Pinehill Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Pinehill Hospital is operated by Ramsay Health Care UK. Originally it was a large house, but has had numerous extensions. The hospital has 37 beds; this includes 25 inpatient beds over two floors and a 12-bedded day ward. Facilities include three operating theatres with individual anaesthetic rooms and a recovery area. There is one minor theatre used for endoscopies and local anaesthetic procedures. Other facilities include general x-ray, ultrasound, two outpatient treatment rooms and a physiotherapy gymnasium.

The hospital provides surgery, endoscopy, outpatients and diagnostic imaging. Services for children and young people were ceased in September 2018.

The hospital provides an inpatient and outpatient service for various specialties to both private and NHS patients. This includes, but is not limited to, orthopaedics, gynaecology, general surgery, diagnostic imaging and urology.

We inspected this service using our comprehensive inspection methodology. We carried out an unannounced (staff did not know that we were coming) inspection on 4 to 5 December 2018. To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

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

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

Services we rate

Our rating of this hospital/service improved. We rated it as **good** overall.

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had completed safeguarding adult and children's training.
- The hospital managed patient safety incidents well. All staff recognised incidents and reported them appropriately. Managers investigated incidents thoroughly and shared lessons learned with teams throughout the hospital. When things went wrong, staff apologised and gave patients honest information and suitable support. There was good awareness of Duty of Candour and this was applied appropriately. There was a culture of openness and honesty at all levels.
- Staff generally kept appropriate records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Services in the hospital provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- The service had enough medical and allied health professional staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment all the time.

Summary of findings

- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed hospital policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- There was good multidisciplinary working across the hospital. Staff in different teams worked together to benefit patients. Doctors, nurses and other healthcare professionals, supported each other to provide good care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. They were communicated with and received information in a way that they could understand.
- Hospital services were planned and developed to meet the needs of the local population for both private and NHS patients.
- The service had suitable premises and equipment. Hospital premises were clean, well maintained, and suitable equipped. There was an equipment replacement programme to ensure that all large items of equipment were replaced when they became outdated.
- The hospital took account of patients' individual needs. Reasonable adjustments were made for patients who had additional or complex needs.
- People could access services when they needed it. Waiting times from referral to treatment for surgical procedures, and arrangements to treat and discharge patients, were in line with good practice. There was an emphasis on the importance of flexibility, choice and continuity of care across the hospital. Services were delivered at times that were suitable for patients through the provision of out of hours services, and the use of additional clinics and appointments to meet areas of high demand.
- The hospital treated concerns and complaints seriously. Managers investigated them thoroughly and made responses within agreed timescales. There was an appropriate escalation process for complaints when patients were not satisfied with the outcome of a complaints investigation. Lessons were learned from complaints and were shared widely with all staff.
- Managers at all levels in the hospital had the right skills and abilities to run services and provide high-quality sustainable care. There were named and experienced heads of department for each area. Each service lead was passionate about the service they led and worked well with the team of staff in their department.
- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action. The hospital set a five-year strategy and vision from 2018 to 2021. All staff we spoke with were aware of the vision for the hospital, and understood their role in achieving it.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

Summary of findings

- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

We found the following areas for improvement:

- There were inconsistencies with the completion of risk assessments post-operatively which were necessary to maintain patient safety. Not all risk assessments were reviewed post-operatively.
- We were not assured that staffing levels were always safe at night when a second ward area was opened. During the night when there were additional wards opened, safe staffing levels were not always achieved.
- Carpet was present in consultation and treatment rooms and the general waiting area in outpatients and physiotherapy, which could be an infection control risk. However, a plan was in place to remove all carpet in clinical areas in the future.
- In the diagnostic imaging service, we did not find processes in place for the management of medicines that were stored within the service. There was no stock rotation and replacement process and no pharmacy support to ensure safe management of medicines in the service.
- Although outcomes were generally monitored, we did not always see action plans in place when a service did not achieve the hospital's standards. This meant that we could not be assured there were processes in place to address any shortfalls in compliance.
- The diagnostic imaging service did not have systems in place to routinely obtain feedback from patients in order to improve the service.
- The diagnostic imaging service did not have processes in place to monitor turnaround figures (wait times from procedure to reporting). We were not assured that they could demonstrate they were meeting their targets.
- Not all staff were aware of their service's performance as this information in some services was not routinely shared with staff.
- Not all equipment was within date for safety testing. Electrical safety testing had expired on some equipment meaning that we could not be assured that it was safe for use.
- Although the premises and environments were kept clean, we saw that hand hygiene was not always maintained by all staff.
- Training compliance for some staff was below the hospital target.

Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with two requirement notice(s) that affected the surgery core service. Details are at the end of the report.

Amanda Stanford
Acting Deputy Chief Inspector of Hospitals (Central)

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care	Not sufficient evidence to rate	Medical care services were a small proportion of hospital activity. The only service provided was endoscopy. Where arrangements were the same, we have reported findings in the surgery section. We did not have sufficient evidence to rate this service.
Surgery	Good	Surgery was the main activity of the hospital. Where our findings on surgery also apply to other services, we do not repeat the information but cross-refer to the surgery section. We rated this service as good because it was well led, effective, caring and responsive, although it requires improvement for being safe.
Outpatients	Good	We rated this service as good because it was safe, caring, responsive, and well-led. Effective is not rated.
Diagnostic imaging	Good	We rated this service as good because it was safe, caring, responsive, and well-led. Effective is not rated.

