Park Hill Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Park Hill hospital is part of the Ramsay Healthcare Group and is registered as a provider under the name Independent British Healthcare Limited. Facilities at the hospital included 21 beds, made up of 17 single rooms and one four bedded room; all rooms had en-suite facilities. There were also six outpatient consulting rooms, a treatment room, and dedicated use of a fully-equipped laminar flow theatre on the site of the adjoining NHS hospital trust.

We inspected the hospital as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine planned inspection. We inspected the following two core services at the hospital: surgery, and outpatients and diagnostic imaging. We carried out the announced part of the inspection on 3 and 4 August 2016. We also carried out an unannounced visit on 12 August 2016.

We rated the hospital as requires improvement overall. Surgery was rated as requires improvement and outpatient and diagnostic imaging was rated as requires improvement. For the hospital overall we rated the key questions as follows:

Are services safe at this hospital

We rated the safe key question as requires improvement overall. An electronic risk reporting system was in place. However, there was some confusion amongst staff of what constituted an incident and a lack of confidence in reporting this on the hospital's electronic system. We saw limited examples of learning from incidents being shared with staff or being used to drive improvements. There had been one never event in in the past 12 months. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The never event involved surgical placement of the wrong implant or prosthesis. There had been a full investigation into the cause of this incident and learning had been identified. Other serious incident investigations reports we reviewed were not robust and did not identify appropriate learning in order to drive improvements. There was a broad understanding of the duty of candour. 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. There was a strong culture of being open and honest with patients. However, there was no formal training or system in place to ensure the duty of candour was consistently applied at the time of inspection.

Medications were stored appropriately and we saw that these were dispensed correctly in the majority of cases. However, there had been no quality assurance or stock check of controlled drugs undertaken by a pharmacist for over six months. The management of medication prescription pads was not in line with national guidance and we saw that intravenous fluids had not been correctly prescribed on the medication charts we reviewed. The hospital was visibly clean and infection rates were in line with other providers. Equipment was appropriately used and maintained. The resident medical officer (RMO) was based in the hospital and provided medical cover 24 hours a day. We reviewed RMO cover and found it was sufficient. Staffing levels and projected occupancy ratios were reviewed regularly and staffing was planned based on the expected activity levels of the service. Mandatory training figures were low. Staff received mandatory training in the safeguarding of vulnerable adults and children and the nursing and medical staff we spoke to were generally aware of their safeguarding responsibilities and of appropriate safeguarding pathways to use to protect vulnerable adults and children. The matron was the named safeguarding lead for the hospital. However, we saw no evidence that they had level four safeguarding training as required by the Intercollegiate Document on Safeguarding Children and Young People (2014). The hospital told us that they were able to seek assistance from a level four trained link nurse within the wider Ramsay group. There was varying compliance with safeguarding training from staff and we were not assured that staff had received the appropriate level of safeguarding training for their role. The records we

reviewed were of an appropriate standard and we saw that appropriate risk assessments took place in the majority of the records we reviewed. There was a deteriorating patient pathway and a clinical escalation policy in place. There was a formal arrangement for patients to be transferred to the local NHS hospital if their clinical condition could not be safely managed at the hospital and the resuscitation team from the local NHS hospital would attend emergencies.

Are services effective at this hospital

We rated the effective key question as requires improvement overall. We saw that very few staff had undergone an appraisal within the past two years. The senior team were aware of this issue and had begun to put plans in place to ensure that appraisals were taking place. There was a lack of training and awareness around mental capacity and deprivation of liberty safeguards. The hospital had an annual audit schedule, but this had not been consistently monitored or actions identified to address non-compliance. The hospital also contributed to a small number of national audits, but did not benchmark its performance nationally outside of the Ramsay group. Staff were aware of how to access hospital policies and guidance, and we saw that these were in line with evidence based practise and were prepared nationally by the Ramsay group. All clinical and nursing staff had undergone checks on their professional registrations. Consultants were granted practising privileges to work at the hospital. Practising privileges are when authority is granted to a doctor or dentist to provide patient care in the hospital by a hospital's governing board. We saw that effective multidisciplinary team working took place between staff at the hospital and also with the local trust. There had been five unplanned transfers of patients in the period April 2015 to March 2016; this was lower than the average for independent hospitals. There had also been five unplanned returns to the operating theatre in the period April 2015 to March 2016. Senior managers were aware of this and had undertaken a review of the reasons for these patients returning for further surgery.

Are services caring at this hospital

We rated the caring key question as good overall. Patients were cared for compassionately and with dignity and respect. Patients spoke positively about care and treatment and felt involved in the planning of their care. Staff gave examples of providing emotional care to patients and we saw staff being flexible around visiting hours for patients who needed this. We observed positive interaction between staff and patients. The hospital had a high score (100%) in the Friends and Family Test but response rates were low (between 40% and 5%). The hospital's internal patient surveys showed generally high (99%) levels of patient satisfaction.

Are services responsive at this hospital

We rated the responsive key question as requires improvement overall. Services were planned to meet the needs of local people and individual patients. Delays and cancellations to appointments and planned surgery were low and referral to treatment times data showed that the hospital had routinely exceeded the indicators. However, the reasons for cancellations were not formally analysed. There was also an inconsistent system for booking patients for surgery that resulted in peaks and troughs in activity that staff told us were difficult to handle. We also saw that routine calls to patients prior to surgery did not always take place. This meant that some patients were unprepared and that planned surgery was cancelled as a result. There was a lack of formal feedback or evidence of improvements being made as a result of complaints received by the hospital. The arrangements and systems in place to respond to the specific needs of individuals (for example, translators or chaperones) were not systematic. This meant that there was a risk that patients with specific needs would not have these met by the hospital.

Are services well led at this hospital

We rated the well led key question as requires improvement overall. The hospital manager and matron had only been in post for 8-12 weeks at the time of our inspection. This meant that they had not yet had time to fully assess or address any issues they had identified. However, the senior team was proactive in identifying areas for improvement and told us about a range of actions that they planned to take place. There was a regional strategy in place and staff were aware of this. However, senior staff had not yet had time to finalise a local strategy for the hospital. The hospital had a

governance structure in place. Although departmental meetings had not always taken place, these were planned to occur more frequently going forward. Heads of Department meetings also took place and fed into the Medical Advisory Committee (MAC). We saw limited evidence that these meetings involved discussion around the quality and outcomes associated with patient care. We also noted that the corporate risk register had been updated in July 2016, but did not highlight mitigating actions being taken to address the risks it identified. Risk management processes were not robust and there was no assurance that lessons learnt from incidents and complaints was cascaded to staff or used to drive improvement. There was a policy in place for the MAC to determine whether a doctor was suitable to practice and we saw that systems were in place for revalidation of medical staffing and for the effective management of doctors' practising privileges. The hospital had not yet completed the Workforce Race Equality Standard (WRES) data submission and did not have a local action plan in place to address this. Staff spoke positively about the new senior leadership team and felt confident in their ability to make changes and improve working practices. Staff described that they had begun to be engaged about changes within the hospital and felt that this would continue to improve as the senior team further embedded into the hospital.

There were areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure that incident reporting processes are robust so that incidents are appropriately identified and reported, comprehensively investigated and lessons learned are identified and shared with all staff.
- Ensure that all staff have had a meaningful and consistent appraisal and are completed within the timescales determined by the hospital policy.
- Ensure staff competencies are completed in accordance with the hospital policy and professional standards.
- Ensure that mandatory training is completed in accordance with the hospital policy.
- Ensure that staff receive appropriate levels of safeguarding training for their job roles.
- Ensure that infection prevention and control measures are in place.
- Ensure that staff have access to the appropriate manual handling equipment and are properly trained in its use.
- Ensure that patient care is personalised, takes into account individual needs and the assessment of these needs and the care required to meet these needs is recorded.
- Ensure that the Duty of Candour requirements are embedded in policy and practice.
- Ensure that there are in operation effective governance, reporting and assurance mechanisms that provide timely information so that performance and outcomes are monitored effectively and in line with hospital policy and risks can be identified, assessed and managed.
- Ensure that there are alert systems in place to identify when actions are not effective and need to be reviewed, particularly in relation to incidents.

In addition the provider should:

- Ensure that information is available to patients on how to make a complaint and the complaints process and establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons
- Provide a system to track the use of prescription pads within the outpatient department and to ensure medication administration and storage compliance has been met.
- Improve the booking arrangements for patients to ensure a more consistent flow of patients attending for surgery.
- Ensure that an appropriate risk register is in place which fully reflects the risks, mitigating actions identified by the hospital, and timescale in which a review of the risk will take place.
- Implement the Workforce Race Equality Standard (WRES).
- Ensure emergency call requests including the use of the crash team have been tested to ensure response times are appropriate and safe.
- Consider the implementation of a system to record data regarding patients who fail to attend appointments.

Summary of findings

- Provide staff with the information and training in support of an advocacy service for all patients, should they require one.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	We rated this service as requires improvement because: We found that staff were aware of their roles and responsibilities for maintaining safe management of patients attending the service, but that there was a lack of documentation to support this. Staff reported effective multidisciplinary team working, with common goals for the provision of high quality patient care and demonstrated motivation to achieve this. There was an incident reporting system, but there was a lack of understanding amongst staff regarding the definition of an incident and when this should be reported. Patient records were accessible for all attendees. Information was shared with patient's GPs to enable continuity of care. Service level agreements were in place for the provision of support services and emergency transfers. However, there were some problems with the provision of radiological imaging in theatre. There were infection prevention and control policies in place and most areas were visibly clean and well maintained. The environment made implementation of some infection prevention and control principles difficult. The service had an audit schedule in place, but this had not always been followed. Staff were provided with a robust induction programme, but subsequent mandatory training figures were low. There was no action plan in place to improve this. Staff on the ward and in theatre had not all received an appraisal in the previous year and only a small number had received an appraisal since April 2016. There were some plans to improve this. Governance systems were not robust and the risk register did not reflect all the risks. There was a lack of monitoring of compliance against current policies and learning from incidents and complaints. Information relating to this was not

Summary of findings

shared consistently with all staff in the hospital and we did not see examples of discussions around incidents and complaints taking place at governance meetings.
Management of complaints about the service from patients was not robust and there was little evidence of learning from complaints.
The annual audit schedule was up to date but there was limited evidence that improvements required were being implemented.
The hospital strategy and vision was in development at the time of inspection. The new management team were aware of the main issues within the service and were working towards developing and implementing plans for improvement.
Patients were positive about the care they received. Friends and family surveys showed high levels of satisfaction with services experienced by patients.
The service consistently achieved 100% referral to treatment time targets.

Outpatients and diagnostic imaging

Requires improvement

We rated this service as requires improvement because:
Staff were aware of their roles and responsibilities for maintaining safe management of patients attending the service. Staff also reported effective multidisciplinary team working, with common goals for the provision of high quality patient care.
However, there was some confusion amongst staff around the definition of an incident and when this should be reported. Learning from these incidents was not cascaded formally to staff and we did not see evidence of regular discussion of incidents within governance meetings.
Service level agreements were in place for the provision of support services and emergency transfers. However, the agreement for the provision of pathology services was due to be reviewed. An email had been sent by the matron to instigate this, at the time of our inspection.
There were infection control policies in place and all areas were visibly clean and well maintained.
We saw the hospital had an audit calendar in place.

Summary of findings

The outpatients department flexed working hours to meet the demands of the service, with an on call system to support this. Patient records were accessible for all appointments and were found to be thorough, and of a high standard. Information was shared with GPs to enable continuity of care.
Staff were provided with a robust induction program, but subsequent mandatory training figures were low. There was no action plan in place to improve this. Staff within the outpatients department had not received an appraisal in the previous and current appraisal year.
The management of medication prescription pads was not in line with national guidance, with no daily checks of stock levels, or audits.
The hospital strategy and vision was in development at the time of inspection.
Governance systems were not robust and were not monitoring compliance against policies or learning from incidents and complaints. Information relating to this was not shared consistently with all staff in the hospital.
The service consistently achieved referral to treatment time targets. Staff were positive about the teams they worked within and proud of the care they provided. Staff within each clinical area reported strong local leadership.

Summary of findings

Contents

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Park Hill Hospital

Services we looked at
Surgery; Outpatients and diagnostic imaging

Summary of this inspection

Background to Park Hill Hospital

Park Hill hospital is part of the Ramsay Healthcare Group and is registered as a provider under the name Independent British Healthcare Limited. Facilities at the hospital included 21 beds, made up of 17 single rooms and one four bedded room; all rooms had en-suite facilities. There were six outpatient consulting rooms, a treatment room, and dedicated use of a fully-equipped laminar flow theatre on the site of the adjoining NHS hospital trust. Park Hill hospital became operational in 1995 and signed a 25-year lease agreement with the trust. Diagnostic imaging services were provided under contract from the local NHS trust and was not inspected.

The hospital had been inspected by the CQC five times since initial registration with the CQC. The most recent inspection took place in December 2013 and the hospital was found to be meeting all the standards of quality and safety it was inspected against.

This inspection was conducted as part of our independent hospital inspection programme. The inspection was conducted using the CQC's comprehensive inspection methodology. It was a routine, planned inspection. The inspection team inspected two core services provided at Park Hill hospital:

- Surgery
- Outpatients and diagnostic imaging

At the time of our announced inspection, an application was outstanding with the CQC for the registered manager to be changed to a person who also managed another Ramsey Healthcare hospital. When we returned for our unannounced inspection this application had been confirmed.

Our inspection team

Our inspection team was led by:

Inspection Lead: Berry Rose, Inspection Manager, Care Quality Commission

The team included CQC inspectors and specialists including a consultant surgeon and an outpatient department manager.

How we carried out this inspection

We carried out the announced part of the inspection on 3 and 4 August 2016. We also carried out an unannounced visit on 12 August 2016. We talked with patients and members of staff, including managers, nursing staff (qualified and unqualified), medical staff, allied healthcare professionals, support staff and managers. We observed how patients were being cared for and reviewed patients' clinical records.

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

Information about Park Hill Hospital

Facts and data about Park Hill Hospital

Activity (April 2015 to March 2016)

- 1,149 overnight inpatients
- 1,853 day case inpatients
- 13,205 outpatient appointments (including follow-up appointments)

Summary of this inspection

- The most commonly performed surgeries were total knee replacements (345 procedures), laparoscopic cholecystectomy (273 procedures), and total hip replacements (219 procedures).
- There was a high percentage of NHS patients seen at the hospital for surgery, with 75% of overnight inpatients and 71% of day case inpatients being NHS funded. For outpatient appointments, this percentage dropped to 45% of patients being NHS funded.
- Historically, children between the ages 3-18 were accepted for outpatient consultation at the hospital. The Ramsay Healthcare policy on this was reviewed in May 2016 and it was agreed that Park Hill would withdraw this service. This was communicated to consultants in June 2016 and no children or young people were seen on site at the time of our inspection.

