvement

Outpatients and diagnostic imaging

- All formal complaints were reported on the hospital's electronic incident reporting system.
- We reviewed departmental meeting minutes and saw that complaints were a standing agenda item at the radiology department meeting but there was no evidence that complaints were discussed at the outpatient department meeting. Staff we spoke with told us the outpatient manager would discuss complaints with staff when they were received. Complaints were also discussed at the monthly heads of department meetings and were reviewed at clinical governance committee meetings.
- We saw evidence of actions taken in response to complaints received. For example, the radiology department had changed the format of the appointment letter sent to private patients. Additional signage regarding the cost of consultations and treatments had also been introduced throughout the outpatient department. We saw evidence of this during our inspection.
- Leaflets on how to complain were throughout all areas of the outpatient and diagnostic service. Patients were also sent information on the complaints procedure with their appointment letter.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement.

See Surgery section for main findings.

Leadership and culture of service

- The overall lead for the outpatient and diagnostic imaging service was the matron. Outpatients was led by a head of department. The hospital had been unable to recruit a head for the radiology department since May 2015; this was being managed by the head of physiotherapy. The hospital had recruited a senior radiographer to oversee technical requirements.
- The radiology department had a remote radiation protection advisor and radiation protection supervisor who was available to offer support and advice to the team. This ensured staff had access to clinical expertise when required. They also ensured the department met the requirements of IR(ME)R.
- We saw strong leadership, commitment and support from senior managers within the service. Staff told us that leadership was good and felt they could approach managers with concerns. Managers told us they had an 'open door' policy and they encouraged staff to share any issues, concerns or ideas they may have. Staff we spoke with confirmed this. We observed good, positive and friendly interactions between staff and managers. Staff knew the senior management team.
- We noted the concerns we raised about storage of medicine keys and prescription pads in the outpatient department had been addressed promptly when we made our unannounced inspection.
- Staff felt that line managers communicated well with them and kept them informed about the day to day running of the clinical areas and any issues or concerns that had been raised. We observed that senior managers were regularly visible in each department.
- Staff were overwhelmingly positive about their experience of working at the hospital and showed commitment to improving patient care and experience.
- The rate of outpatient nurse turnover was below the average of other independent acute hospitals in the reporting period from July 2015 to June 2016. The low staff turnover (less than 20%) reflected the positive regard in which staff held the service and their colleagues.

Vision and strategy for this core service

- Staff were able to describe the corporate vision and values called the 'Ramsay Way'. A vision for the hospital had recently been developed by senior managers, which was focused on providing exceptional clinical outcomes, outstanding patient experience, developing the team and excellent operational and financial delivery.
- At the time of our inspection the hospital vision had not been formally communicated to staff. Senior managers told us that meetings with staff had been scheduled to launch the new vision and would provide staff with the opportunity to discuss what the new vision means to them and how they can tailor it to their department and

role. We were told that staff objectives would be set in relation to the hospital's vision. The vision was displayed in various areas of the outpatient and diagnostic imaging service.

- The hospital's patient charter stated that care would be delivered to patients in privacy, with compassion, dignity and respect.
- There was no specific strategy for the outpatient and diagnostic imaging department. However, there was a clinical strategy for the hospital which detailed the hospital's priorities for 2016/17. The priorities were determined by the senior management team and heads of each department and took into account patient feedback, audit results, national guidance and recommendations from various hospital committees. The priorities were focused on driving patient safety, clinical effectiveness and improving the experience of all people visiting the hospital. The strategy was shared with staff at team meetings and staff forums. Staff were encouraged to contribute ideas as to how the vision and strategy could be delivered within their service.
- Plans to develop the outpatient and diagnostic imaging service were detailed in the hospital's five year plan and included the expansion of outpatients to accommodate 15 consulting rooms and the purchase of a static magnetic resonance imaging (MRI) scanner. Staff had some knowledge of plans to develop the service.
- Staff were committed to the corporate vision and values and were focused on improving patient care and experience.