Summary of findings

Contents

Good

Pinehill Hospital

Services we looked at

Medical care; Surgery; Outpatients; Diagnostic imaging;

Summary of this inspection

Background to Pinehill Hospital

Pinehill Hospital is operated by Ramsay Health Care UK. The hospital opened as an NHS hospital in 1948 and was purchased by Ramsay Health Care UK in 2007. It is a private hospital in Hitchin, Hertfordshire. The hospital primarily serves the communities of the Hertfordshire area. It also accepts patient referrals from outside this area.

The hospital has a registered manager who is the hospital director. He has been in post since November 2017. There is a head of clinical services who has been in post since February 2018. This post holder is also the safeguarding and infection prevention and control lead and has clinical responsibility across all departments.

The hospital is registered for the following regulated activities:

- Diagnostic and screening procedures.
- Family planning
- Surgical procedures
- Treatment of disease, disorder or injury

There are 163 consultants working under practising privileges; none were directly employed by the hospital. There were 25.8 full time equivalent nursing and midwifery staff and 24.5 operating department and health care assistant staff across all departments. In addition, there were 68 full time equivalent other staff, including health professionals, administrative and clerical and support staff, who were shared across the hospital services and who were employed by the hospital.

The outpatient department comprises of 10 consulting rooms and two minor treatment rooms on the ground level. Adjacent to the main outpatient department is the imaging department which comprises of an x-ray room, and ultrasound facility. There is a mobile computerised tomography unit (CT) and magnetic resonance imaging unit (MRI), which visit the site regularly, managed by Ramsay Diagnostic services. In addition to outpatients and imaging services, there is a physiotherapy department on the ground floor, which has a gymnasium, four treatment rooms and two curtained treatment cubicles.

There is a small pharmacy department providing services for both inpatients and outpatients.

Clinical inpatient areas consist of two inpatient wards, the first floor has 13 patient rooms including two two-bedded rooms. The second floor has 12 patient rooms. The day surgery unit has six daycase pods, and six beds. The theatre department consists of three main theatres with laminar flow, plus an endoscopy unit. The endoscopy service was awarded the Joint Advisory Group (JAG) accreditation in April 2014. This is a governing body that assess the quality and standards of endoscopy services in relation to patient care. Following an annual review, the service was not able to demonstrate adherence to the JAG standards. The accreditation status changed to 'assessed: improvements required'. They were found to not be adhering to 6 standards and they required actions to be completed by April 2019. The service has created an action plan and had completed four out of the six actions with the other two in progress.

The hospital undertakes a range of surgical procedures and provides outpatient consultations for a range of specialities for adults.

The hospital was last inspected in October 2016 when it was rated as Requires improvement. During this inspection three requirement notices were issued, against regulations 15 (premises and equipment), 17 (good governance), and 18 (staffing). These requirement notices have now been lifted.

The hospital is managed by Ramsay Healthcare UK Operations Ltd part of a network of over 30 hospitals and day surgery facilities and two neurological rehabilitation homes, across England. In addition, they own and run hospitals in Australia, Indonesia and France.

The hospital provides care for private patients who are ether paid for by their insurance companies or are self-funding. Patients funded by the NHS (approximately 58%), mostly through the NHS referral system can also be treated at Pinehill Hospital.

Summary of this inspection

Our inspection team

The team that inspected the service comprised a CQC lead inspector, three other CQC inspectors, an inspection manager, and five specialist advisors with expertise in surgery, outpatients, radiography and governance. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Information about Pinehill Hospital

The hospital has one ward and is registered to provide the following regulated activities:

• Diagnostic and Screening procedures

• Family planning

• Surgical procedures

• Treatment of Disease, Disorder or injury

During the inspection, we visited the inpatient ward, daycase unit, theatres, endoscopy, outpatients' departments and imaging department. We spoke with 56 staff including; registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 24 patients and relatives. During our inspection, we reviewed 23 sets of patient records. In addition, we sent comment cards and boxes to the hospital for patients to provide anonymous feedback about their experience of care. We had 103 completed comment cards returned.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital had been inspected one in October 2016 when they were rated as requires improvement overall.

Activity

In the reporting period from August 2017 to July 2018, there were 1463 inpatient cases, 6417 daycase episodes and 48,876 outpatient attendances recorded at the hospital. 53% of inpatient and daycase patients were NHS funded and 63% of outpatient cases were NHS funded.

The accountable officer for controlled drugs (CDs) was the Head of Clinical Services.

Track record on safety

One never eventClinical incidents 286 total. 245 no harm, 35 low harm, 5 moderate harm, 0 severe harm, and 1 death.126 non-clinical incidents.3 serious injuries.No incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA),No incidences of hospital acquired Methicillin-sensitive staphylococcus aureus (MSSA)No incidences of hospital acquired Clostridium difficile (c.diff)No incidences of hospital acquired E-Coli64 complaintsServices accredited by a national body

Joint Advisory Group on GI endoscopy (JAG) accreditation; this is a governing body that assess the quality and standards of endoscopy services in relation to patient care. The endoscopy service was awarded JAG accreditation in April 2014. However, following an annual review in 2018, the service was not able to demonstrate adherence to the JAG standards. The award of

accreditation was deferred until 9 April 2019. The accreditation status changed to 'assessed: improvements required'. The service was found to not be adhering to six standards and had improvement actions identified, to be completed by 9 April 2019. The service has created an action plan and had completed four out of the six actions at the time of inspection, with the other two in progress.