Core services offered

- Surgical care
- Outpatient consultation.

Staffing (headcount and full time equivalents)

- 109 doctors and dentists working under practising privileges
- 13 nurses:
- Inpatient departments 3.6
- Theatre departments 6.6
- Outpatient departments 2.8
- 11.8 care assistants:
- Inpatient departments 4.6
- Theatre departments (including operating department practitioners) 6.2
- Outpatient departments 1

At the time of the inspection an application to make Mrs Deborah Craven the registered manager was being processed by the CQC. Mrs Craven was a registered manager at another Ramsey Healthcare hospital and was confirmed as registered manager of Park Hill subsequent to our announced visit. Mrs Victoria Lancashire, Matron, was the controlled drugs accountable officer.

Outsourced services

- Pharmacy
- Pathology
- Medical Imaging
- Resuscitation
- Endoscopy
- Critical care
- Maintenance (PPM)

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	N/A	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Requires improvement

Surgery

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

Information about the service

Park Hill hospital is a purpose built unit, based in South Yorkshire and located in the grounds of a local NHS Hospital. The unit became operational in 1995. Park Hill hospital is part of the Ramsay Healthcare Group and is registered as a provider under the name Independent British Healthcare Limited.

The hospital provides out patients services, day surgery and inpatient treatment for NHS, self-paying and insured patients across a range of specialities including orthopaedics, gynaecology, upper gastrointestinal, urology and cosmetic surgery. The hospital is connected to the orthopaedic theatre suite of this NHS trust hospital and has use of one laminar airflow theatre in this suite.

There are 17 single rooms with en-suite and a four-bedded bay on one ward on the first floor of Park Hill Hospital.

Between April 2015 and March 2016 there were 3,002 admissions. Out of these 1,853 (62%) were day cases. Nearly 50% of the surgical procedures (1,401) were elective orthopaedics with 564 cases being total hip or total knee joint replacements. The hospital treated a higher than average number of NHS patients (73%) during this period when compared with other independent hospitals.

Surgery is only provided to patients aged 18 and over. The service had not had children as patients for a number of months and there were no plans to treat children in the future. Eighty eight per cent of the patients (2,643) were under the age of 75 years.

As part of our inspection, we visited the ward and the theatre suite. We spoke to 17 staff of different grades, from kitchen staff to consultants and the senior management team. We observed care and treatment and spoke with five patients using the service and two relatives. We also looked at seven medical and nursing records, three medication administration charts as well as performance information supplied to us by Park Hill hospital.

Requires improvement

Surgery

Summary of findings

Overall, we rated the service as requires improvement.

We found that staff were aware of their roles and responsibilities for maintaining safe management of patients attending the service, but there was a lack of documentation to support this.

There was an incident reporting system, but there was a lack of understanding amongst staff regarding the definition of an incident and when this should be reported.

Service level agreements were in place for the provision of support services and emergency transfers. However, there were some problems with the provision of radiological imaging in theatre.

There were infection prevention and control policies to guide staff, and most areas were visibly clean and well maintained. The environment made implementation of some infection prevention and control principles difficult.

Staff were provided with a robust induction programme, but subsequent mandatory training figures were low. There was no action plan in place to improve this.

Staff on the ward and in theatre had not all received an appraisal in the previous year and only a small number had received and appraisal since April 2016. There were some plans to improve this.

Governance systems were not robust and the risk register did not reflect all the risks. There was a lack of monitoring compliance against current policies and learning from incidents and complaints. Information relating to this was not shared consistently with all staff in the hospital and we did not see examples of discussions around incidents and complaints taking place at governance meetings.

Management of complaints about the service from patients was not robust and there was little evidence of learning from complaints.

The hospital strategy and vision was in development at the time of inspection. The new management team were aware of the issues within the service and were working towards developing and implementing plans for improvement.

However:

Staff reported effective multidisciplinary team working, with common goals for the provision of high quality patient care and demonstrated motivation to achieve this.

Patient records were accessible for all attendees. Information was shared with patient's GPs to enable continuity of care.

Patients were positive about the care they received. Friends and family surveys showed high levels of satisfaction with services experienced by patients.

The service consistently achieved 100% referral to treatment time targets.

Requires improvement

Surgery

Are surgery services safe?

Requires improvement

We have rated safe as requires improvement because:

- Staff did not receive formal feedback when incidents were reported. There were limited examples of lessons learned from incidents and a lack of assurance that the required changes had been made following incidents.
- Staff were aware of the procedures for reporting incidents but there was a lack of understanding amongst staff regarding the definition of an incident and when this should be reported.
- There were issues with the environment in theatre and on the ward that made infection prevention and control principles difficult to implement.
- Mandatory training figures were low in every area. We saw no action plan to improve this.
- The service had not performed medication stock level control audits or checked the controlled drugs record book for over six months.
- There was insufficient equipment present on the ward for patient handling. In particular there was no patient handling hoist and no bariatric equipment.
- The implementation of the duty of candour requirements was not robust.
- Patients did not have clear communication if they required assistance or advice after they had been discharged from the ward.

However:

- There had been a change in practice following learning from a never event.
- Most areas were visibly clean.
- Staffing levels had been maintained at a safe level with low sickness rates and low agency staff usage.
- Staff used appropriate protective equipment and took appropriate precautions for infection prevention and control.
- All equipment was maintained annually by either manufacturers or the estates department within the hospital group.

Incidents

- There had been one never event in the service in the past 12 months. 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.
- The never event involved surgical placement of the wrong implant or prosthesis. There had been a full investigation into the cause of this incident and learning had been identified. We spoke to staff about the incident and they explained how systems had changed to prevent this happening again. A different method of ordering had been initiated to prevent any potential confusion between implants. There were also additional checks in the checking process in theatre.
- There had been one unexpected death during the 12 months prior to our inspection. This had been investigated and was not related to the surgical procedure or the treatment received in the service.
- There had also been two serious incidents reported in the 12 months prior to our inspection, one was an injury to a patient's bowel during surgery and the other was related to a missing controlled drug tablet.
- We reviewed three root cause analysis (RCA) investigations and reports for the never event and the two serious incidents. The RCA for the never event was comprehensive, but the action plan lacked any follow up audit process for checking the actions required had taken place and were embedded in practice. An audit was required to ensure this had happened. The RCAs for the two serious incidents were much less robust, as different members of staff had undertaken these. There had been no changes to the way controlled drugs were checked and stored as suggested in the RCA recommendations.
- An incident involving handling and storage of blood products was reported and had been investigated. We were told that the administration of blood products did not occur often at this hospital. There was a policy and procedure for this. The incident had occurred as a result of a staff member not being aware of the policy and procedure. However, additional training was subsequently provided.
- Incidents were reported on the provider's electronic reporting system. The rate of incident reporting in this

hospital was lower than other independent hospitals per 100 patients. The low level of reporting increased the percentage of severe harm or death to 2%, which is higher than other independent hospitals.

- There had been 58 incidents involving the inpatient ward and theatres between April 2015 and March 2016. Patient falls were the main cause for incident reporting with 10 falls reported. We did not see any plans to reduce the number of falls occurring on the ward. The next most common cause for reporting was post-operative complications (9) including extended length of stay.
- Staff told us that some staff had received formal training on the use of the electronic incident reporting system. Staff we spoke with were not all confident in doing this, as they had not been trained. Some staff had not had experience of using the system. However, they did say they would report to the person in charge if an incident had occurred and expect that person to enter it on the electronic reporting system. Senior managers were aware of this but we did not see an action plan to improve this.
- Some occurrences were not reported as incidents, for example staff would not report staffing shortages as an incident. However when patients needed to overstay their expected discharge date an incident report was completed.
- We found on a review of complaints received by the hospital that a patient had complained about developing pressure damage to their heel whilst on the ward. This had not been reported as an incident.
- Staff told us they did not always hear about incidents that had occurred in the hospital. They said if there was a change in procedures or practice a document would be sent around for staff to read and sign to say they had read it. We saw an example of this in theatre relating to the never event. Staff did not always see any formal minutes of heads of department meetings where they thought incidents might be discussed.
- Senior managers were aware of the level of incident reporting and the standard of the RCAs. They were developing an action plan for improvement.

Duty of Candour

- 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. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- We saw that complaint response letters to patients offered an apology and explanation when things had gone wrong. However, we were not assured that a robust system was in place to implement the requirements of the duty of candour as indicated in the provider 'Being Open' policy.
- Staff we spoke with were broadly aware of the principles behind the duty of candour and could describe the principles of being open and honest with patients. However none of the staff we spoke with at the hospital had received formal training on the duty of candour requirements. The provider complaints policy did not mention duty of candour requirements.
- There was a notice on the staff noticeboard about the duty of candour. Staff told us there was a culture of being open and honest with patients.

Safety thermometer or equivalent (how does the service monitor safety and use results)

- The hospital collected data on safety thermometer indicators. The NHS Safety thermometer is a nationally developed improvement tool for measuring, monitoring and analysing patient harms and harm free care. It examines risks such as falls, pressure ulcers, blood clots (venous thromboembolism or VTE) and urinary tract infections with catheters.
- There was no safety thermometer information on display for patients and visitors to see. However the information supplied by the hospital shows that there had been 100% harm free care on the ward on 13 July 2016.
- VTE risk assessments were audited and information supplied to us showed the screening rates were above 95% between April 2015 and March 2016. Records we reviewed showed VTE risk assessments had been completed. However, there had been two instances of hospital acquired VTE in the period April 2015 to March 2016. Investigations into the cause of these VTEs had been carried out and lessons to be learned had been identified.

Requires improvement

Surgery

Cleanliness, infection control and hygiene

- The ward environment was clean and tidy. However there was no labelling system used to advise staff that bed spaces and equipment was clean and ready to use. Staff used the whiteboard in the office to indicate if a bed space required cleaning.
- In April 2013, Patient Led Assessment of the Care Environment (PLACE) was introduced. This assesses the quality of the patient environment. The assessments are undertaken by local people and look at how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The PLACE survey score for cleanliness was 98.8% in 2016, which was the same as the England average for independent hospitals.
- Ward cleaning staff had a schedule to follow in relation to cleaning. All cleaning products were kept locked away in the cleaner's cupboard.
- Cleaning staffs' schedules also included the requirements for the control of waterborne bacteria. We saw a recording sheet that indicated the required level of flushing to minimise the risk of waterborne bacteria was incomplete, showing only the rooms with patients in were being flushed daily. This was not in line with the service policy. The senior manager was made aware of this at the time of the inspection.
- Cleaning and environment audits were not conducted regularly so there was no assurance that the correct cleaning procedures were being followed.
- Carpet lined the main corridor areas on the ward and was also in eight bedrooms. Carpet is difficult to clean and is not best practice to maintain infection prevention and control principles. Since the inspection, the hospital has confirmed that the use of carpets has been reviewed corporately. The outcome of this review is that replacing carpets with solid flooring will be considered in the local refurbishment programmes.
- There were no non-touch tap hand washbasins for staff to use in any of the single rooms on the ward or in the four-bedded bay. There were also no hand washbasins in the corridors. However hand washbasins were available in the ensuite bathrooms but these did not have taps that allowed a non-touch operation. Hand washbasins in some of the clinical areas such as the medicines' room also did not have non-touch taps.
- Cleansing hand gel was available at numerous points around the ward, in clinical rooms, in each of the single rooms and in the four-bedded bay.
- We asked staff about the procedure for contaminated waste being removed from rooms and were told this was done by taking the appropriate bag to the room. Items to be disposed of would be double bagged and then taken to the dirty utility room. We did not observe any procedures being undertaken at the time of our inspection.
- The disposable curtains in the four-bedded bay had not been changed since 26 August 2015. The curtains appeared clean but there was no system in place to ensure that curtains were changed regularly. There was no policy or procedure in the hospital's standard infection control precautions relating to curtain changing. The recommendation from the CQC national infection prevention and control (IPC) advisor was to change curtains at least once every six months.
- Visitors were encouraged by written signage to use hand cleansing gel prior to entering the ward and also in each of the rooms.
- The lead nurse for infection prevention and control for the hospital had been absent from work for a prolonged period. The new matron was taking on this role in the interim.
- IPC environmental audits were due every three months. An audit had taken place in February 2016. There were identified actions required but no date for completion on the audit record. A further audit had taken place in July 2016 with 84% compliance. Actions were identified but no date for completion was given.
- Hand hygiene audits were due every six months. This had taken place in April 2016 and the result was 100% compliance.
- Peripheral venous cannula audits were due every six months. These had taken place in September 2015 when compliance was 100% and in July 2016, when compliance was 93%.
- Infection prevention and control audit results were presented to the clinical governance meetings and the Heads of Department meetings.
- The theatre environment was cluttered in places, such as the corridor and the preparation room adjacent to the theatre. Some of this area was not the responsibility of this service but there were cardboard boxes on the

theatre corridor that would prevent the proper cleaning of that area and allow the accumulation of dust. The theatre manager was aware of the problem but this had not been addressed with the local trust.

- The hospital had identified there was an issue with the storage of formalin in a locked cabinet in a 'dirty' area of the theatre and were then taken to a 'clean' area to be used. Lack of space had prevented any relocation of the formalin pots.
- Deep cleaning in theatres was undertaken by the local trust on a rolling programme. Communication with the theatre manager took place and the details of this were sent to the senior management team.
- The service reported no cases of Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile (C.diff.) or Methicillin Sensitive Staphylococcus Aureus (MSSA) infections in the period April 2015 to March 2016.
- Screening for MRSA was undertaken as part of the preoperative assessment process but this was not audited.
- Surgical site infections (SSI) data supplied by the service was reviewed. There had been seven SSI in the period April 2015 to March 2016. Two for knee replacements, two in other orthopaedic surgery, one for spinal treatment, one for breast surgery and one for gynaecological surgery. This was similar to the average in independent hospitals.
- The matron investigated SSI. One infection had resulted in a patient returning to theatre and the others were treated with oral antibiotics. We reviewed the matron's investigations and found there were no patterns to the infections.
- There was personal protective equipment (PPE) for staff to use such as gloves and aprons in dispensers around the ward. We saw staff wearing aprons for serving meals.
- One member of clinical staff on the ward was noted not to be bare below the elbow with a wristwatch and rings being worn.
- Mandatory training for infection prevention and control was undertaken by all staff annually using an e-learning package. Additional training was given face to face regarding the use of PPE. Compliance with this mandatory e-learning training was 89%. The provider and the hospital had not set a target for compliance.
- Cleaning schedules had recently been implemented in the anaesthetic room by the staff at Park Hill hospital. This did not include flushing of taps to minimise the risk of waterborne infections. The theatre manager was made aware of this at the time of our inspection and this was to be added to the schedule.