Governance, risk management and quality measurement for this core service

- There was a governance framework in place to support the delivery of good quality care.
- Heads of department met monthly and discussed items including significant events and complaints, health and safety, new legislation and corporate policies and audit results. We saw evidence of these in meeting minutes. The heads of department would cascade information to staff at departmental meetings and we saw evidence of this in meeting minutes.
- Clinical governance committee meetings were held every other month. This committee had an overview of governance risk and quality issues for all departments. Heads of department and the senior management team attended. Topics discussed included incidents, complaints, audits and infection control issues.
- The outpatient department had its own risk register, which had listed six risks at the time of our inspection. One risk concerned the refurbishment of the dirty utility room and had been categorised as an infection control risk. One risk was the inability to recruit registered nursing staff and had been categorised as a leadership and management risk. The remaining four risks concerned the failure of three items of equipment and the inaccuracy in procedure charging, which may lead to loss of revenue; these were all categorised as financial risks. However, the risk register did not include any details of what actions had been taken to mitigate risks and what assurances the hospital had in place. According to meeting minutes, the risk register was discussed monthly at the heads of department meeting. However, the minutes lacked any detail regarding actions the hospital had taken to address these risks. Furthermore, the outpatient risk register did not align with the hospital risk register. For example, the hospital risk register did not include all the risks identified on the outpatient risk register, such as equipment failure and the refurbishment of the dirty utility and the inaccuracy of clinical coding was categorised as a communication and information risk, not financial. Therefore, we were not assured the hospital had full oversight of risks and that actions had been taken to mitigate these risks.
- The hospital did not monitor the number of patients who did not attend (DNA) clinic appointments, or the number of cancelled clinics. This meant we were not assured that senior managers had oversight of DNA rates and clinic cancellations and may have missed potential issues and opportunities to improve service provision and ensure DNA's and cancellations were kept to a minimum.
- Mandatory, safeguarding, basic life support and intermediate life support training did not meet the hospital target of 100% compliance. We saw evidence that training compliance was discussed at department meetings. However, based on compliance figures provided, we were not assured effective action was taken to address non-completion of training with staff.

Requires improvement

Outpatients and diagnostic imaging

- The outpatient and diagnostic imaging department took part in regular audits, which included consent, medical records, hand hygiene and radiology referral forms. We saw evidence that actions were taken in response to audit results.
- The radiology department completed regular audits, in line with the ionising radiation (medical exposure) regulations (IR(ME)R.
- Staff we spoke with in radiology were aware of risks within the department, such as the failure of the patient archive communication system (PACS). We saw evidence that the senior management team had oversight of this risk and actions had been taken to mitigate risks. PACS was scheduled for an upgrade in March 2017. This risk was detailed on the corporate risk register.

Public and staff engagement

- Patient views and experiences were gathered and acted on to shape and improve services. Patient feedback was obtained through the NHS friends and family test questionnaires and 'we value your feedback' forms. Patient feedback forms were displayed in all areas of the outpatient and diagnostic service, which encouraged patient's to leave feedback. We also saw; 'We value your opinion' questionnaires throughout outpatient departments, which encouraged patient's to rate the hospital on care, cleanliness, staff, accommodation and food. Patients were also invited to leave comments about what the hospital did well and what they could improve on. Complaints and patient feedback were discussed at heads of department, clinical governance committee and departmental meetings. We saw evidence of actions taken in response to patient feedback.
- The hospital had a social media account, which was reviewed regularly for feedback.
- Patients and relatives we spoke with were overwhelmingly positive about the service and care they received.
- The results of patient feedback were displayed in public areas throughout the department.
- The hospital participated in the patient-led assessment of the care environment (PLACE) audit. The PLACE audit involves local people in the assessment of how the hospital environment supports the provision of clinical care, such as privacy, dignity, food and cleanliness. The hospital scored lower than the England average in some areas, such as condition, appearance and maintenance of premises and privacy, dignity and respect. We requested details of actions taken in response to findings from the PLACE audit but the hospital did not provide us with this evidence. Therefore, we were unable to determine whether the hospital had taken any action to improve on feedback received.
- Outpatient and diagnostic imaging services held regular team meetings, which all staff were invited to attend. Staff felt engaged and were encouraged to share ideas of how to improve services.
- Staff spoke highly of the opportunities for training and development offered by the hospital.
- Throughout the inspection staff were welcoming and willing to speak with us. All staff we spoke to were proud of the department and the hospital.
- The hospital provided us with some results from the staff survey carried out in 2016. The staff survey results for 2016 showed 95-97% of staff agreed that:
  - they knew how to deal with safety issues
  - procedures followed in the workplace enabled them to complete their work effectively
  - they understood what was expected of them in their role
  - they always worked for the best interests of patients and colleagues
  - they understood the impact their work had on delivering excellent patient care.
- The hospital was not able to provide us with the complete staff survey results. Therefore, we were unable to determine whether any negative feedback had been received and what actions had been taken as a result of any negative feedback. We were told that actions taken as a result of the staff survey included 'meet and greets' with the general manager and chief executive office and planning schedule of events for 2017.
- The hospital held quarterly staff forums. Staff told us these kept them well informed of changes and news across the hospital.