Services provided at the hospital under service level agreement

Clinical and non-clinical waste removal

Interpreting services

Grounds Maintenance

Laser protection service

Laundry

Maintenance of medical equipment

Theatre sterilisation services

Summary of this inspection

Histology services

Blood transfusion service

Pathology services

Clinical Cardiology services

Audiology services

Computerised tomography scanning (CT) and magnetic resonance imaging (MRI)

RMO provision

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- Although the service generally controlled infection risk well, we saw that hand hygiene was not always maintained by all staff in all areas. In addition, carpet was present in some clinical areas, which could be an infection control risk.
- Although the service had suitable premises and equipment and generally looked after them well, not all equipment was within date for safety testing. Electrical safety testing had expired on some equipment meaning that we could not be assured that it was safe for use.
- Although staff assessed risks to patients, we found inconsistencies with the completion of risk assessments post-operatively to maintain safety.
- Although the service mostly had enough staff with the right qualifications, skills, training and experience, at night there were additional wards opened without minimum staffing levels achieved. We were not assured that staffing levels were always safe at night when a second ward area was opened.
- Although mandatory training in key skills was available to all staff, training compliance for some departments was below the hospital target.
- Although services generally gave, recorded and administered medicines well, we did not find processes in place for the monitoring of medicines stored in the diagnostic imaging service.

However:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had completed safeguarding adult and children's training.
- The service had enough medical and allied health professional staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment all the time.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

Summary of this inspection

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The risks associated with anticipated events and emergency situations were recognised and systems were in place to deal with these.

Are services effective?

Good

We rated effective as good because:

- The hospital provided care and treatment based on national guidance and evidence of its effectiveness.
- Staff gave patients enough food and drink to meet their needs and improve their health. Services made adjustments for patients' religious, cultural and other preferences.
- The hospital made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of services.
- There was a regular audit programme for all departments across the hospital.
- Staff were supported to complete additional training and development.
- Staff in different teams worked together to benefit patients. Doctors, nurses and other healthcare professionals, supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed hospital policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- Services mostly monitored the effectiveness of care and treatment and used the findings to improve them. However, we did not always see action plans in place where a service did not meet the hospital's standards. This meant that we could not be assured there were adequate processes in place to oversee any shortfall in compliance.

Are services caring?

Good

We rated caring as good because:

Summary of this inspection

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. They were communicated with and received information in a way that they could understand.

Are services responsive?

Good

We rated responsive as good because:

- The hospital took into account patients' individual needs.
- The hospital planned and provided services in a way that met the needs of the local population for both private and NHS patients.
- The hospital treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- People could access services when they needed to. Waiting times from referral to treatment and arrangements to treat and discharge patients were in line with good practice.

However:

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- The diagnostic imaging service could not provide us with the turnaround figures for time taken from referral to procedure, meaning we were not able to be assured that they were meeting their targets.

Are services well-led?

Good

We rated well-led as good because:

- Managers at all levels across the hospital had the right skills and abilities to deliver services which provided high-quality sustainable care.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The hospital systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish. The hospital was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

Summary of this inspection

- The hospital had a vision for what it wanted to achieve and workable plans to turn into action, which it developed with staff and patients. All staff we spoke with were aware of the vision for the hospital, and understood their role in achieving it.
- The hospital engaged well with patients, staff, and the public to plan and manage appropriate services, and collaborated with partner organisations effectively.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Not rated	Not rated	Not rated	Not rated	Not rated	Not rated
Surgery	Requires improvement	Good	Good	Good	Good	Good
Outpatients	Good	Not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Not sufficient evidence to rate

Medical care

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

Information about the service

Pinehill Hospital is operated by Ramsay Health Care UK Ltd. The hospital provides medical care for adults and older people. The medical service consists only of the endoscopy service.

The endoscopy service is located within the theatre department and consists of one theatre.

We carried out an unannounced inspection on 4 and 5 December 2018.

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

Are medical care services safe?

Not sufficient evidence to rate

This domain was inspected but not rated.

Pinehill Hospital is operated by Ramsay Health Care UK Ltd. The hospital provides medical care for adults and older people. The medical service consists only of the endoscopy service.

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Mandatory training

- See information under this sub-heading in the Surgery Report section.

Safeguarding

- See information under this sub-heading in the Surgery Report section.

Cleanliness, infection control and hygiene

- Systems and processes were in place for the decontamination of reusable medical devices. The Department of Health (DoH) Health Technical Memorandum (HTM) 01-06, provided best practice guidance on the decontamination of endoscopes. Endoscopes are lighted, flexible instruments used for the examination of inside the body. The processes adapted at Pinehill Hospital were in line with DoH recommendations, which meant there was a clear system in place regarding the tagging and numbering of endoscopes and their traceability. An external company audited the scope tracking system annually. The service completed an audit by the Institute of Healthcare Engineering and Estate Management (IHEEM) in July 2018 which looked at the decontamination of the scopes. This audit showed good compliance and achieved a rating of 'green' which was the best rating. Any issues with decontamination were discussed within the hospital infection control committee.

Not sufficient evidence to rate

Medical care

- The endoscope washer-disinfector (EWD) was audited on an annual basis by the national decontamination lead and regular cleaning audits were performed. The compliance of the EWD was audited as part of the IHEEM audit in July 2018 and was found to be satisfactory. Daily tests of the EWD washer were performed by endoscopy staff and weekly checks were done by the hospital engineer.

Environment and equipment

- Staff had training on specific endoscopic equipment from manufacturers' representatives who attended the department. For example, the staff had received training on the endoscope cleaning system from the company who manufactured it.
- The endoscopy equipment was dated which was raised as a concern by consultants. This was discussed in the endoscopy specialty meeting in November 2018. Pinehill are on the corporate list for an equipment upgrade as part of a project. There was no date as to when the equipment would be upgraded.