Environment and equipment

- The PLACE survey score for condition and appearance in 2016 was 95%, which is higher than the England average for independent hospitals.
- Twice daily patient food storage fridge and freezer temperature checks took place where the minimum and maximum temperature were recorded. When we reviewed the records for these for the four weeks prior to our inspection we found temperatures were within range. However, there were three gaps in recordings in the afternoons during a week in July 2016. Staff knew what to do if the temperature was out of range.
- There was no patient hoist on the ward. Staff told us that if a patient fell nursing staff would pick them up. This is not in line with national guidance on patient handling. We were told that if a hoist was required one could be obtained from the local trust. We were also told that due to the type of patient cared for on the ward patient falls were rare. However, the incident reporting information provided to us showed that there had been 10 patient falls between July 2015 and July 2016. Nine of these patients were over 70 years old.
- Manual handling training was mandatory via an e-learning package and compliance was 74%, but this training did not include practical use of a hoist or PAT slide. The senior management team advised us that practical training was provided by the local trust, and 26% of staff who needed practical training had received this.
- The ward environment had some wallpaper coming off in some of the single rooms. The bed frames in the four bedded by were old and had chipped paintwork.
- The resuscitation trolley was next to the nurses' station. This was supplied by the local trust theatres. It was sealed and had a date clearly displayed on the cover as to when this needed to be checked and re-stocked by theatre. Therefore, staff on the ward were not required to perform any checks on the trolley.
- Daily checks of the portable suction machine and defibrillator were performed. Records showed checks had not been done on three occasions during July 2016. Staff on the ward told us the need for patient resuscitation on the ward was very uncommon. Senior

managers were aware that the provider policy regarding resuscitation was not being followed, as there had been no resuscitation scenarios held for more than 18 months.

- An anaphylaxis box was kept in the locked room where patient medication was stored. This box should be checked daily but the record showed this had not been done on four occasions in the last 17 days. An audit of the contents of this box in April 2016 had found that two items were out of date.
- Portable appliance testing (PAT) for safety had been performed on most electrical equipment that we checked. One electrical item had been missed and the ward sister requested this be done whilst we were on inspection. The PAT service was provided by the local trust.
- The dirty utility room was not kept locked. However, this had been risk assessed and there was signage on the door indicating this was an area for staff only.
- Dirty laundry was stored here in plastic bags and collected twice weekly by an external contractor. More frequent collections could be arranged if required.
- The linen room was clean and tidy and items of clean laundry were kept covered.
- The anaesthetic room was well equipped but there was damage to the laminated surfaces and two of the cupboard doors. Some of the walls and the wall mounted containers used for storing disposable items were not clean.
- The recovery room was shared with the local trust. This was on the other side of the main corridor from the theatre. There was one bed space for Park Hill to use with all the equipment required available.
- The theatre itself was spacious and had laminar flow. Another theatre was available for Park Hill to use if required. We were told this would be in the evening or at a weekend if an additional theatre list was arranged.
- The equipment in the anaesthetic room and theatre was maintained by the local trust medical engineering. The senior management team received reports from the local trust regarding deep cleaning and ventilation checks and we viewed these on our inspection.
- Theatre staff told us they would report missing instruments from theatre packs and trays to the local trust as they supplied this equipment. These occurrences were not reported as incidents.
- Staff on the ward said they felt safe at night time. The hospital was locked at night and the connecting doors to the local trust hospital were also locked. The local trust security staff could be contacted if required out of hours and staff said they responded promptly if required.
- We randomly checked some disposable items stored on the ward, in the anaesthetic room and in recovery and found they were all in date.

Medicines

- Ward stock medicines were kept in a locked room. Weekly stock checks were undertaken by nursing staff and ordered from the local trust as part of the service level agreement with the local trust. All stock we checked was in date.
- There were lockable medicine storage cabinets in each of the patient rooms in which the patient's medication was stored. Patients told us staff were very vigilant in checking their identity prior to administering medication. We observed a nurse checking a patient's wristband and verbally confirming their identity prior to administering a medicine.
- The temperature of the drug storage fridge on the ward was recorded daily with no omissions seen. The minimum and maximum temperatures were within range. There were instructions in the folder with the recording charts advising staff what to do if the temperature was outside normal limits.
- The controlled medications recording book on the ward was completed daily and there were no gaps. Stock we looked at was all in date. However there had been no quality assurance or stock check undertaken by a pharmacist for over six months. We were advised that the provider's chief pharmacist was aware of this. We were told that quality assurance and stock checks were not in the service level agreement with the local trust. Therefore there was a lack of assurance regarding monitoring of controlled drugs on the ward.
- Medication was ordered from the local trust. We were told there were no problems obtaining medication from the local trust dispensary.
- Nursing staff on the ward prepared patients' medication to take home (TTOs). The regular medications that were used for TTOs was kept as stock and after the doctor had prescribed the TTOs the nursing staff would give these to the patient when they were ready to go. Staff told us this process was undertaken with two members of staff, one registered nurse with another registered nurse to check or a health care support worker to check.

- There had been two medication errors between 1 February 2016 and 31 May 2016. These had been reported on a separate electronic reporting system. One related to omission of medication and the other was related to incorrect frequency of the administration of eye drops. There was no evidence in the clinical governance meetings that these had been investigated and if lessons were learned.
- We reviewed three medication charts and saw antibiotic review dates had been entered. We saw on the same charts that two had the reason that a medication was omitted recorded but the other one did not.
- We saw intravenous fluids were not prescribed correctly on the medication charts. The dates were omitted and the batch numbers and expiry dates had not been entered on the chart. Some of the intravenous fluids prescribed in theatre had not been signed as being administered by two members of staff. This was not in line with national record keeping practice for the administration of medications. An anaesthetic audit in September 2015, had identified this as an area to improve but there was no action plan to ensure any measures were taken.
- There was piped oxygen to the first four single rooms on the ward. There were portable oxygen cylinders available for other areas when required. These were stored in a locked room but there was no signage indicating that medical gases were stored within. No patients were prescribed oxygen at the time of our inspection.
- A medication audit on the ward in May 2016, showed low compliance in medicines reconciliation. This is the process of checking all medications a patient is taking including drug name, dosage, frequency, and route and comparing against the physician's admission, transfer, and/or discharge orders, to ensure the correct medications are given to the patient. However, on the three charts we saw a pharmacist had reviewed patients' medications whilst they were on the ward.
- The controlled drugs book in the anaesthetic room showed the stock levels were checked twice daily. However signatures were missing on four occasions in July 2016.
- There was also a drug key handover record kept in the anaesthetic room and the signatures for this were missing on 12 occasions in July 2016.
- The drug storage fridge and freezer in the anaesthetic room were checked daily and minimum and maximum temperatures had been recorded with signature missing once and twice respectively in July 2016. The ambient temperature in the anaesthetic room was also recorded daily with two days missed in July 2016.
- The drug storage fridge in the recovery area was locked and the daily minimum and maximum temperatures had been recorded every day and were within range with no omissions.
- Daily temperature checks were also undertaken in the fluid storage cupboard. These were all completed on the records we reviewed.
- The sharps disposal bin in the anaesthetic room was very large and positioned on the worktop. It was too high to see when it was full and not easy to reach to use. There was a risk of staff causing injury to themselves.

Records

- Medical and nursing records of patients were kept on site for six months post ward attendance. These were kept securely in a locked room on the ward. A record book of staff who accessed the room was also kept. We saw that this had been signed and dated by staff.
- Medical and nursing records older than six months were stored longer term in storage facilities provided off site by an external company. If these records required retrieval, a request to the company would be responded to within 24 hours. The hospital informed us there had been no occasions in the past three months where the full medical records of a patient seen on the ward had not been available.
- There were facilities on site for disposal of confidential waste.
- Audit of records was part of the hospital's auditing schedule. This was undertaken on a quarterly basis and result showed that compliance ranged from 94% to 96% compliant.
- We looked at three sets of medical records and found that VTE risk assessments were completed. A medical management plan was also documented. One of the records did not have the name or grade of the doctor clearly recorded. Two of the records did not have evidence of the consultant reviewing the patient daily. However, staff told us that all patients were seen daily. The operation notes and the anaesthetic charts were all complete.

- We found that the World Health Organisation (WHO) surgical safety checklist had been fully completed in five records we reviewed. There were specific areas in the medical, theatre and nursing notes where this could be recorded.
- Medical, nursing and theatre records we reviewed were all signed and dated.
- Delegation of responsibility statement in the nursing records had not been signed in two of the three nursing records we viewed. This meant it was not clear which nurse was responsible for the care of the patient. This is not in line with professional guidance in relation to record keeping or the provider's policy.
- The nursing documentation consisted mainly of paper records that were pre-printed as specific care pathways. These were in a checklist format, which required an initial from the nurse undertaking the check.
- We saw that falls risk assessments were completed pre-operatively. Patients with an identified risk were placed in rooms that were closer to the nurses' station.
- Mandatory training for data protection was at 92%. The provider had not set a compliance target for this.
- Prior to admission, patients were asked to complete a medical questionnaire that detailed past medical history, medications taken and details of the condition. This was kept in the patient's notes.

Safeguarding

- The hospital matron was the safeguarding lead for the hospital. This member of staff had received level 3 safeguarding children training and level 2 safeguarding vulnerable adults training.
- The hospital had a policy for safeguarding adults at risk of abuse or neglect, which had been updated in January 2016. This included additions as required under the Care Act 2014 such as new definitions of adult risk, modern day slavery, female genital mutilation, self-neglect and institutional abuse.
- Staff received mandatory training in safeguarding children and vulnerable adults as part of their induction. This was followed by annual refresher training.
- Mandatory training records supplied by the service showed that 89% of staff had received training in safeguarding adults. However it was not clear what level this training was. It would be expected that staff working with patients would require level 2 safeguarding vulnerable adults training. Eighty seven per cent of staff were compliant with safeguarding children level 1 training and 50% were compliant with level 2 safeguarding children training. The provider and the hospital had not set any compliance targets for training.
- Staff we spoke with were aware of the safeguarding process and there was information on the ward notice board about this.
- The hospital had not made any safeguarding alerts or referrals in the 12 months prior to our visit.

Mandatory training

- Training records supplied to us by the service showed a range of topics were covered in mandatory training. However, this did not include medicines administration or mental capacity act training.
- Overall the hospital reported 68% compliance with mandatory training. The hospital was unable to provide training figures for each department.
- Compliance levels for basic life support and fire safety was 80%, health and safety was 94% along with emergency management. Blood transfusion training compliance was 67%. The provider or the hospital had not set a target for staff compliance with mandatory training.
- The human resources department monitored staff records and contacted staff individually if they were not up to date with mandatory training. Staff told us they had received emails to remind them to attend training sessions.

Assessing and responding to patient risk

- Nursing staff were aware of the risk assessments required for patients admitted to the service. This included a pre admission assessment to identify if the patient was appropriate to attend the hospital. Patients with complex past medical histories or at high risk were referred to the local acute trust to minimise the risk of post-operative complications.
- We saw in patient records risk assessments were completed. For example, there were VTE risk assessments, nutrition risk assessments and falls risk assessments, which were completed pre admission. Not all these assessments were updated whilst the patients were on the ward.
- The ward used a recognised national early warning score (NEWS), which was calculated as part of physiological observations. The NEWS indicated when a patient's condition may be deteriorating and 'trigger' a

need for a higher level of care. The NEWS was used on all patients post operatively. There was a clear pathway of escalation if a patient was showing signs of deterioration. Nursing staff explained how they used this and that escalation processes were simple and effective as there was a doctor resident (RMO) on the ward 24 hours per day who could review the patient quickly.

- Patients who became unwell and required a higher level of management were transferred to the adjoining NHS hospital. This was arranged through the consultant responsible for the patient and on call consultants in the NHS trust.
- Staff on the ward also told us there were sometimes difficulties in obtaining scans from the local trust out of hours. This could delay diagnosis of post-operative complications. Senior managers were aware of this but there were no plans in place to address this.
- The hospital told us that all consultants are able to return to the hospital within 30 minutes if required. If a consultant was going to be unavailable a consultant colleague with practising privileges was identified to the heads of department as their cover. We saw this was the case during our inspection, as a consultant orthopaedic surgeon was on annual leave.
- Only 32% of staff who required the mandatory training on intermediate life support skills had received this. The provider had not set a target for compliance. However, the RMO files we reviewed showed they had received training on advanced life support skills and were on site 24 hours per day.
- The service used the WHO checklist which is a 19 point surgical safety checklist aiming to decrease errors and adverse events, and increase teamwork and communication in surgery.
- The theatre manager audited compliance against the checklist in June 2016 by checking six sets of patient records using a shortened audit tool. The results showed 100% compliance. The audit schedule showed the surgical safety audit, which was more in depth should be carried out every three months. The surgical safety audit completed in February 2016 showed an overall compliance of 97%. However, it highlighted concerns about the debrief process at the end of an operation where there was 20% compliance. In May 2016, the surgical safety audit showed overall compliance of 97% and some improvements in the debrief process but compliance was 30% . In the documentation provided by the hospital there were no actions identified to make improvement and no timescales for improvement. There have been no further audits of this since May 2016.
- In July 2016, a surgical safety audit focussing on peripheral cannulation had been completed which showed 93% compliance, with a clear action and date to be completed.
- There were sometimes difficulties in obtaining radiology imaging in the theatre. This service was currently provided by the local trust and response times to requests could be slow resulting in delays to lists. We were told the service was recruiting a bank radiographer to reduce the delays.
- We saw the surgeon marked patients' skin prior to the operation in order to identify the correct operative site. This was in line with the safer steps to surgery guidance.
- If a patient was to require a critical care bed post operatively this would be arranged by the anaesthetist pre operatively with the local trust. If a patient required a critical care bed unexpectedly post operatively, either directly from the recovery area or from the ward this would be arranged with the local trust. Staff reported that the local trust responded quickly in these circumstances.

Nursing staffing

- The ward did not display the number of nursing staff on duty. There was no display board advising patients or visitors who the ward team were.
- Staff told us there had been a high turnover of qualified staff this year, which had affected the ward team. They were happy that new staff were starting soon but had some concerns about the time a new team takes to work well together. Information supplied to us by the hospital showed there had been a 75% turnover of registered nursing staff on the ward in the period April 2015 to March 2016. This was higher than the average national turnover rate for independent hospitals.
- An electronic system of rostering was used on the ward and in the operating theatre.
- The hospital did not use an acuity tool to plan staffing levels on the ward or in theatre. Staffing levels were based on forecasted activity levels. Senior staff considered the number of patients due to come in for surgery and the type of surgery to be performed and then staff each area to meet these demands. This resulted in off duty rotas showing which staff members

were working on each day being approved with short notice to staff of only one or two weeks. Staff told us that changes to the off duty rota could also occur at very short notice.