Requires improvement

Outpatients and diagnostic imaging

Innovation, improvement and sustainability

- The hospital was committed to developing the outpatient and diagnostic imaging service. We saw evidence that the hospital planned to expand the outpatient department and purchase a static MRI, in order to meet increasing patient demand.
- The outpatient department was proactive in developing staff. An apprenticeship scheme was available, which could lead to qualification as a registered nurse.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- Review the arrangements for the security of children and young people whilst they are day or in patients on the ward so that their safety can be assured at all times.
  - Review the arrangements for staffing of the ward and in recovery when there are children and young people present. There must always be a registered nurse (child branch) present to care for children.
  - Review clinical policies, with regards to children and young people so that they reference the most up to date national guidance available.
  - There was no audit schedule for children and young people to assess patient outcomes. Put in place an audit programme for the children and young people's service, so that continuous improvement can be assured.
  - Recognise and review the risks associated with caring for children and young people and consider including them on the hospital wide risk register.
  - Review training compliance processes and ensure all staff have received their required mandatory, safeguarding and annual resuscitation training.

Action the provider SHOULD take to improve

- All areas of the hospital and equipment should be clean and free from dust
  - Staff should be accessing and using the most up to date policies in line with national guidance
  - Medicines and prescription pads should only be accessible by authorised members of staff.
  - All risks within the outpatient department are mitigated and reviewed regularly.
  - Compliance for staff appraisals on the ward was low; however, staff had been booked for their appraisals at the time of inspection.
  - Consider the need for improved availability of paediatric resuscitation equipment in outpatients.
  - Children and young people's preoperative medical questionnaires and co-morbidity checklists should be reviewed by a registered nurse (child branch).
  - All records should be fully completed.
  - Fluid balance charts should be completed appropriately.

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 15 HSCA (RA) Regulations 2014 Premises and equipment **Regulation 15 (1) (b) Premises and equipment which states:** **All premises and equipment used by the service provider must be:** **(b) secure** How the regulation was not being met: • Children and young people were admitted to rooms on one side of the second floor ward at the hospital. Adult surgical patients were admitted to the other side of the second floor ward. There was no division between the two sections and no security measures in place to ensure that adults could not access children on the ward. There was no monitoring of this area to ensure unauthorised personnel could not gain access to children.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(1) (2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good governance, which states: The provider did not operate effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users.** How the regulation was not being met: • Risks were not always identified, monitored and mitigated, in children's services

This section is primarily information for the provider

Requirement notices

- Not all clinical policies referenced the most up to date national guidance available.
- There was no audit schedule for children and young people to assess patient outcomes.
- Risks we identified on inspection with regards to the care of children and young people had not been recognised. The hospital wide risk register did not have any paediatric risks listed.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18.—(1) Staffing, which states: Sufficient numbers of suitably qualified, competent, skilled and experienced persons** **must be deployed in order to meet the requirements of this part.** **(2) Persons employed by the service provider in the provision of a regulated activity must—** **(a) receive such appropriate support, training, professional development, supervision and** **appraisal as is necessary to enable them to carry out the duties they are employed to perform.** How the regulation was not being met: • There were insufficient staff with the right skills and qualifications to care for children and young people. There was sometimes only one registered nurse (child branch) to care for in patients. This meant that patients were temporarily left in the care of member of staff who was not suitably qualified. • Not all staff who were caring for children and young people were trained to the right level in safeguarding. This did not meet the Royal College of Paediatrics and Child Health (RCPCH) guidelines or those contained in the Intercollegiate Document (March 2014) which

This section is primarily information for the provider

Requirement notices

states that clinicians who are potentially responsible for assessing, planning, intervening and evaluating children's care, should be trained to level 3 safeguarding.

- Not all staff in outpatients and diagnostic imaging were compliant with mandatory, safeguarding and annual resuscitation training, as required by hospital policy.