Assessing and responding to patient risk

- The hospital used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. There was a WHO 'safer endoscopy checklist' used in the endoscopy procedure room. We looked at two endoscopy patient records and saw for both patients the WHO checklist had been carried out appropriately.

Nurse staffing

For the endoscopy procedure room, planned staffing levels were two registered nurses and one health care assistant (HCA). In the recovery area, there were two registered nurses; these were trained recovery staff from the theatre department. During our inspection, we found that the actual staffing met the planned staffing levels.

Medical staffing

- This aspect of the service was not inspected.

Records

- See information under this sub-heading in the Surgery Report section.

Medicines

- This aspect of the service was not inspected.

Incidents

- This aspect of the service was not inspected.

Safety Thermometer (or equivalent)

- This aspect of the service was not inspected.

Are medical care services effective?

Not sufficient evidence to rate

This domain was inspected but not rated.

Evidence-based care and treatment

- The endoscopy service was awarded the Joint Advisory Group (JAG) accreditation in April 2014. This is a governing body that assess the quality and standards of endoscopy services in relation to patient care. Following the annual review in 2018, the service was not able to demonstrate adherence to all of the JAG standards. Their accreditation status was deferred for six months and changed to 'assessed: improvements required'. They were not adhering to six standards and had to demonstrate adherence to these standards by April 2019. The standards they needed to meet were to evidence: (i)use of the global rating score, (ii)completion of an in year IHEEM audit, (iii)collecting and acting on feedback from the workforce, (iv)processes were in place to review key performance indicators, (v)processes were in place to review morbidity and mortality related to endoscopy, and (vi)patients were involved by seeking their feedback. The service had created an action plan and at the time of inspection had completed four out of the six actions with the other two in progress.

Nutrition and hydration

- This aspect of the service was not inspected.

Pain relief

- This aspect of the service was not inspected.

Patient outcomes

- This aspect of the service was not inspected.

Competent staff

Not sufficient evidence to rate

Medical care

- Staff reported within the October 2018 endoscopy staff survey that they would like to receive further training such as cannulation and attend an endoscopy course. Staff were due to attend the course but the planned dates had been cancelled. The manager was planning to rearrange these.
- Staff within the department were skilled. The nurses were able to perform different roles such as scrub and anaesthetic.
- The endoscopy staff at times worked in the other theatres, not endoscopy. Staff said that they would prefer to be rostered to work only in endoscopy to develop their skills and provide continuity of care.

Multidisciplinary working

- This aspect of the service was not inspected.

Seven-day services

- This aspect of the service was not inspected.

Health promotion

- This aspect of the service was not inspected.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw two sets of patient records which evidenced that informed consent had been appropriately sought from patients undergoing endoscopy procedures.

Are medical care services caring?

Not sufficient evidence to rate

This domain was inspected but not rated.

Compassionate care

- Patients completed a friends and family test (FFT) related to their experience in the endoscopy department. The results of this were discussed in the theatre team meeting in September 2018. Staff stated that the completion rates for June 2018 were poor with only 33 patients completing the forms. This had been discussed with the day surgery unit to assist with handing the forms out and encouraging completion. There had been an improvement in the number of responses received, with 89 in October 2018 and 78 in November 2018. 100% of patients were extremely likely to recommend the gastroenterology service in November 2018. Comments from the survey included: "Extremely friendly staff, process was very quick, completely comfortable", "Friendly, clear instruction and efficient. Flexible to accommodate around work and travel commitments" and "everyone is kind and helpful". Results of these feedback surveys were discussed in the endoscopy specialty meeting in November 2018.

Emotional support

- This aspect of the service was not inspected.

Understanding and involvement of patients and those close to them

- This aspect of the service was not inspected.

Are medical care services responsive?

Not sufficient evidence to rate

This domain was inspected but not rated.

Service delivery to meet the needs of local people

- This aspect of the service was not inspected.

Meeting people's individual needs

- There was a dementia link nurse was also the learning disabilities link nurse. However, not all patients with learning disabilities were flagged in advance if they had come through a GP direct access route. This was when a GP could book a diagnostic endoscopic procedure directly, meaning the patient did not follow the pre-assessment process. In this situation the link nurse could not find out what adjustments patients might need, for example, putting them first on the list or speaking to them beforehand to offer some reassurance.

Access and flow

- The hospital monitored the number of cancellations and procedures were only delayed or cancelled when necessary. Any patients who were cancelled were rebooked as quickly as possible. Cancellations were discussed within the clinical governance committee meetings and actions for improvements were put in place. For example, they reported that in July 2018 three

cancellations were due to an issue with the boilers. This meant they were unable to wash the endoscopes appropriately. They had since replaced the faulty part and put plans in place for a new boiler room, with work to commence in spring 2019. Meeting minutes for September 2018 stated that cancellation rates remained high; the reduction in cancellations on the day was one of the clinical priorities for 2018/19.

Learning from complaints and concerns

- This aspect of the service was not inspected.

Are medical care services well-led?

Not sufficient evidence to rate

This domain was inspected but not rated.

Leadership

- See information under this sub-heading in the Surgery Report section.

Vision and strategy

- See information under this sub-heading in the Surgery Report section.

Culture

- The service undertook a staff endoscopy survey in October 2018. All staff reported that they had good support from the endoscopy lead and felt that they worked very hard in the department. The staff felt that the whole team were supportive of each other. All staff felt valued within their current roles.
- All staff were extremely positive and engaged in their roles and enjoyed working within what they described as 'a close-knit team'. Staff felt they were able to provide a high standard of care.