- Minimum staffing on the ward at night and during the day was two registered nurses and one health care support worker. We reviewed the nursing rotas for six weeks prior to our inspection and found that the minimum levels had been consistently met.
- Staff told us that earlier in the year staffing areas in the hospital had been difficult due to staff leaving and other absences. They said that things were improving now.
- Agency staff were rarely used and gaps were filled by staff working additional hours and from a pool of regular bank staff. The fill rates for bank registered nursing staff was between 7% (September) and 14% (January, February and March) during the period April 2015 and March 2016. The fill rates for health care support workers for the same period was between 2% (March) and 11% (April). The use of agency staff in this hospital was much less than in other independent hospitals. This was good for continuity of care for patients.
- Sickness levels were low for the period April 2015 to December 2015 compared to other independent hospitals. However there were variable sickness levels reported from January 2016 to March 2016 when there was an increase in sickness levels (up to 10%) amongst registered nurses, which was higher than the average for independent hospitals.
- The establishment of the ward was one ward manager, three registered nurses, which equated to 3.6 whole time equivalent (WTE) staff. There were also six health care support workers, which equated to 4.6 WTE staff. Support staff included two administrative staff, three cooks and housekeeping staff. There were ten members of bank nursing staff, five were registered nurses and the other five were health care support workers.
- An agency nurse had just been recruited to the team to fill the gaps until new members of nursing staff took up their posts and had worked through their induction period. At the time of our inspection there were 3.5 WTE nursing vacancies.
- Information supplied to us by the hospital showed there were no unfilled shifts on in the operating theatre in the three months leading up to our inspection. Our review of the duty rotas showed that minimum staffing levels were achieved consistently in theatres.
- We reviewed theatre staffing rotas and we found a core staff of four operating department practitioners, four scrub nurses, three recovery nurses, three health care support workers with a bank of two registered nurses and four operating department practitioners. Shifts started at 6:30am and finished at 9pm.
- There were no vacancies in the theatre staff establishment.
- There was an on call rota for theatre staff. Three staff were available at all times but were based at home – a theatre nurse, an operating department practitioner and an anaesthetic nurse.
- Staff on the ward were aware of the escalation procedure if they were in charge of the ward and an incident occurred. There was a system of an on call manager who could be contacted directly via mobile phone.
- Handovers on the ward took place up to three times a day at shift changes. The RMO attended the morning handover. Trained staff worked long shifts on most days. During our inspection we observed a handover. There were five patients on the ward at this time. The handover was thorough with a clear review of each patient. We also saw that the information about the patients was recorded on a white board that was visible to staff only behind the reception desk.

Surgical staffing

- The service was consultant led and there were 109 doctors employed by the hospital. All patients were referred under the care of a named consultant. Most of the consultants were employed by local NHS trusts and had practicing privileges to run clinics, carry out treatment and procedures and operate at this hospital. The registered manager held information for every consultant. The Medical Advisory Committee had oversight of arrangements for consultants.
- The senior management team and medical advisory committee (MAC) monitored the competence of the consultants. This ensured that consultants were able to perform the procedures they were proposing to complete within the hospital. However, we saw that a complaint regarding a consultant and the discussion that followed had not been escalated to the MAC, as it was not recorded in the minutes.
- Information supplied to us by the hospital showed 23% of the consultants with practicing privileges had carried out less than ten episodes of care between April 2015

and March 2016. Forty-two per cent had carried out between 10 and 99 episodes and 35% had carried out more than 100 episodes in the same period. Most of the procedures performed at the hospital were orthopaedic surgery.

- Five consultants held practicing privileges for cosmetic surgery and these were on the General Medical Council specialist register. Cosmetic surgery was performed less frequently with 53 breast augmentation operations between April 2015 and March 2016.
- The anaesthetist remained responsible for the patient for 24 hours post operatively after which time the consultant surgeon was responsible. The RMO and nursing staff knew how to contact the relevant consultant.
- The consultants saw their patients on the ward daily and arranged for colleagues to cover if they were unable to attend the ward. Nursing staff and the RMO told us they would be informed of cover arrangements.
- Consultant staff were contacted by telephone, email or via their secretaries to offer advice to the RMO or nursing staff if they were not present at the hospital.
- The RMOs were sourced from an agency. The current arrangement for this cover was two doctors working opposite to each other with two weeks on duty and two weeks off duty with a verbal handover at the changeover. Any sickness absence was covered by the agency.
- The RMOs did not leave the ward for the two weeks they were on duty. They told us they received little training or consultant supervision whilst in the RMO role. However they said they did feel supported by the consultants and were able to contact them if required.
- We saw in the personnel records that both RMOs had received an induction with the hospital and a further week shadowing as part of a checklist.
- The RMOs told us they had experience of working with patients across all specialties. They reported that the induction at Park Hill hospital was good covering mandatory training and orientation. The senior management team told us the induction for the RMOs included advanced life support, and we saw evidence of this in the personnel files.

Major incident awareness and training

- The hospital had an overarching business continuity policy put in place by the wider Ramsay Health care group.
- Staff we spoke with were aware of the major incident policy and could describe how they would access this in an emergency.

Are surgery services effective?

Requires improvement

We rated effective as requires improvement because:

- We saw there were no appraisals completed for staff in the previous year and the rate for this year was low.
- The hospital contributed to a small number of national audits and performance indicators and therefore did not robustly benchmark performance nationally.
- No members of staff had received Mental Capacity Act or deprivation of liberty safeguards training and policies and procedures did not reflect the requirements of the Act.
- There were problems identified in accessing radiology imaging in theatre in a timely manner, which caused delays in completing procedures.

However:

- Staff were aware of and able to access hospital policies and guidance, which were in line with evidence-based practise.
- Validation figures for registration of doctors and nurses working under rules or privileges was 100% between April 2015 and March 2016.
- Staff reported effective multidisciplinary team working.

Evidence-based care and treatment

- Patient care and treatment was carried out according to national guidelines such as National Institute for Health and Clinical Excellence (NICE) and guidance from Royal colleges.
- We saw that the care pathways for specific procedures and operations were evidence based. For example the joint replacement care pathway included elements of the NICE Quality standard (QS49) for the prevention of surgical site infection.
- We saw care pathways for total hip replacement and for total knee replacement and these included elements of enhanced post-operative recovery, which included medical, nursing and therapy inputs.
- Patients told us they were prepared well for their elective surgery with information about how to look

after themselves prior to the operation, what to expect after the surgery and when they were discharged. We saw examples of written information supplied to patients at pre admission assessment and post operatively.
- The hospital contributed to the NHS safety thermometer and the medicines thermometer on a monthly basis.

Pain relief

- Patients we spoke with told us they had been given pain relief when they had required it. They said that pain relief was offered at every medication round.
- We saw medication to control pain was routinely prescribed both regularly and on an as required basis.
- The NEWS charts we reviewed also indicated that patients' pain was assessed and recorded when observations of vital signs were taken.
- There was no dedicated pain team on site. However, the hospital offered specific pain management services. Nursing staff informed us that consultants referred to specialist nurses or teams at other locations directly and they often attended appointments with consultants.
- Two of the six unplanned readmissions between November 2015 and February 2016 were due to uncontrolled post-operative pain.

Nutrition and hydration

- We saw that water was left in reach of patients and this was changed at least twice per day. Ice was available if patients requested it.
- Patients had a nutritional assessment completed as part of the preoperative assessment.
- Intravenous fluids were used to keep patients hydrated post operatively.
- Meals were prepared in the ward kitchen by the cook. Patients were asked in person by a member of housekeeping staff what they would like for the next meal. The menu was varied and the meals were hot when served and looked appetising.
- Patients said the food was good and there was enough to eat.
- The PLACE survey score for ward food in 2016 was 95%, which was better than the national average of 89% for independent hospitals.
- Instructions were given to patients prior to their admission regarding fasting times.
- Fluid balance charts we reviewed on inspection were up to date and had been added up correctly.

Patient outcomes

- The hospital participated in national audits for hip and knee replacements. Patient reported outcome measures (PROMS) data was collected and the results were similar to the national average with 79% of patients stating their general health status was improved post operatively for knee replacement surgery.
- There were no PROMS available for cosmetic surgery and there was a lack of bench marking against internal organisations and external organisations.
- The hospital contributed to the National Joint Registry, and in February 2016 were performing well for consent (98.1%) and linkability, which is the ability to link all operations relating to a single patient (99.6%) with the national benchmark being 95%.
- We found some audits had been undertaken, but there was no action plan documented if non-compliance had been found. For example the clinical effectiveness audit in December 2015, identified non-compliance regarding the use of tourniquets in theatre. There was no action plan recorded and the scheduled audit for June 2016 had not taken place.
- There were audits completed by the physiotherapy team. This included evaluation of care and physiotherapeutic treatments and clinical management audits. The compliance rates were 90 – 100% and 84% respectively.
- There had been five unplanned transfers of patients in the period April 2015 to March 2016; this was lower than the average for independent hospitals.
- There had been 19 unplanned readmissions within 28 days of discharge in the reporting period April 2015 to March 2016. This figure was also lower than average for independent hospitals. Two of these patients had returned due to not passing urine post operatively. One of these patients made a complaint about this.
- There had been five unplanned returns to the operating theatre in the period April 2016 to March 2016. Senior managers were aware of this and had undertaken a review of the reasons for these patients returning for further surgery. No themes or trends were identified in this review.

Competent staff

- The hospital provided us with information that demonstrated there had been validation of professional

registration of all consultants with practising privileges. We saw evidence in the personnel files that this had been undertaken. There were also copies of the consultants' most recent NHS appraisals in the files.
- The hospital had not removed practising privileges, suspended or placed any consultants on supervised practise in the 12 months prior to our inspection.
- Forty-six per cent of consultants had performed 10 – 99 surgical procedures and 35% had performed more than 100 surgical procedures between April 2015 and March 2016.
- The ward and theatre were used as student placements for nurses and operating department practitioners. Students told us they enjoyed their time in the service. One registered nurse had returned as a bank nurse following qualification as the placement had been good.
- One student nurse told us that access to a mentor could be difficult at times but they were well supported by other staff.
- We were told that one mentor out of the four staff who were mentors for students was not up to date with their training. Senior managers were aware and were addressing this in the near future.
- We found very few staff had received an appraisal in the past 12 months. For example no staff in theatre had received an appraisal in the 12 months before April 2016. On the ward, no nursing staff had received an appraisal in the 12 months before April 2016, and only 5% of other staff working on the ward had done so.
- Since April 2016, no staff on the ward had received an appraisal. However in theatre, 25% of nursing staff and 10% of ODP and HCAs in had received an appraisal.
- Staff we spoke with told us a date was planned for their appraisal to take place and some preparation work had started for this. Most staff we spoke with said they were offered training opportunities if they needed them.
- Induction for new staff to the service was described by staff as good with a corporate and local programme. Staff spent a four week period of being supernumerary.
- Nursing staff on the ward were trained in venepuncture but it was the RMO who usually took blood from patients. The theatre manager had a wide range of previous experience and still worked clinically one or two days per week to maintain clinical skills and support staff.
- We were told there was bariatric-trained theatre staff who would be teamed up for cases having weight loss surgical treatments. This surgical procedure took place less than 36 times during April 2015 to March 2016. Specialist input for this procedure was also available from the local trust. A member of staff from the local trust had also joined the Park Hill hospital bank and would be rostered to cover these lists. There was no weight loss surgery taking place at the time of our inspection.
- Some theatre staff had been trained to be surgical assistants through an accredited training programme so they were able to hold cameras for laparoscopic procedures and limbs for joint replacements.

Multidisciplinary working

- There was good multidisciplinary team working on the ward. A dedicated physiotherapist worked six or seven days a week. They were supported by part time physiotherapy assistants. All patients were seen post operatively by the physiotherapist. Referrals to the community physiotherapy teams was a straightforward process.
- Excellent team work was demonstrated by all staff working in the theatre.
- The responsible consultant would contact the relevant consultant at the local trust if a patient's condition changed or deteriorated and it was not appropriate for them to remain on the ward. Staff told us transfers to the local trust usually worked well, but was not a frequent occurrence. Information supplied to us by Park Hill hospital showed there were five unplanned transfers to another hospital in the period April 2015 to March 2016.

Seven-day services

- There were a number of services and facilities that were not available within the hospital. However there were facilities that were accessed via the local trust. These included imaging, diagnostics, portering, pharmacy and medical engineering.
- Theatre lists ran every day with the exception of Christmas Day, Boxing Day, New Year's Day and Easter Day.

Access to information

- All the patients we spoke with told us they had been given good information prior to and after their surgery. One patient showed a quantity of leaflets they had been given regarding exercises and what to expect post-surgery and to assist in the recovery process.

- The ward produced a letter which was sent to the patients' GP on discharge.
- Information supplied to us by the hospital showed that all patients' medical notes were available when they were required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider had a policy for consent to treatment for competent adults and children/young people. This included mention of the Mental Capacity Act in the appendices.
- In the three medical records we reviewed we found the consent to surgical treatment form had been completed correctly and signed by the patient and the responsible doctor. Staff we spoke with understood the principals of informed consent. However, we did not find written evidence in patient records that all care and treatment was given with the consent of the patients.
- At the time of our inspection, there were no patients on the ward for cosmetic surgery. We looked in the records of two patients who had been in recently for breast augmentation surgery and saw that a cooling off period had been allowed as part of the pre-operative planning process. This is in line with the Royal College of Surgeons requirements.
- Mental Capacity Act training was not included in the hospital's mandatory training programme. Staff were required to complete mandatory training on informed consent. However, no staff had received this.
- There was information on the staff notice board regarding Deprivation of Liberty Safeguards.

Are surgery services caring?

Good

We rated caring as good because:

- Patients we spoke with were very happy with the service they had received.
- Friends and Family test results demonstrate a very high level of satisfaction with the care and treatment.
- We observed patients being treated with dignity and respect with good interactions between staff and patients and their visitors. Flexibility around visiting times was observed.
- Most of the staff had received equality and diversity training.

However:

- There was a lack of emotional support on the ward for those patients undergoing cosmetic or weight loss surgery.

Compassionate care

- Friends and Family test results were displayed on the staff noticeboard. These results were consistently at 100% recommending Park Hill Hospital as a place to receive care and treatment, with a response rate of 40% for January to March 2016. The results in June 2016 showed a 5% response rate which is lower than the England average. However, 100% recommended the hospital as a place to receive care and treatment, which was above the England average.
- The provider was not able to provide details of patient satisfaction scores for surgery, but the hospital did conduct internal patient surveys.
- Patients said the nursing and therapy staff on the ward were very kind and could not do enough for them.
- We observed staff interacting well with patients and visitors.
- There were a number of thank you cards on display and staff said there was never a shortage of chocolates given by patients to show their appreciation.
- The PLACE survey score for privacy, dignity and wellbeing for 2016 was 73%, which was below the national average of 84% for independent hospitals. This was despite some changes to the window dressings on the ward, with more appropriate blinds fitted from the previous PLACE survey and patient feedback.
- Patients were also invited to give feedback via the Friends and Family test.
- We saw call bells were left within reach of patients so they could summon assistance. We observed call bells were answered promptly.

Understanding and involvement of patients and those close to them

- Patients were treated with dignity and respect. We were told by patients that all staff knocked on the doors of the single rooms prior to entering. We saw this happening during our inspection.

Requires improvement

Surgery

- Patients said they had been kept informed of progress and knew what was happening to them. Relatives we spoke to also told us this.
- Staff introduced themselves by name to the patients.
- Equality and diversity training was part of the hospital's mandatory training programme. This was delivered as an e-learning package and 93% of staff had completed this.

Emotional support

- The ward had fixed visiting times. For private patients these were 9am to 9pm, and for NHS patients these were 2:30pm to 4:30pm, and 7pm to 8pm. However, we saw that this was flexible and a visitor was able to stay beyond this as the NHS patient had been off the ward for a test during visiting time.
- The pathway for each procedure prompted nursing staff to ask patients if they felt anxious, as well as to discuss their expectations and any worries. However, a nurse we spoke was not able to expand on the issues a patient may face when undertaking cosmetic surgery.
- There was follow up for bariatric patients having surgical treatment for weight loss.

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Staff received no feedback from complaints and there was limited evidence of changes being implemented in response to patient feedback.
- The system for booking patients in for surgery was inconsistent in the management of theatre time, available beds and staff. This resulted in peaks and troughs of activity, which were difficult for staff to manage. Some patients were cancelled on the day of their operation due to shortage of theatre time.
- Patients were not being contacted 48 hours prior to admission as per policy, which had resulted in some patients not being properly prepared for their surgery and cancelled on the day of their operation.
- Arrangements for recording and responding to individual needs were not systematic. For example there was a lack of prompts and no space in the nursing documentation to assess, plan and implement appropriate care for patients with special needs such as sensory impairment or communication difficulties.
- Some staff were using family members to translate when a patient's first language was not English.

However:

- Waiting times and delays were minimal and managed appropriately. Patients were offered appointment times quickly, kept informed of any changes or delays and raised no concerns about timely access to services.
- Audits showed that all referral to treatment indicators were 100% met.
- Cosmetic surgery patients were offered a cooling off period in which to reflect on the information received and the options discussed.

Service planning and delivery to meet the needs of local people

- Staff told us that planning in the service needed to be improved to prevent inconsistencies in access and flow and reduce the number of cancelled operations due to running out of theatre time.
- The service had agreements in place with the local clinical commissioning group regarding referral and treatment of NHS patients. The hospital's service development plans included NHS work.
- Seventy-three per cent of the patients treated in the hospital between April 2015 and March 2016 were NHS funded, which was higher than the national average for independent hospitals.
- Staff were asked to work additional shifts if additional theatre lists were arranged to meet demand.

Access and flow

- The majority of patients who used the service were NHS patients allocated to Park Hill hospital from the local acute hospital trust, as a spot purchase.
- The booking office at Park Hill hospital arranged appointments and the patients attended out patients for a consultation and assessment for the service. The booking office would then arrange the date of admission.
- The referral to treatment time for NHS patients using the service was consistently less than the 18 week indicator.

- Patients would arrive for their operations on the day the surgery was due to be carried out. For morning theatre lists this would be from 6am.
- Patients should have been contacted 48 hours prior to their scheduled admission by staff from the preadmission team but this had not been happening. We saw that this was not recorded in the patients' records and this was also evident in the hospital's records audit, where there was 0% compliance for this in January 2016. Staff told us the reason given for this was shortage of staff and a lack of clarity as to who should be undertaking this role. This could result in patients not being suitably prepared for their surgery, for example not fasting or not having made necessary adjustments to their medication regime. The senior management team were aware of this and a plan was being developed to address this including the appointment of a pre-assessment lead clinician.
- Staff told us the flow of patients was not consistent with some weeks being very much busier than others. This could result in workloads being heavy on some occasions and quiet on others. During busy times staff told us they were overstretched and patients may not receive a high standard of care.
- Consultants informed the booking office when they were available and the booking office staff filled the theatre lists with patients. Sometimes the number of patients on the list was excessive. When staff from theatre informed the booking office of this, no changes were made. Patients would be scheduled and the theatre list would over run. This could mean the next list was late starting, putting pressure on staff and causing delays to patients. This system had been in place for a long time but staff told us they would like to see this change and believed that senior managers were looking at improving this. The senior management team confirmed that this was the case.
- Information supplied to us by the hospital show the bed occupancy rate was 61.2% between April 2015 and March 2016.
- There were 28 cancelled procedures for a non-clinical reason in the 12 months prior to our inspection. Of these patients, 26 were offered another operation date within 28 days of the cancellation. The remaining two patients had cancelled themselves for different reasons. The main reason for cancellation was lack of theatre time for the reasons indicated above. Senior managers were aware of this but there was no clear plan on how to address this.
- Patients were given an estimated discharge date, for example an NHS patient having a joint replacement would be allocated five days in the service. If the patient was not progressing towards this estimated discharge date they would be referred to the NHS rehabilitation provision. However, this facility did not always have beds available at the time of need. This sometimes meant that patients remained on the ward for a longer period.
- Patients told us they were impressed at the speed at which they had been seen at the hospital from the time of referral to appointment time to the time of their surgery being a matter of weeks.
- There were three theatre lists daily Monday to Friday – morning, afternoon and evening and two on Saturday and one or two lists on Sunday.
- Discharge arrangements involved information being sent with the patient and a letter being sent to the patient's GP.
- Follow up care included telephone contact from the physiotherapy service and referrals onto community-based therapy.

Meeting people's individual needs

- There was a policy for patients who require additional support, access to information and services.
- Access to interpreting services was through a telephone translation service or face to face interpreting which required advanced booking. Staff reported a mixed response to the request for interpreters through this service. However, some staff said they would use family members to translate, but did not indicate they would ask for the patient's consent. This was not in-line with the policy for patients who require additional support. Some staff acknowledged using family members to translate was not best practice.
- Ward staff said they usually knew in advance of a patient attending that an interpreter would be required.
- Specific dietary needs could be met but there was no access to a dietician on the ward. The cook was made aware of patients with dietary needs by the pre admission assessment nurses and had a whiteboard in the kitchen for this purpose. The cook was then able to order appropriate food in advance to meet their needs.

Requires improvement

Surgery

- Nursing care plans were not individualised. There were defined care pathways that were based on the operation/procedure the patient was admitted for. This lacked personalisation. There were no prompts for staff to record any actions required to meet any special needs a patient may have. For example communication difficulties or a sensory impairment and indicating what adjustments or actions were needed to address these. This could result in staff not addressing these needs. There were no patients with special needs on the ward at the time of our inspection.
- There was no bariatric equipment on the ward. There was only one wheelchair and one commode on the ward of standard size. Bariatric patients were admitted to the ward for weight loss surgery. If equipment was needed this was sourced from the local trust.
- The PLACE survey score for dementia in 2016 was 81% compared to the England average of 75% for independent hospitals. Patients with cognitive impairment were not often admitted to the ward for treatment.
- The PLACE survey score for disability in 2016 was 73% against the national average of 79%.

Learning from complaints and concerns

- There had been 14 complaints about the ward in the 12 months prior to our inspection. This was a lower number per 100 patients compared to other independent hospitals.
- Leaflets were on display for patients and visitors informing them of how to make a complaint.
- There was no log kept of informal complaints. A senior manager had responsibility of dealing with formal complaints.
- There was not a robust system for assisting patients who experienced problems after discharge. We noted in complaints, comments from patients and in meeting minutes that patients who had contacted the ward post discharge were not receiving the information they required.
- There was a clear written policy and process in the organisation for dealing with complaints and learning from them. The senior management team told us that learning from complaints was cascaded to staff in the departmental meetings. There were no notes available from these meetings.
- We were told that departmental meetings had not been minuted or had not taken place due to staffing shortages. However, the senior management team were aware of this and there were plans to address this.
- We reviewed these complaints and the responses sent. The themes were communication, discharge arrangements and staff issues.
- Complaints were reviewed at the heads of department meeting and the clinical governance meetings. Meeting minutes show there was little discussion and no action plans created as a result of any learning to be shared. There was no auditing of the complaints process at the hospital, which was not in line with the provider policy.
- The hospital had not been monitoring performance on responding to complaints and the senior management team were aware responses to complaints were not happening in a timely manner. An action plan to address this was being developed with a senior manager leading the work to ensure compliance with response times stated in the provider complaints policy.

Are surgery services well-led?

Requires improvement

We rated well led as requires improvement because:

- There was a draft hospital clinical strategy in place. This was still in development with no agreed completion date.
- Risk management and governance processes were not robust. Lessons learned from incidents and complaints were not shared across all teams and there was no process to ensure the risk register was reviewed on a regular basis.
- Governance meetings did not address quality outcome issues and audit activity on a systematic basis.
- Complaints were not managed effectively and responses were not handled in a timely manner, although senior managers were aware of this and had a plan to address this.
- The annual audit schedule was up to date but there was limited evidence that improvements required were being implemented. There were lower compliance rates in July 2016 than previously and a lack of timescales for actions to be completed.

However:

Requires improvement

Surgery

- Staff reported strong departmental leadership and felt that the recent newly appointed senior management team had made an immediate positive difference.
- Staff were positive about the working environment and reported strong teamwork and they demonstrated this during our inspection.

Vision and strategy for this this core service

- There had been significant change at Park Hill Hospital in the 12 months prior to our inspection. This had resulted in many plans being in the early stages of development. The senior management team were still in the process of developing a hospital strategy and vision. We saw there was a Northern vision for the Ramsay group called 'Our People', which outlined the local values within the Ramsay hospitals in the North of England.
- Staff we spoke with were aware the strategy was being developed but were unclear about what it meant.
- Staff we spoke with knew about "The Ramsay Way". This represented the values of the organisation, which were to provide caring, progressive work in which staff felt the value of integrity, credibility and to provide positive outcomes for all.
- Senior managers told us that development plans were in place. However, timescales were not determined and there was no action plan to capture the development plans.
- There was a corporate vision for the service, which considered quality as well as commercial elements.

Governance, risk management and quality measurement for this core service

- The service had a governance structure in place with clinical governance and medical advisory committee meetings taking place regularly against a set agenda. We reviewed notes from these meetings during our inspection and could not find consistent evidence of discussion around quality outcomes or measurements regarding patient care.
- A monthly clinical governance report was completed by the hospital and monitored on a local level. We did not see any actions plans as a result of this.
- There was a lack of assurance that learning was consistently taking place after incidents or complaints. For example there was no evidence that a change of practice had occurred as a result of two patients going home having not passed urine post operatively. There was a lack of formal minute taking at meetings. However, the senior management team had recognised this prior to our inspection and were developing a plan to address this.
- We were able to review the risk register. A number of risks had been identified relating to the ward and the theatre. However, some risks had not been properly identified, recorded or managed. For example, the risk register did not include infection prevention and control issues relating to the environment.
- We spoke with a member of the senior management team about issues regarding staff raised in complaints from patients and families. They were not aware of this as a concern and stated the previous managers had not handed this over earlier in the year. Therefore, this matter had not been recognised or addressed. On further discussion we were told how this would be investigated using human resources processes.
- Review of medical advisory committee notes showed that a grievance had not been followed up as the member of staff had left the hospital. There was potential for other staff to be affected by the grievance that had been made.
- There was a lack of robust investigation in two serious incidents. The senior management team were aware of this and were reviewing these.
- The action plan following the never event investigation lacked follow up actions. For example there was no planned audit of the proposed change of procedures in theatre.
- There was a lack of consistency with the reporting of incidents and not all staff were trained to use the system. Although the senior management team were aware, this was not identified on the risk register.
- There was a lack of evidence in staff knowing of learning from complaints due to the lack of departmental meetings where this information and learning could be shared. The senior management team were aware of this and had plans to address the way information was cascaded to staff at ward and department level.
- The hospital had a corporate audit programme, which included infection prevention and control audits.

Leadership / culture of service related to this core service

Requires improvement

Surgery

- The overall lead for the hospital was the senior management team. Most of the staff in these senior positions were relatively new in post and new to the hospital.
- The ward was led by a senior nurse supported by a team of registered nurses, health care support workers and housekeeping staff.
- A theatre manager led the theatre and recovery area supported by a team of theatre nurses and operating department practitioners. Staff we spoke with were aware of the reporting and accountability structure.
- Staff told us they felt the recent introduction of a new management team was a positive step and the recent changes that had been implemented were improving services.
- Staff in theatre said they were a happy team at present.
- There was a good team spirit in the hospital. Non-permanent staff such as student nurses and bank staff confirmed this. The RMO said that the hospital was a friendly place to work – "the best they had been in".
- A staff nurse told us the ward manager was a fantastic support.
- A number of staff had been working at the hospital for a long time which they felt was indicative of the way they felt about their job and working at the hospital.
- The hospital had not yet completed the Workforce Race Equality Standard (WRES) data submission and did not have a local action plan in place to address this. There was evidence of provider-level workforce equality data in an 'Equality duty report' in May 2016. However this did not refer to the WRES requirements or indicators.

Public and staff engagement

- Staff told us they now felt more involved with decisions about the service and senior managers were engaging with them.
- Due to low staffing levels there had not been staff meetings in theatre or on the ward for several months.
- Staff notice boards had very recently been placed in the hospital and these contained various information about the service and policy updates.
- There were plans to start holding staff engagement meetings with senior managers.
- Staff thought the input from another hospital in the group would be beneficial and they could learn from each other. This was being facilitated by one of the senior managers who was covering both locations.
- Staff said they were happy to work at the hospital, and felt they gave a good service to patients. Some staff had worked in the service for a long time and felt this indicated it was a good place to work. Eighty three per cent of all employees who responded to the 2015 staff survey stated they felt supported by their direct manager.
- Staff received customer care training as a mandatory e-learning package. Information supplied to us showed 94% of staff had completed this training.
- The response rate to the staff survey for Park Hill Hospital was 79% for 2015. In this survey, 93% of staff indicated they knew what was expected of them and 89% said the hospital had a strong patient/customer focus.
- Patients were invited to give feedback on "We Value Your Opinion" leaflets about their experiences and how the service could be improved. We saw these leaflets on the ward in display racks but the hospital was not able to provide a breakdown of the results for each department.
- Staff said they received regular emails to notify them of any policy changes or safety concerns.
- The hospital had a complaints policy to guide staff if patients made a complaint about the service.

Innovation, improvement and sustainability

- The hospital was planning to implement a new electronic health care rostering system that had an integrated dependency and staffing tool.