Governance

- An endoscopy specialty meeting was held on a quarterly basis. It was attended by the head of clinical services, theatre manager, endoscopy lead and endoscopy consultants. There was good attendance in November 2018. There were standard agenda items including, actions from previous meetings, planning and productivity, equipment, JAG reports and audits, patient feedback and decontamination. The minutes from November 2018 showed proactive management of the service and development of actions to rectify issues. For example, the endoscopy lead had received administration rights to the computer system and this meant they were able to run more reports. This meant that the collation of information for JAG would be a simpler process.

Managing risks, issues and performance

- See information under this sub-heading in the Surgery Report section.

Managing information

- See information under this sub-heading in the Surgery Report section.

Engagement

- See information under this sub-heading in the Surgery Report section.

Learning, continuous improvement and innovation

- See information under this sub-heading in the Surgery Report section.

Good

Surgery

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

Information about the service

Pinehill Hospital is operated by Ramsay Health Care UK Ltd. The hospital wards have 37 beds which were spread across two floors. This included 13 beds on the first floor, and 12 on the second floor. There was also a purpose-built day case unit on the first floor which includes six "PODS" and six bedrooms. The hospital has three theatres (with laminar flow) and an endoscopy unit minor procedure theatre.

The hospital offered a full range of specialities including orthopaedics, urology, general surgery and cosmetic surgery.

There had been 7,880 visits to theatre from August 2017 to July 2018, 1463 inpatients attendances and 6417 daycase attendances.

During the inspection, we visited the surgical service. We spoke with twenty-five members of staff including; ward and theatre managers, staff nurses, sisters, operating department practitioners, health care assistants, medical staff, and senior managers. We spoke with five patients. We also reviewed six sets of patient records.

Are surgery services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

- Staff did not always assess the risks to patients so they were supported to stay safe. We found inconsistencies with the completion of risk assessments post-operatively. This meant that staff may not always be aware of patients at risk which could lead to patient harm.
- The service mostly had enough staff with the right qualifications, skills, training and experience. However, at night there were additional wards opened without minimum staffing levels achieved. We were not assured that staffing levels were always safe at night when a second ward area was opened.
- The service provided mandatory training in key skills to all staff. However, training compliance for ward staff was slightly below the hospital target for modules such as basic and immediate life support.

However:

- The service controlled risk of infection well. Staff kept themselves, equipment and the premises clean.
- The service had suitable premises and systems to ensure that equipment was well looked after.
- The service prescribed, gave, and recorded medicines well. Patients received the right medication at the right dose at the right time.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had completed safeguarding adult and children's training and had achieved above 99% compliance for safeguarding levels one and two in both theatres and the ward.

- The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment all the time.

Mandatory training

- **The service provided mandatory training in key skills to all staff.** However, training compliance for ward staff was slightly below the hospital target for modules such as basic and immediate life support.
- The service had a mandatory training programme for all staff. This included topics such as basic life support, infection control, manual handling, fire safety, data protection and safeguarding. The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. For example, clinical staff received training in adult immediate life support and non-clinical staff completed basic adult life support training.
- Training was provided using e-learning courses as well as some face-to-face sessions. Training dates were displayed within the staff rooms for up and coming training. Managers checked staff compliance using a spreadsheet, which showed the staff training status. The head of each department was responsible for ensuring the staff attended mandatory training. Staff within the service understood their responsibility to complete training.
- The overall compliance for mandatory training for the clinical staff on the ward was 90% and for theatres was 96%. The hospital target for completion of mandatory training was 95%. Nine out of 21 modules for the wards and 13 out of the 21 modules for theatre staff achieved above compliance. The ward staff were below 95% for basic and immediate life support. This was discussed at November 2018 clinical head of department meeting and further department training was to be arranged.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) recommends that all specialist staff within theatre recovery areas have appropriate training in advanced life support (ALS). The recovery area was always staffed with a nurse who had completed training in ALS.
- Two senior sisters based on the wards had completed ALS training. This was not a requirement but they had completed this to add additional support to the nursing teams. They had also become trainers for Acute Illness Management (AIM) training so were able to provide onsite training for clinical staff.
- The company providing the services of the registered medical officer (RMO) were responsible for ensuring they had the appropriate mandatory training, which included ALS.
- The hospital had a mandatory training policy which was one of the Ramsay Health Care UK group policies. The policy set out mandatory induction and ongoing training requirements for all staff. The policy contained a mandatory training matrix tool which listed all the mandatory training determined as necessary for each group of employees. The matrix also indicated the frequency at which that training should be repeated and the appropriate delivery method. Training was delivered through face to face sessions and an online e-learning system.
- The hospital had a human resources coordinator who was responsible for overseeing the hospitals mandatory training compliance. The coordinator set up face to face training sessions with training providers and heads of departments were responsible for booking staff onto training sessions. The coordinator recorded attendance at face to face training sessions using a tracker which was kept on a shared drive and available for all staff to view. All staff had an individual login for the e-learning system in order to access online training sessions and view their compliance. The coordinator produced monthly reports for face to face and e-learning training compliance which were sent out to heads of departments. Reports were also sent to the senior leadership team for discussion at clinical governance meetings. At the time of inspection, overall training compliance across the hospital for face to face and e-learning sessions combined, was 89%. The hospital target for training compliance was 95%.

Safeguarding

- **Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.** Staff had completed safeguarding adult and children's training and had achieved 99% compliance which was above the hospital standard of 95% for safeguarding levels one and two in both theatres and the ward.