Requires improvement

Outpatients and diagnostic imaging

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

Information about the service

Park Hill hospital is a purpose built unit, based in South Yorkshire and located in the grounds of a local NHS Hospital. The unit became operational in 1995. Park Hill hospital is part of the Ramsay Healthcare Group and is registered as a provider under the name Independent British Healthcare Limited. The hospital consists of 21 beds made up of 17 single rooms and a one four bedded room. There are six consulting rooms located on the ground floor, one minor operations suite and a fully equipped laminar flow theatre. The hospital provides outpatient services to NHS and other funded (insured and self-pay) patients from Doncaster and the surrounding areas. The hospital has an outpatient department hosting a number of different specialities including orthopaedics, gastroenterology, dermatology, endocrinology and cosmetic surgery as well as physiotherapy. The hospital did not provide services to children at the time of inspection. Services for children ended in May 2016.

The outpatient department is open 8am to 8pm Monday to Friday and 8am to 2pm on Saturdays.

Diagnostic imaging services were provided at the local NHS trust and were available 24 hours a day, seven days a week for inpatients and 8am to 5pm on weekdays. There was a service level agreement in place for these services with Park Hill Hospital.

From April 2015 to March 2016, the hospital outpatient department saw 13,205 patients of which, 4,754 were new appointments (first attendance) and 8,451 were follow-up appointments. The hospital saw 6,006 NHS appointments and 7,199 other funded appointments. The majority of appointments were mainly elective orthopaedic NHS patients referred to meet waiting list initiative targets from local NHS trusts with 6006 (85%) of cases being NHS funded. The majority of outpatient appointments were for orthopaedics, ophthalmology, gynaecology and cosmetic surgery. The teams within outpatient and physiotherapy services consisted of qualified nurses, health care assistants and physiotherapists. Each clinical area had a head of department and the out patients head, reported directly to the matron.

During the inspection, we visited the outpatient and physiotherapy departments. We spoke with nine patients, six qualified nursing staff, one consultant, three administrative staff, one physiotherapist, two managers, one healthcare assistant, one student nurse and two members of hotel staff. We observed the outpatient and physiotherapy environments, checked equipment and looked at patient information. We reviewed 12 patient medical records in clinics, as well as performance information from the hospital. We observed the delivery of care and treatment to patients in the clinic areas.

Requires improvement

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated the service as requires improvement.

Staff were aware of their roles and responsibilities for maintaining safe management of patients attending the service but there was some confusion around the definition of an incident and when this should be reported. Learning from these incidents was not cascaded formally to staff and we did not see evidence of regular discussion of incidents within governance meetings.

There were infection control policies and audit processes in place and all areas were visibly clean and well maintained.

Staff were provided with a robust induction programme but subsequent mandatory training figures were extremely low. There was no action plan in place to improve this.

Staff within the outpatients department had not received an appraisal in the previous and current appraisal year.

The management of medication prescription pads was not in line with national guidance and there were no daily checks of stock levels, or audits.

Governance systems were not robust and were not monitoring compliance against policies, incidents and complaints. Information relating to this was not shared consistently with all staff in the hospital.

The hospital strategy and vision was in development at the time of inspection.

However:

Staff reported effective multidisciplinary team working, with common goals for the provision of high quality patient care.

The outpatients department flexed working hours to meet the demands of the service, with an on call system to support this.

Patient records were accessible for all appointments and were found to be thorough, and of a high standard. Information was shared with GPs to enable continuity of care.

Patients were included in decision making regarding treatment plans and were positive about the care they received. Friends and family surveys showed high levels of satisfaction with services experienced by patients.

The service consistently achieved referral to treatment time targets.

Staff were positive about the teams they worked within and proud of the care they provided. Staff within each clinical area reported strong local leadership. There had been significant change within the management team recently at the hospital but staff overall felt the new appointments brought positivity and renewed enthusiasm.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Requires improvement

We have rated safe as requires improvement because:

- Staff were aware of the procedures for reporting incidents but did not receive formal feedback and we saw no examples of lessons learnt as a result of this.
- The management of medication prescription pads was not in line with national guidance, meaning that there was the possibility for loss of, or inappropriate use of prescriptions. There was no evidence of stock checks or medication audits to ensure safe administration was maintained.
- Mandatory training figures were low in every area. We saw no action plan to improve this.
- Although a standard National Early Warning Score (NEWS) chart was used to record patient's observations, there was no guidance available to nursing staff on how to respond to raised NEWS scores and when intervention and escalation was necessary to ensure that deteriorating patients are always recognised and treated.

However:

- All areas were clean and well maintained.
- Staff used appropriate protective equipment and had awareness of actions to be taken in the event of communicable infections or blood spillages within departments.
- All equipment was maintained annually by either manufacturers or the estates department within the hospital group.
- There was sufficient equipment to meet the needs of the service.

Incidents

- The services reported no never events for the outpatient department between April 2015 and March 2016 and during the time of our inspection. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital had an incident reporting policy in place which included guidance on how to report incidents and how to investigate concerns. Staff we spoke to were aware of the policy and we saw incidents logged on the hospital's electronic database.
- Staff told us they were confident about reporting issues and raising concerns with senior staff. However, there was some confusion amongst staff as to what constituted an incident. For example a member of staff told us about an incident involving a confused patient who was found to have disconnected their IV line and was wandering the corridor unsupervised. Staff we spoke to including a senior manager was unsure if this should have been logged as an incident. Another member of staff told us that dealing with verbally abusive comments would be considered 'part of the job' and they would not log these as incidents. The Ramsay Healthcare incident reporting policy refers to incidents as 'An actual occurrence or event that has caused loss, damage or harm. A near miss is defined as 'An occurrence or event that has had the potential to cause harm'. The examples of events given by staff would fall within these definitions and should have been reported.
- There were no serious untoward incidents in the outpatients department for the twelve months prior to the time of inspection (April 2015 and March 2016).
- There were 33 clinical incidents reported by the hospital; nine of which related to the outpatient department. There were no non-clinical incidents reported. Of the nine clinical incidents we saw, all were rated minor or moderate. Staff were unable to confirm that managers fed back the learning from incidents and discussed with them how they could do things differently to improve. We were unable to gain any examples of change in practice following an incident.
- There had been no deaths related to the outpatient department and therefore no mortality reviews were undertaken.

Duty of Candour

- 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. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

- We saw evidence of letters to patients offering an apology and information about incidents and complaints. However, we were not assured that a formal system was in place to implement the requirements of the duty of candour and apologies were not always made in a timely manner.
- Staff we spoke with were broadly aware of the principles behind the duty of candour. 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.
- Staff within the out patients department had not received formal training relating to the duty of candour at the time of inspection; however, there was a strong culture of being open and honest with patients amongst all staff groups and grades of staff.
- All staff could describe the principles of being open and honest with patients. All staff we spoke to said that they would be happy to speak to patients and their families if an incident had occurred.

Cleanliness, infection control and hygiene

- There was infection control information displayed in patient areas and we observed visitors using alcohol hand gels.
- Policies and procedures for the prevention and control of infection were available to guide staff. Staff understood them and could describe their role in managing and preventing the spread of infection.
- All departments and patient areas were visibly clean and we saw staff wash their hands and use hand gel between treating patients. Separate hand washing basins, hand wash and hand gel dispensers were available in the departments and patient areas. However, we saw there was no handwashing sink in the minor operations room. Staff told us that they used the sink outside of the room.
- Access to the clean utility room on the ground floor was through the dirty utility room. Used instruments were stored in this area. There did not appear to be any alternative access to the dirty utility room. We did not see any risk assessment for this, however a senior manager told us the room was no longer used as a dirty utility area.
- Staff adhered to uniform policy and followed bare below the elbow guidelines.
- The lead nurse for infection prevention and control for the hospital had been absent from work for a prolonged period. The new matron was taking on this role in the interim.
- IPC environmental audits were due every three months. There were identified actions required but no date for completion on the audit record. Hand hygiene audits were due every six months. This had taken place in April 2016, and the result was 100% compliance. Peripheral venous cannula audits took place every six months.
- We noted outpatient waiting areas were carpeted although they did appear clean. We did not see a risk assessment for this and therefore there was potential for hazards associated with lack of regular cleaning due to spillages, wear and tear in heavy traffic areas. Since the inspection, the hospital has confirmed that the use of carpets has been reviewed corporately. The outcome of this review is that replacing carpets with solid flooring will be considered in the local refurbishment programmes.
- We saw the consulting rooms were cleaned in between appointments and in readiness for the next patient.
- The hospital had no occurrences of reported methicillin-resistant Staphylococcus Aureus (MRSA) from April 2015 to March 2016.
- Waste management was handled appropriately with separate colour coded arrangements for general waste, clinical waste and sharps, clearly marked with foot pedal operated lids. Bins were not overfilled.
- The Ramsay hand hygiene policy states that handwashing audits be performed at least every six months. We saw that the hospital was consistently achieving 100% for this audit.

Environment and equipment

- The environment in outpatient areas appeared uncluttered, and well maintained.
- All consulting rooms were locked when not in use with either keypad or key access. Keys were held by all nursing staff.

- Appropriate containers for disposal of clinical waste and sharps were available and in use across all departments.
- Staff told us they had sufficient equipment to meet the needs of patients.
- We looked at equipment and refrigeration and found these were appropriately checked, cleaned and maintained.
- We found equipment safety checks and calibration stickers were in place on fridges, and equipment and labels were clearly evident and in date.
- We saw that within the clean utility room there were several plastic syringes which were out of date. The expiry dates were June 2016. We also saw five sterile gel sachets within the dressings trolley in a consultation room which were also out of date. The expiry date was May 2016. These issues were brought to the attention of the sister who ensured these were replaced immediately.
- There was a single resuscitation trolley that was centrally located and easy to access by all departments on the ground floor.

Medicines

- The hospital had a service level agreement with the local acute trust for the provision of medications and pharmacy services. This included the provision of the resuscitation trolley.
- Medicines in the departments were stored and monitored appropriately. The chief pharmacist for Ramsay Healthcare audited medicines management practice and compliance with policies. We were told that no significant issues were identified. Medicines management audits we saw, carried out between April 2015 and October 2015, showed 100% compliance.
- Medicines were kept in locked cabinets and we saw evidence that daily temperature checks of medication fridges and the ambient room temperature were recorded, which were all in appropriate temperature ranges.
- All drugs that we checked during our inspection were found to be in date and correctly stored.
- Within the outpatients department, there was no pharmacy dispensary service. Patients who required a prescription item were issued with a private prescription.
- We were told that consultants attending the department for a clinic were issued with a prescription pad upon request. This was kept in the sister's office. We could not see any systems to log the use of these pads such as signing them in and out. 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.
- Nursing staff informed us that medication information was available for patients, and they explained that new medications were discussed with the patient detailing side effects.

Records

- We reviewed 12 sets of medical records across the outpatient department. We found these were of a good standard. They contained sufficient up to date information about patients including referral letters, medical and nursing notes including patient care pathways, operation and anaesthetic records and discharge documentation.
- At the time of inspection, we saw patient personal information and medical records were managed safely and securely. We saw records were appropriately stored within the departments we visited. The outpatient and physiotherapy departments used paper records. These were stored in the records office in lockable cabinets. Notes for outpatients appointments were collected by the consultants, depending on who`s clinic it was, from the office and the notes were returned once the clinic was completed.
- The hospital had a policy that consultants should not take patient medical records out of the hospital. Staff told us that all consultants adhered to the policy.
- A patient told us that during a consultation her patient files were left unsupervised for a brief period of time. She was particularly unhappy about this as she felt other patients may have had access to her information. We saw within the information security update dated the 16 May 2016 provided by the hospital, that the issue of managing information in a secure manner will be discussed at the next staff forum and managers meetings.
- Staff told us all patients attending an outpatient appointment would have either a GP referral letter, or their current records from a previous appointment or admission to the hospital available.

Requires improvement

Outpatients and diagnostic imaging

- Staff told us that if any patient information or paperwork were absent, then depending on the nature of the missing details, this would be obtained from either the patient or consultant in advance of an appointment.
- The hospital reported that in the three months leading up to our inspection, no patients were seen who did not have medical records.
- Diagnostic imaging referrals and requests were made on paper forms or via fax from GPs. Information was transferred onto an electronic patient administration system and reports were produced electronically. This was an external service as there was no imaging on site.

Safeguarding

- The hospital matron was the safeguarding lead for the hospital. This member of staff had received level 3 safeguarding children training and level 2 safeguarding vulnerable adults training.
- Safeguarding training for staff within the outpatients department showed 40% of staff had completed Safeguarding Adults training level 1. 50% of staff had completed safeguarding children level 2. We did not see an action plan to improve this.
- Safeguarding policies and procedures were available and staff were able to demonstrate how to access them. Staff were aware of their roles and responsibilities in relation to safeguarding and could describe what types of concerns they would report and how they would raise matters of concern appropriately.
- There had been no safeguarding concerns reported to the Care Quality Commission during the reporting period of April 2015 to March 2016.
- The hospital had not raised any safeguarding alerts to the local authority during this same time frame.

Mandatory training

- Mandatory training was available via on-line e-learning courses.
- Overall the hospital reported 68% compliance with mandatory training. The hospital was unable to provide training figures for each department and we saw no action plan to improve this.
- The sister within OPD had completed advanced life support training. All nurses we spoke to had completed resuscitation training. One sister had completed advanced life support training.
- Medical staff completed mandatory training at their main employing NHS trust. There were assurance systems in place to make sure that medical staff were up to date with mandatory training.
- A member of the administration team told us that they maintain the training matrix. However, this was not shared with the sister in OPD.
- Staff at all levels felt well supported in relation to participating in training opportunities, both internal and external and there were opportunities to visit other hospitals within the group to develop skills.

Assessing and responding to patient risk

- Nursing staff were aware of the risk assessments required for patients admitted to the service. This included a pre admission assessment to identify if the patient was appropriate to attend the hospital. Patients with complex past medical histories or at high risk were referred to the local acute trust.
- Prior to admission, patients were asked to complete a medical questionnaire which detailed past medical history, medications taken and details of the condition. This information was reviewed and appointments allocated to the consultant as appropriate
- There were systems and processes for escalation of care or transfer out to local NHS hospitals should nursing staff and the resident medical officer (RMO) have concern about a patient.
- During inspection, we observed that clinical observations were recorded appropriately and NEWS scores calculated accurately. Actions taken according to patient clinical condition were in line with the patients' escalation plan. We saw a deteriorating patient pathway within the hospital procedures but, staff within the outpatient department were not clear about it.
- We saw the hospital had an agreement with a local NHS Hospital to transfer critically ill patients but this agreement had expired at the time of inspection. The matron had sent an email in July 2016, to the local NHS Hospital to undertake its review.
- The service had processes for managing acutely unwell patients. The consultant and RMO were called to review the patient in a clinical emergency; transfer to the acute trust was arranged via ambulance. Nursing staff were able to describe previous occasions when this system had been used.

- There was a procedure to call for emergency assistance and the crash team at a local NHS Hospital would respond to these calls. There was however no testing of this arrangement through the use of practice emergency calls.

Nursing, allied health professional and care assistant staffing

- The outpatient department had a dedicated team of registered nurses, healthcare assistants, and administration staff. Physiotherapy staff were managed separately but worked closely with the outpatient department team.
- There were no baseline staffing tools used in outpatients department to monitor staffing levels. However, our observations and interviews with staff confirmed there were adequate numbers to safely manage the outpatient's department clinics. During the inspection, actual staffing levels met the planned rota for staff needed per area.
- Nursing staff described the service and staff as being flexible to the clinic needs, with staff changing shifts if necessary to meet the demands.
- Staff in the outpatients department told us they were busy. The sister in charge was the acting lead nurse in OPD to cover for a colleague that was currently on sick leave.
- The matron told us a new outpatient staff nurse would commence in September 2016.. A pre-assessment lead member of staff was also due to start around this time. The posts were designed so that pre-assessment and outpatient services could be managed specifically and streamlined to improve patient outcomes.
- The OPD used dedicated bank staff as and when required, from the hospital's own pool of bank staff.
- All staff received a structured induction programme and the staff we spoke with felt supported on joining the organisation.
- The hospital reported there was no sickness absence during the period of April 2015 to March 2016. However the lead for OPD was on sickness leave at the time of our inspection.
- We saw that there was a human resource (HR) process for checking General Medical Council and Nursing and Midwifery registration, as well as other professional registrations for physiotherapists and that all relevant staff had up-to-date professional registration.

Medical staffing

- All patients were referred under the care of a named consultant. All consultants were employed by surrounding NHS trusts and had practising privileges to run clinics, carry out treatment and procedures and operate at this hospital. The registered manager held information for every consultant. The Medical Advisory Committee had oversight of arrangements for consultants.
- The senior management team and medical advisory committee (MAC) monitored the competence of the consultants. This ensured that consultants were able to perform the procedures they were proposing to complete within the hospital. We saw however that a complaint regarding a consultant and the discussion that followed, had not been recorded anywhere.
- There was a resident medical officer (RMO) onsite 24 hours a day, seven days a week on a two weekly rotation with a Monday handover. The hospital employed two RMO's through an agency. There was provision of an onsite residence for the RMO.
- The two RMO's who provided on duty cover was supplied through an agency. Both had received an induction with the hospital and a further week shadowing as part of a checklist. We were not able to see the RMO induction checklist at the time of inspection.
- The RMOs had experience of working with patients across all specialties .They reported that the induction at Park Hill hospital was good, covering mandatory training and orientation.
- Medical staff were contacted by telephone, email or via their secretaries to offer advice to staff if they were not present at the hospital and there was an arrangement in place for consultant's to provide cover for each other if required.

Major incident awareness and training

- The hospital had an overarching business continuity policy put in place by the wider Ramsay Health care group.
- Staff we spoke with were aware of the major incident policy and could describe how they would access this in an emergency.

Requires improvement

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services effective?

We inspected, but did not rate effective:

- We saw that there were no appraisals completed for staff within the outpatient department in the previous and current appraisal year.
- The hospital had a yearly programme of audits which was not consistently reported or monitored.
- Outpatient staff provided patient appointments over weekends according to clinical need, with on call provision for imaging emergencies at weekends.
- No members of staff within the outpatient department had received mental capacity or deprivation of liberty training.

However:

- Staff were aware of and able to access hospital policies and guidance, which were in line with evidence based practise.
- Validation figures for registration of doctors and nurses working under rules or privileges were 100% between April 2015 and March 2016.
- Staff reported effective multidisciplinary team working.

Evidence-based care and treatment

- Care and treatment within the outpatient department was delivered in line with evidence-based practice. Policies and procedures, assessment tools and pathways followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- We saw examples of policies referring to evidence based guidance from professional bodies. For example, the chaperone policy referred to recent professional guidance from the General Medical Council and the consent to treatment for competent adults and children / young people, referred to the Mental Capacity Act 2005.
- The hospital took part in the national clinical audits National Joint Registry (NJR), The Medicines Safety Thermometer and The Patient Safety Thermometer. The Patient Safety Thermometer showed that from October 2015 to October 2016, the hospital achieved 100% harm free days. This related to pressure ulcers, falls, new VTE's and catheter related urinary tract infections. The hospital was not able to show us data regarding the medication safety thermometer, as these audits had recently commenced in May 2016. Patient Recorded Outcome Measures (PROMS) for total hip and knee replacements (NHS patients only) were also completed and scores were generally reported as improved.
- There was a programme of audits which was carried out by nurse managers but outcomes were not consistently reported to the Clinical Governance Committee. The audit of medical records, care pathways, infection control, handwashing and VTE were not regular agenda items.
- Senior managers at Park Hill were reassured that diagnostic services provided by the local trust were conducted in accordance with NICE guidance. They told us there was regular dialogue between the two providers and we saw evidence of this within meeting minutes.

Pain relief

- We saw evidence of pain relief being prescribed and administered safely to patients before during and after surgery. Where care pathways were used this was pre-planned.
- Staff described how they would offer support to patients who reported being in pain. Staff said they would assess the level of pain and contact the RMO for pain relief to be prescribed.
- Some of the minor procedures that took place in the outpatient department were performed under local anaesthetic. A consultant was present for the procedure and administered the pain relief. We saw a patient pathway for this treatment. Patients we spoke with had not required pain relief during their attendance at the outpatient departments.
- We reviewed twelve patient files and saw that pain levels were recorded upon admission, recovery and upon discharge.
- The hospital offered specific pain management services, but nursing staff informed us that consultants referred to specialist nurses or teams at other locations directly and they often attended appointments with consultants.

Nutrition and hydration

- There were water fountains in each department and the outpatient department had a hot drinks machine for patients to use as required.

- An occupational therapist told us there was availability to refer patients to dieticians when required.

Patient outcomes

- Patient outcomes in physiotherapy were monitored by recognised outcome measures such as range of movement, pain scores and quality of life measures to establish effectiveness of treatment.

Competent staff

- Managers told us formal arrangements were in place for induction. All staff, including bank and agency staff, completed full local induction and training before commencing their role. Staff we spoke to confirmed this.
- Staff told us that heads of department offered support through a buddy system with equivalent practitioners in other organisational hospitals and support through regional team leads. This enabled staff development and maintenance of clinical skills and supervision.
- We looked at three staff files, specifically in relation to competencies. We saw that clinical skills competencies had been recently signed off on the 25 July 2016 in one file. The other file showed that competencies had been signed off on the 23 July 2016. Both of these files were for qualified staff. There was no evidence to show that these competencies had been recorded or signed off previously. The third file was for a health care worker. The competency for day surgery performed in the department had not been signed off.
- The hospital policy showed that staff should receive a formal annual appraisal and mid-term appraisal every year. We saw no appraisals had been completed for outpatient nurses and health care assistants in the previous and current appraisal year. Staff told us this was due to staff shortages across the departments. There were assurances from the senior management team that there would be 'a renewed impetus in personal development reviews' for staff. Staff told us they had been given dates for their appraisal to be completed.
- Systems had been set up for revalidation of medical staffing and for the effective management of doctors' practising privileges which included contributing to their annual appraisal. Appraisals were based on GMC guidance and completed by a medically qualified appraiser. Copies of consultants' up-to-date appraisal documents were available in all personnel files we reviewed. Qualified nurses were supported with re-validation requirements.
- The hospital offered placements for students from the local university, and this was observed during inspection.
- We saw that there were no registered nurses on the rota for every clinic held on a Saturday. We asked administration staff if they had been asked to be a chaperone for consultants during Saturday clinics and they advised that they had. We could see no training in place to support this and staff confirmed that they had not received training. The hospital subsequently told us that training was planned for September 2016 for non-clinical staff.
- Validation figures for registration of doctors and nurses working under rules or privileges were 100% between April 2015 and March 2016.

Multidisciplinary working

- A range of clinical and non-clinical staff worked within the outpatients department and staff told us they worked well together as a team.
- Nursing staff were observed working in partnership with physiotherapists, administration staff, and consultants. Staff were seen to be supportive of each other to provide the best care and experience for the patient.
- A member of staff told us 'we show consultants respect, as they do us'.
- There were clear agreed protocols for staff to follow and where specialist advice was required, staff told us they were able to access consultants and specialist staff easily, an example being, the hospital leads for safeguarding to discuss required interventions.
- There were no regular department meetings for frontline staff. We spoke with four staff who told us this was due to staffing shortages and there had not been the time to formally arrange them.
- We were informed the patients GP's were kept informed of treatments provided; follow up appointments and medications to be taken on discharge. We saw evidence of this during the inspection.

Seven-day services

- The outpatient department was open between 8am and 8pm, Monday to Friday, and 8am to 2pm on Saturday.

Requires improvement

Outpatients and diagnostic imaging

- The physiotherapy team were available at weekends and provided outpatient support Monday to Friday.

Access to information

- All staff had access to the hospital intranet to gain information relating to policies, procedures, NICE guidance and e-learning. Paper copies of local policies were also kept in folders in the nurses' office.
- Medical notes included all information pertaining to assessment and treatment plans including details of specific patient pathways. Copies of all external communications (such as GP letters) were also stored in the patient's notes. There were systems to flag up urgent unexpected findings to GPs and medical staff. This was in accordance with the Royal College of Radiologist guidelines.
- Clinic information was shared with patients' GPs in letter format. These were produced by the clinician following the appointment and copies sent to GPs and patients.
- Staff were able to access patient information such as blood results and paper medical records and separate physiotherapy records as required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act (MCA, 2005) and Deprivation of Liberty Safeguards (DoLS).
- All staff reported that they were aware of the consent policy and how to access this on the organisation intranet. Staff appeared to have a broad understanding of issues in relation to capacity. They explained that any concerns would be escalated to the matron for further advice or assistance.
- Patient records in outpatients contained care pathways specific to each medical specialty and all had a section to complete by staff regarding consent for surgical procedures. All records we looked at had been completed appropriately and showed patients had been provided with information to make an informed choice.
- We saw that two members of staff within the outpatient team had been considered as 'not requiring' informed consent training. There was no clear explanation for this. Only one member of the department (20%) had received formal training.
- No members of staff within the outpatient department had received mental capacity training.

Are outpatients and diagnostic imaging services caring?

Good

We rated caring as good because :

- We spoke to nine patients and one carer and all commented positively about the care provided from all of the outpatient and physiotherapy staff.
- People were treated courteously and respectfully and their privacy was maintained.
- Patients were pleased with the care they had received and would recommend the hospital to their family and friends.
- Patients were kept up to date with and involved in discussing and planning their treatment.
- Patients were able to make informed decisions about the treatment they received.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions or treatment.

Compassionate care

- All patients we spoke with told us staff had treated them well and respected their privacy and dignity when delivering care. We observed staff communicating with patients and their families in a respectful and considerate manner. Within the discussions with patients, there were no negative comments about the compassionate and caring aspects of the service.
- We observed staff interacting with patients and their relatives across all departments in a professional and compassionate manner in clinic and in the waiting areas. This included staff visiting the patient waiting area to check on the status of patients waiting for appointments.
- The hospital had a policy concerning the use of chaperones. This provided guidance on chaperones and their availability to patients. We saw chaperones were available in the departments we visited.
- We could not see any record of a chaperone being offered, in any of the patients' files that we checked.

Requires improvement

Outpatients and diagnostic imaging

- Consulting rooms were fitted with a code controlled lock. Staff were observed to knock on doors before entering when patients were in treatment areas and consulting rooms.
- The friends and family survey results for March 2016 showed a 100% response rate. 98% were extremely likely to recommend the hospital to others.
- The patient satisfaction survey showed consistently high results. Patients were who were asked whether they felt they had been treated with dignity and respect during their stay scored 99% during June 2015 and June 2016.
- We saw patients and staff had a good rapport with staff putting patients at ease. Staff offered tactful help and support to complete forms when patients had difficulty understanding the questions being asked.

Understanding and involvement of patients and those close to them

- We observed staff spending time to explain procedures to patients before gaining written consent.
- Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their treatment.
- All of the nine patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about the care and treatment they could have. They all confirmed they felt informed and involved in their care and were given time to make decisions. They also stated that staff made sure they understood the treatment options available to them.

Emotional support

- We saw staff spend time talking to patients and showing empathy and encouragement to complete aspects of therapy.
- The pathway for each procedure prompted the nurse assessor to ask a question in relation to patient anxiety and expectations. However a nurse we spoke with was not able to expand on the issues a patient may face when undertaking cosmetic surgery, such as psychological needs.
- We observed staff of all grades and specialties talking to patients. They reassured them during procedures and engaged with their patients. They informed them of what would happen and was happening to them during the procedure.

Are outpatients and diagnostic imaging services responsive?

Requires improvement

We have rated responsive as requires improvement because:

- Staff received no feedback from complaints and there was limited evidence of change in response to patient feedback.
- Reasons for cancellations were not formally analysed or monitored.
- Arrangements for recording and responding to individual needs were not systematic, for example, in relation to chaperones, disability and language needs.
- There were no specific arrangements in place to support patients with a learning disability or dementia.
- The use of interpreter services was not robust. Staff were not clear on the arrangements for booking services and when they should be used.
- The hospital did not collate data for patients who did not attend appointments.

However:

- Waiting times, delays and cancellations were minimal and managed appropriately. Patients were offered appointment times quickly, kept informed of any changes or delays and raised no concerns about timely access to services.
- Audits showed that all referral to treatment indicators had been consistently met.
- Facilities and premises were appropriate for the services delivered.
- Cosmetic surgery patients were offered a cooling off period in which to reflect on the information received and the options discussed.
- Services were planned and delivered to meet the needs of the local population.
- Complaints within the outpatient department were acknowledged within the policy guidelines.

Service planning and delivery to meet the needs of local people

- The hospital engaged with the two local Clinical Commissioning Groups to plan and deliver contracted services based on local commissioning requirements.

Requires improvement

Outpatients and diagnostic imaging

There was a range of outpatient clinics offered (around 18 specialities) including a variety of surgical specialties, trauma and orthopaedics, physiotherapy, dermatology, podiatry and neurology.

- Most patients who used the department, whether as a NHS patient or other funded patient were referred by their GP. Patients were offered appointments quickly and all appointment and waiting times met the required standards. The hospital scored 100% in referral to treatment times between the period of April 2015 to March 2016.
- Outpatient, physiotherapy and diagnostic imaging services were provided for adults aged 18 years and over (diagnostic imaging services were provided by arrangement with a local NHS Hospital, which is located on the same site). Clinics were planned according to demand and staffing arrangements were flexible, to meet the demands during busier periods. We observed that only one receptionist was usually available, which sometimes meant delays in answering calls or seeing patients. We saw the telephone rang around the department for some time before a member of staff answered the call.
- Seating was appropriate for the number of patients present in clinic. A television screen was mounted on the wall in the main outpatient waiting area, advertising Ramsay Healthcare services.
- The route from the car park to reception was step-free and allocated disabled car parking spaces were available opposite reception, which were shared with a local NHS Hospital.