- There were processes and practices in place to safeguard adults and children from avoidable harm, abuse, and neglect that reflected relevant legislation and local requirements.
- Staff told us what steps they would take if they were concerned about potential abuse to their patients or visitors. The hospital had a named safeguarding lead for adults and staff said they were accessible.
- Staff received mandatory training in safeguarding of vulnerable adults and children via e-learning courses. Safeguarding training level one and two for the wards was 99% and for theatres was 100%. Safeguarding level three compliance was 100%. All senior clinicians completed training on children's level three safeguarding every three years.
- Prevent awareness training, which explains how to safeguard vulnerable people from being radicalised into supporting terrorism, or becoming terrorists themselves, formed part of the mandatory training. Training figures for the wards showed that only 63.5% of staff had completed their training whereas 94% of theatre staff were compliant.
- There had been no safeguarding concerns about Pinehill hospital reported to CQC in the reporting period from August 2017 to July 2018. A safeguarding incident was discussed within the clinical governance committee in September 2018 and it was dealt with appropriately by the hospital.
- The safeguarding lead held a 'safeguarding supervision' meeting twice a month. This meeting was to encourage and support staff to learn from safeguarding events, through discussion of cases of concern. Learning was identified and shared, and staff were supported to manage difficult situations. The meeting minutes showed discussions of safeguarding incidents, how staff felt and advice provision for handling situations in the future.
- The hospital had a chaperoning policy and staff knew how to access it. Nursing staff accompanied patients while they were having procedures or were being examined by consultants.
- Although staff in the service had received training about female genital mutilation (FGM), as part of their safeguarding children's training, some staff demonstrated a lack of awareness of FGM issues. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Following our inspection, the head of clinical services created an action plan to improve staff knowledge around this and this included a 'learning@lunch' session specifically related to FGM.
- There were adult and children's safeguarding policies in place at the hospital which were Ramsay Health Care UK group policies. The policies included details of how to manage suspected abuse and details of who to contact for further help and guidance. There were flowcharts displayed with a systematic guide of how to make a referral as well as local contact details for safeguarding teams and the local safeguarding boards.

Cleanliness, infection control and hygiene

- **The service controlled risk of infection well. Staff kept themselves, equipment and the premises clean.** Control measures were in place to prevent the spread of infection.
- There were systems in place to prevent and protect people from a healthcare associated infection. This was in line with current legislation from the National Institute for Health and Care Excellence (NICE) Quality Standard 61: Infection Prevention and Control (2014). The ward areas, theatres and other clinical areas appeared visibly clean, tidy and free from clutter. Appropriate handwashing facilities were in place and hand sanitiser gel dispensers were available in corridors, ward areas, bedrooms, and clinical areas.
- The hospital had policies and procedures in place to manage infection prevention and control. Staff accessed policies using the hospital intranet and could demonstrate how these policies were easily available.
- Hand hygiene posters were on display next to all sinks to remind staff of the correct procedure for hand washing. There were bus stop signs to highlight alcohol gel stations around the ward area. Staff had 'arms bare below the elbow' and decontaminated their hands in between patient interventions. Staff were observed following the World Health Organisation (WHO) five moments of hand hygiene guidelines for hand washing. We observed the correct use of person protective equipment (PPE) such as disposable gloves and aprons.

The ward operational audit for July 2018 showed that 90% of staff were compliant with the hand hygiene policy. We spoke to five patients on the ward and they all said that staff were diligent with handwashing prior to contact.

- The service completed monthly hand hygiene audits. The infection control nurse observed up to ten members of staff to see if they were washing their hands at the appropriate moments in line with the five moments of hand hygiene. In July 2018, compliance with the audit standards was 98% and in August 2018 it was 80%. There was an action plan created to improve compliance. It stated that the infection control nurse had retrained the non-compliant member of staff at the time of the audit.
- An environmental infection prevention and control (IPC) audit was completed in October 2018. The ward and theatre both achieved 99% compliance and pre-assessment clinic was 100% compliant.
- The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2018 showed Pinehill achieved 98.4% for cleanliness of the hospital.
- The operating theatre department and ward areas were visibly clean and tidy. The daily cleaning records were completed most of the time. The service had appropriate facilities and systems to meet the National Institute for Health and Care Excellence (NICE) CG74 regarding surgical site infection. Theatre staff cleaned each theatre between theatre cases. However, we observed theatre staff cleaning the theatre before the anaesthetised patient had been transferred out into the recovery room. This meant that there was a risk that not all traces of potential infection were eradicated prior to the next theatre case. Following the inspection, we received an action plan which stated the theatre manager was going to discuss this at the next team meeting to ensure staff were aware of the correct cleaning procedure.
- Theatre cleaning was undertaken by Pinehill contract staff, who cleaned the theatres at the end of every day. They completed a checklist to show which areas were cleaned; this was filled in most of the time.
- All three main theatres had laminar air flow ventilation systems. This was compliant with Health Technical Memorandum 03-01 Specialist ventilation for healthcare premises. This meant there was an adequate number of air changes in theatres per hour, which reduced the risk to patients of infection. For the period from August 2017 to July 2018, there were 20 reported surgical site infections (SSIs). Infection prevention meeting minutes showed that that the reported SSI's were discussed. The theatre manager said they had recently changed their preoperative skin preparation due to a higher number of infections than expected. Patient preoperative skin preparations are used to clean the skin to prevent infection that may be caused by surgery. The ward also provided leaflets about preventing SSIs within their discharge packs and educated patients on their wound care prior to discharge. All ward nurses had completed or were in the process of completing their wound competencies.
- The segregation and storage of clinical waste was in line with current guidelines set by the Department of Health. Sharps containers and clinical waste bags were managed in accordance with the current guidelines. The theatre team were 100% complaint with sharp safety and used safety needles and safety blades.
- Storage of equipment was organised and there was a clear system in place for identifying which piece of equipment was clean.
- The hospital had a lead nurse who specialised in infection prevention. Link nurses in each clinical area supported them. Link nurses were responsible for collating audit data, producing actions to address any non-compliance and attending the quarterly infection prevention control (IPC) meetings. The infection prevention nurse also carried out audits to ensure standards were maintained and that audit results were reliable. The infection prevention nurse networked with other infection control nurses within the Ramsay group. This meant that good practice and any themes or concerns could be shared.
- The IPC annual report, produced in February 2018, showed the hospital was 100% compliant with their reporting of surgical site infections. There were a total of 15 surgical site infections from July 2017 to June 2018. There were no reported cases of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) or E.Coli