Access and flow

- From April 2015 - March 2016, the hospital outpatient department saw 13,205 patients of which, 4,754 were new appointments (first attendance) and 8,451 were follow-up appointments. The hospital saw 6,006 NHS appointments and 7,199 other funded appointments. There had been a significant rise in outpatient activity over the past two years, mainly of elective orthopaedic NHS patients to meet waiting list initiative targets from local NHS trusts.
- The hospital exceeded the indicator of 95% of non-admitted patients beginning treatment within 18 weeks of referral and was at 100% for each month between April 2015 and March 2016.
- Patients we spoke to commented they were impressed with the way appointments for procedures could be quickly scheduled, after initial consultation.
- The hospital told us they do not currently have a reporting system that historically collects data on patients that did not attend appointments within the hospital.
- Staff in outpatient clinics told us that clinic capacity was determined by availability the consultants gave and there was no cap on appointment numbers within the department and no minimum number of patients required for a clinic to run.
- When consultants were not available, a designated consultant was appointed to cover their patients during this period. The covering consultant was communicated to ward / theatre and outpatient administrators. Patients attending the outpatient department for routine appointments were rescheduled by instruction of consultants for when they are available.
- There was no information on waiting times displayed in the reception and no clock available in this waiting area. Staff advised patients on arrival if clinics were running late. Patients we spoke with were happy with their wait time, although we observed one patient who had waited 30 minutes to be seen and was then told the consultant was not available and was to have the appointment rescheduled for the next day.
- The hospital told us they did not currently have a reporting system that historically collects data on cancelled appointments. A cancellation tracker was introduced from 1 July 2016, which records cancellations 72, 48 and 24 hours prior to admission for day case or inpatient treatment. There was no data to review at the time of inspection.
- In the last 12 months the provider has cancelled 28 procedures for a non-clinical reason of whom 26 were offered another appointment within 28 days. The Provider commented that one patient was not prepared to wait, then decided not to proceed with surgery. The other patient gave no reason why they wished to cancel following admission, and were referred back to their GP and CCG were informed.
- Reasons for cancellations were not formally analysed or monitored. There was evidence of problems in accessing a radiographer from a local NHS Hospital which had resulted in last minute cancellations, which were noted in the Medical Advisory Committee in April 2016. As a result, action was taken to provide Park Hill

requirements to DRI on a weekly basis. However, there was evidence of another example where diagnostic equipment (from DRI) was not available, which had resulted in a cancelled operation, indicating the arrangements were not yet fully effective in avoiding cancellations.

Meeting people's individual needs

- Managers told us they were able to access telephone interpreting services if required. However, staff told us that while interpreters were usually arranged prior to arrival by GPs, that friends and family were sometimes used to interpret and staff were unsure how to access an interpreter on the day if needed. We heard an example where an appointment had been cancelled because no interpreter had been booked and the patient had no friends or family to interpret for him.
- The hospital did not have a standalone policy in relation to interpreter services. However we were told guidance is within the 'Patients with a disability or special needs' policy. It, was the responsibility of the matron to ensure the provision of interpreter services was maintained.
- The patient waiting areas were tidy with sufficient comfortable seating for patients visiting the department. There was a water machine and a television screen advertising Ramsay services for patients who were waiting, but there were no books and magazines available.
- Some information leaflets were available, which provided patients with details about their clinical condition and treatment or surgical intervention.
- Information leaflets were not provided or offered in different formats or languages. Some information leaflets were out of date e.g. leaflets relating to eye conditions, which were on display in a consulting room, were dated 2001 (RNIB leaflets).
- Two patients told us it was very difficult to get through to Park Hill by telephone and that voicemails were not responded to quickly enough. It took a long time before they received a call back. However, patients said staff were friendly and professional on the phone and they were confident to contact staff or to come in to the hospital directly if they needed help or advice. The matron told us an automated message system was planned but there was no date for implementation. We saw that the telephone rang around the department for some time before a member of staff answered the call.
- Patients told us information they received from the hospital about appointments and their procedures, was clear.
- Cosmetic surgery patients were offered a cooling off period in which to reflect on the information received and the options discussed.
- By 31 July 2016, all organisations that provide NHS care must have fully implemented and conform to the Accessible Information Standard - to identify, record, flag, share and meet information or communication needs relating to a disability, impairment or sensory loss. Electronic patient systems and patient registration forms did allow disability or other individual needs to be recorded, however this information was only recorded after a registration form had been completed and was not automatically available for follow-up appointments. As there was no consistent system for identification or flagging of needs, reception staff told us they would not know ahead of arrival if someone had a disability or communication need, unless the patient or carer had called to advise or told staff on the day.
- We spoke with a carer who explained it was frustrating that staff did not read the notes to know about their relative's disability needs ahead of arrival. This meant they had to explain their needs again at each appointment. They also commented that more information about what happens and how long they would need to wait when they arrived, would have been helpful, as their relative was very nervous about the procedure. However, they also reported that staff had responded appropriately once they were aware of the patient's sensory impairments and that they had been able to stay with their relative during the procedure.
- There was no identified lead or link nurse identified for patients with a dementia or learning disability. Staff told us they would ask for advice from a senior manager if required.
- A hearing loop was available and a sticker on reception showed this, however staff were not aware of this or how it was used by patients.
- There were toilet facilities available for patients including toilets with disabled access within the hospital.
- Patients told us that they were asked about their individual needs during outpatient appointments, such as, any religious needs, dietary requirements, and allergies. We saw that these issues were included in the pathway for each procedure.

Requires improvement

Outpatients and diagnostic imaging

Learning from complaints and concerns

- The hospital had a complaints policy and there was a patient information leaflet entitled 'We value your opinion', which was available in the reception area to inform patients, relatives and carers of how they could highlight any concerns. However, this leaflet did not include information on the formal complaints procedure, and there was no other information on display to provide patients with details of how they could make a complaint about their care or treatment.
- Staff described how they would resolve a patient's concerns informally in the first instance, but would ask patients to put complaints in writing to escalate to senior staff if necessary. Administration staff were unclear whether complaints could be accepted if they were not in writing and did not receive feedback on the outcome of complaints or actions taken.
- In the last 12 months the provider received 29 complaints, of which 8 were for outpatients. One complaint related to a missed 48 hour reminder call. The call is made by the hospital to prepare the patient for their appointment, by issuing appropriate advice or treatment. For example, to stop specific medication or to fast prior to surgery. A nurse told us an action plan was put in place to ensure the 48 hour call was made to patients; however of those patients we spoke to, none reported receiving these calls following a procedure. We saw no evidence of the action plan in place at the time of inspection. Two complaints were in regard to poor customer service, two concerned patients who had not received appointments times as requested and another relating to appointments cancelled at very short notice.
- Systems were in place to capture concerns and complaints raised in the department. However, it was not robust. We could see no evidence of systematic reviewing of complaints or lessons learnt as a result of these complaints. Staff told us that they would usually review these at monthly staff meetings; however, staff meetings were irregular due to staff shortages.
- It was acknowledged by the hospital that during the inspection, the hospital had no audit/performance data for complaint response times in last 12 months. Future plans were in place to address this. There was evidence of letters of apology from the general manager meeting with patients to resolve complaints. Timescales in which these were addressed were in line with the hospital policy. The Ramsay Healthcare management of patient complaints policy states that 'The manager will ensure that a resolution letter is provided within 20 working days of receipt of the compliant'. Within the eight complaints that we checked, all had met the policy guidelines.

Are outpatients and diagnostic imaging services well-led?

Requires improvement

We have rated well-led as requires improvement because:

- There was no strategy or vision in place. This was still in development with no agreed completion date.
- Risk assessments for the environment were not in place and those that were had not been reviewed.
- Risk management processes were not robust. Lessons learnt were not shared across all teams and there was no process to ensure the risk register was reviewed on a regular basis.
- Governance meetings did not address quality outcome issues and audit activity on a systematic basis.
- Complaints were not managed effectively and responses were not handled in a timely manner.
- There was limited evidence of improvements across the hospital and staff did not take ownership of opportunities to improve.

However:

- Staff reported strong departmental leadership and felt that the recent newly appointed senior managers had made an immediate positive difference.
- Staff were positive about the working environment and reported strong teamwork.

Vision and strategy for this core service

- There has been significant change at Park Hill Hospital over the last 12 months and as such many plans had not yet been formalised. The senior management team were in the process of developing a hospital strategy and vision, which was in draft at the time of inspection. We saw there was a Northern vision for the Ramsay group which was 'Our People' which outlined the local values within the Ramsay hospitals in the North of England.

Requires improvement

Outpatients and diagnostic imaging

- Staff we spoke to were aware that the strategy was being developed but spoke with pride about "The Ramsay Way". This represented the values of the organisation which were to provide caring, progressive work in which staff felt the value of integrity, credibility and to provide positive outcomes for all.
- Senior managers told us development plans were in place, however time scales were not determined and there was no action plan to capture the developments.

Governance, risk management and quality measurement for this core service

- The service had a governance structure in place, with regular meetings taking place against a set agenda.
- A monthly clinical governance report was completed by the hospital and monitored on a local level.
- We saw that outcomes for patients were discussed during these meetings but it was not clear how this information was shared with staff within the hospital.
- Complaints and incidents were not consistently shared at the clinical governance meetings. We did not see any action plans following complaints or incidents within the outpatient department.
- Although risk was discussed within the clinical governance meetings, it was not discussed fully. For example, investigations were not followed by examples of lessons learnt. There did not appear to be a process in which risk management issues were shared with all staff and risk that was identified was not reviewed on a regular basis.
- We saw that the hospital risk register was updated in July 2016. The risk register included dates for risks to be reviewed but these were frequently a year after the date that the risk had been identified. Following the inspection the hospital provided a further copy of the risk register, which also included dates to review risks. However it was not clear from the information provided whether risks would be more frequently reviewed.
- There was no evidence of a risk assessment associated with the management of medications or prescription pads within the outpatients department. There was no signing in or out system and no audits completed to ensure safe use and compliance.
- Staff were unclear as to what the risk escalation process would be.
- We noted a structured audit calendar for planned audits, but results were not always shared with staff. Staff told us they received information verbally from managers.
- Nursing staff reported that communication across the team was easy due to specialities having such small teams.
- Each clinical area had designated notice boards, which contained information relating to infection control, policy updates, and departmental meetings.
- The senior management team were responsible for ensuring that consultants and visiting clinicians had the appropriate skills and qualifications in place. Specialist nurses attending the department under SLA agreements completed tasks under direct supervision by the consultant.
- There was evidence of some benchmarking against other Ramsay hospitals in the clinical governance report. For example hand washing pilots in three of the Ramsay hospitals, which looked to improve patient perception.
- We saw evidence of regular Medical advisory committee meeting meetings which broadly discussed key themes across the hospital.

Leadership / culture of service

- The ward sister was providing cover in the absence of the outpatient nurse lead due to illness. We were told by a senior manager the cover did not include the completion of audits within the outpatient department.
- Heads of departments were noted as holding appropriate specialist qualifications and skills to manage the departments.
- Staff said managers were available, visible within the departments and approachable. Staff spoke positively about the service they provided for patients and emphasised that quality and patient experience was a priority and the responsibility of every member of staff.
- Staff were proud to work at the hospital and were passionate about their role and the work they did.
- Staff sickness rates were generally very low with minimal turnover of staff.
- The hospital had not yet completed the Workforce Race Equality Standard (WRES) data submission and did not have a local action plan in place to address this. There

was evidence of provider-level workforce equality data in an 'Equality duty report' dated May 2016, however this did not refer to the WRES requirements or indicators.

Public and staff engagement

- Outpatients and physiotherapy staff told us there was a good working relationship between all levels of staff.
- The hospital staff survey results were positive. Staff felt engaged with all developments and staff told us they felt proud to work for the hospital. 83% of all employees who responded to the recent 2015 staff survey stated that they felt supported by their direct manager.
- We saw that there was a positive, friendly, but professional working relationship between consultants, nurses, allied health professionals, and support staff.
- The friends and family survey results for March 2016 showed a 100% response rate; 98% were extremely likely to recommend the hospital to others.
- Staff received regular emails to notify them of any policy changes or safety concerns.
- We saw leaflets "We value your opinion" which were readily available in and around the outpatient department. These leaflets informed patients, relatives and carers of how they could highlight any concerns.
- The hospital had a complaints policy in place.

Innovation, improvement and sustainability

- An electronic rota system is used called 'Allocate Health Roster'. The rota was completed by heads of departments. Patient acuity and dependency is assessed closely and rotas are reviewed and revised to reflect changes. Annual leave and sickness are also recorded and monitored within this tool. We were told by managers that a new system will be implemented in November 2016 called 'I care' which has an integrated dependency / staffing tool.
- A review of outpatient services including the treatment room for dressing clinic was underway. New plans for renovation of the room to ensure clean and dirty utility provisions are fit for purpose. We did not see any dates for implementation.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment must be provided in a safe way for service users.** **(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely.** • Only 26% of staff who required practical manual handling training had received this. • Mental Capacity Act training was not part of the mandatory training programme. No staff had received training on informed consent. **(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs.** • There is was patient handling hoist on the ward for staff to use if a patient has fallen to the floor and is unable to get up. **(h) – assessing the risk of, and preventing, detecting and controlling the spread of, infections including those that are health care associated.** • Insufficient assurances due to a lack of ward and operating theatre cleaning audits • Insufficient assurances due to a lack of waterborne infection risk minimisation measures. • High risk areas such a carpeted patient bed space area. Lack of clinical waste bins and lack of physical hand washing facilities for staff.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems or processes must be established and operated effectively to ensure compliance with the requirements.** **2(a) assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);** • Interviews identified that there was confusion amongst staff as to what constituted an incident and therefore some incidents were not recorded. • There was a lack of clinical audit and an effective audit schedule. **2(b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying of the regulated activity.** • A lack of environmental audits to check for safety in relation to infection prevention and control, environmental safety and practice. • There was no testing of the emergency assistance / crash arrangement through the use of practice emergency calls. • We saw that the hospital risk register was updated in July 2016 but there was a lack of assurance that risks were regularly reviewed. No mitigating actions against risks were identified. **2(f) evaluate and improve their practice in respect of the processing of the information referred to in sub paragraphs (a) and (b)** • We saw limited examples of feedback from complaints and incidents being shared to drive improvement. Staff were unable to confirm that managers fed back the learning from incidents or complaints. • We saw limited example of patient outcomes and audit data being used to inform practice.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

Surgical procedures

Treatment of disease, disorder or injury

Persons employed by the service provider in the provision of a regulated activity must:

(a) receive such appropriate support, training, training, professional development, supervision and appraisal as it is necessary to enable them to carry out the duties that they are employed to perform.

- A majority of staff had not received an appraisal in the previous and current appraisal year.
- There was no evidence to show that staff competencies within the outpatient department had been recorded or signed off previous to 2016.
- Mandatory training figures were low.
- Staff did not have the appropriate level of safeguarding training.