- Patients using the service had a lower rate of infection than the national average for hip and knee replacements and total abdominal hysterectomies. Spinal surgery SSI rate was higher at 3.8% than the national average of 1.8%. This was due to the low numbers of surgery completed.
- Care was provided for some patients in bedrooms with carpets. On the first-floor ward area, nine out of the eleven bedrooms had carpet and in the day surgery unit, all six bedrooms had carpet. Staff said that this carpet was wipeable. There was a risk assessment in place for these and a policy for specific spillages, including bodily fluids. Staff would wipe up spillages with water and a chlorine based disinfectant and then request the housekeeping staff to thoroughly clean with the appropriate and recommended cleaning products. Nursing staff said that housekeeping staff came promptly as there was a button in every patient room, which once pressed, highlighted that the room needed cleaning. We were assured that the service had mitigated the risk as much as they were able. There were plans to replace the carpets, but staff were not aware of the specific dates for this.
- Patients completed a medical questionnaire before they attended the hospital for a procedure. The questionnaire contained a section about infection risks including identifying healthcare workers and any previous Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile infections. This meant the pre-operative team could identify any high-risk patients and make any necessary arrangements prior to the patient's arrival. There were no reported cases of MRSA (which is an antibiotic resistant bacteria), or Clostridium Difficile (which is a bacterium that infects the gut and causes acute diarrhoea) at the hospital during the reporting period of August 2017 to July 2018.
- Staff in theatres were wearing appropriate theatre clothing and shoes.
- All reusable equipment was decontaminated off site. There was a service level agreement in place with an accredited decontamination unit, 'the hub'. Decontamination was a standing agenda item for the theatre team meetings. There were some previous concerns about the surgical instrument sets having holes in the outer cover when received back clean from the hub. This was investigated and as a result, the packaging was changed. The infection prevention control committee annual report 2018 reported that the compliance had improved since the change in packaging.
- Staff completed mandatory training in infection prevention annually. Reports showed that ward staff were 87.5% compliant for face-to-face infection control and hand hygiene training and theatres were 89.5% compliant. Theatre staff were trained in the specific 'scrub technique' and the handling of surgical instruments.
- The IPC nurse created a quarterly newsletter called 'Bugline News'. Notice boards displayed the newsletter within the clinical areas.
- Pinehill hospital had an Infection Prevention and Control Committee (IPPC) who met quarterly. There were infection prevention and control leads in all departments and an infection prevention nurse lead who attended the meetings. There were clear lines of accountability for infection prevention and control matters throughout the organisation. The Director with responsibility for Infection Prevention and Control (DIPC) was the Director of Clinical Services. The IPCC endorsed all infection control policies, procedures and guidance, provided advice and support on the implementation of policies, and monitored the progress of the Infection Control Annual Plan. The committee produced an annual report and associated action plan. The IPPC was a sub-committee of the Clinical Governance Committee which ratified policy and recommendations from the IPCC.
- Infection control meeting minutes showed that there was a set agenda which focused on performance against audit results, areas of leaning from incidents or complaints, and training compliance. There was evidence of discussions held and an associated action plan which was reviewed at each meeting.
- The whole hospital had recently been updated with new alcohol gel dispensers and bus stop hand gel stations identified. Dispensers were available in all patient's rooms and there was a stand in the reception area of the hospital so hospital receptionists could ask patients to practice hand hygiene when they arrived.
- Infection prevention control environmental audits completed in April, June and July 2018 showed that

97% of standards assessed across the hospital, were achieved. A hand hygiene audit in September 2018 showed 80% compliance with standards. A cleanliness audit in June 2018 showed 90% compliance with standards.

Environment and equipment

- **The service had suitable premises and systems to ensure that equipment was well looked after.**
- There was sufficient equipment to maintain safe and effective care, such as anaesthetic equipment, theatre instruments, blood pressure, temperature monitors and commodes.
- There was a regular planned maintenance and equipment replacement programme. A business case had been approved for replacement nurse call bells, a replacement fluid warmer for theatre, and a total refurbishment of the second-floor ward area. The refurbishment was ongoing at the time of inspection. However, there was a lack of planned preventative maintenance service records due to a change of provider. This meant the service could not be assured that all equipment had been serviced in line with manufacturer guidelines. This was on the hospital risk register. All equipment that we saw was in date for safety testing and had an up to date service. The theatre lights and the anaesthetic machines required replacing; all had been serviced but were reaching the end of warranty. This was on the risk register and the theatre manager had requested capital in order to replace these items.
- The hospital had three main theatres and one smaller minor procedures theatre. All had the appropriate anaesthetic equipment in line with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidance. All anaesthetic equipment was checked daily prior to use.
- There was appropriate resuscitation equipment available in the case of an emergency. There were resuscitation trolleys in the theatre corridor and on both the ward and day surgery unit. They were all well organised and had a tamper evident seal in place. Records indicated that the trolleys and their contents were checked regularly in line with hospital policy. Theatres also had a difficult airway trolley available. We saw a comprehensive list of items, which were available on the trolley, and a clear checking procedure that was completed daily. The theatres, however, kept out of date flexible videoscopes within the trolley. We raised this with staff who told us that these were only used for training. This meant that there was a risk in an emergency that the out of date equipment was used in error.
- The theatre department had a clear clean and dirty flow for the disposal of clinical waste and used instruments. Policies were in place to support staff in the disposal of waste and we saw that this was managed appropriately.
- The storage of instruments and equipment within the theatre department was well organised, bar coded and regularly topped up. All equipment checked was in date apart from small nasal packing. This was used for paediatric patients and was no longer required in the department. We raised this at the time and the manager immediately disposed of them.
- Patients who needed implants, such as hip prosthesis, had this clearly recorded in their notes alongside appropriate details such as device number and size. This enabled all implanted devices to be tracked in case any faults developed. The hospital also recorded the implants on national registers such as the breast implant register and the national joint register (NJR). It showed which patient received which type of implant and when, to allow simple tracking if needed. The hospital had been recognised by the NJR and been presented with an award for their quality of data inputted.
- Flammable products deemed as hazardous to health should be locked in metal cupboards. However, we found flammable chemicals were stored in a non-metal cabinet within the ward treatment room. We raised this with the manager at the time of our inspection and they removed these immediately.
- There was limited bariatric equipment available on site. The pre-operative staff would order the equipment if required and complete an advanced notification form to alert the ward staff that a patient, who was due for admission, required bariatric equipment. Staff in pre-operative assessment clinics assessed a patient's weight and calculated their body mass index (BMI). The staff said they did not operate on patients who had a BMI above 35.

- The head of clinical services received alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). The MHRA regulates all medical devices and medicines and reports faults to providers. Ward staff said that the head of clinical services disseminated any relevant alerts and they checked the equipment against the alert and removed any affected devices or equipment.
- There was a regular planned preventative maintenance programme carried out on all equipment being used in Pinehill Hospital. This ensured that the equipment being used was safe for use. The hospital management team reviewed equipment during department quality and business review meetings, with heads of departments. Equipment was reviewed in relation to planned replacement and upgrade. Where replacement was identified, a business case was completed and submitted in order to secure required funding.

Assessing and responding to patient risk

- **Staff did not always assess the risks to patients so they were supported to stay safe. We found inconsistencies with the completion of risk assessments post-operatively. This meant that staff may not always be aware of patients at risk which could lead to patient harm.**
- Patients for elective surgery attended a nurse led pre-operative assessment clinic before their operation. During the assessment all required tests were undertaken, for example, MRSA screening, group and save and routine blood tests. This was in line with NICE guidance CG3: Preoperative assessments and NG45: Routine tests for elective surgery (April 2016).
- Every patient who was referred for surgery completed a medical questionnaire. This was either posted to them or they completed it following their appointment with the consultant. This was undertaken prior to the pre-operative stage. The questions included the patient's past medical history, allergies, current medication, and any previous anaesthetics and infection risks. This information was used to decide if the patient needed a face to face pre-operative appointment or a telephone consultation. This also depended on the operation that they were having. A telephone appointment was made for low risk patients needing minor procedures. All patients who had any associated risk factors or were undergoing major operations had a face-to-face appointment.
- Anaesthetists held clinics every Wednesday from 1600 to 1800 and saw patients who were classed as high risk for anaesthesia or had medical conditions that deemed them at risk of developing complications after surgery.
- The service used the American Society of Anaesthesiologists (ASA) classification system to grade a patient's level of risk. For example, ASA1 was low risk and used for healthy patients, ASA3 was a higher risk, and used for patients with severe systemic disease. Grades were recorded during pre-assessment by nurses and on admission for surgery by anaesthetists. High-risk patients are more likely to have complications following surgery, and are more likely to require high dependency nursing following their procedure. Patients identified as being at higher risk or who had complications diagnosed following their test results were referred to the consultant for further review. Patients operated on in the service were classed as ASA1 or ASA2 risk. Patients graded as ASA3 were not accepted, as there were no high dependency beds at the hospital.
- The hospital undertook practice emergency scenarios on both the ward and in theatre run by resuscitation officers. For example, in November 2018, the theatre department held a scenario on malignant hyperthermia. Malignant hyperthermia is a severe reaction that occurs to particular medications used in general anaesthetic. Twelve members of staff attended the scenario. It was discussed in the November 2018 clinical head of department meeting and the feedback highlighted the need for extra dantrolene to be held in the department, which was in place. Dantrolene is a medicine used to relieve muscle spasticity caused by malignant hyperthermia.
- Comprehensive risk assessments were carried out on patients when they were admitted to the surgery service. Nursing staff used nationally recognised tools to assess patient's risk of developing for example, pressure ulcers (Waterlow), nutritional risks (MUST), falls, infection control, as well as risks associated with moving and handling. However, these were not reviewed post-operatively as per the hospital pathway. This meant that there was a chance that patients risks were

not being identified which could lead to harm. We looked at six records out of the 13 patients on the ward and five of these did not have their risk assessments completed post-operatively. The completion of risk assessments post-operatively was not audited as part of the medical records. We raised this with the senior sister at the time and they agreed that these were not done well and would work to improve this. We also raised it with the head of clinical services who stated that they would put an action plan in place to make improvements. The head of clinical services sent the action plan following our inspection. The head of clinical services had put a number of actions in to address the lack of risk assessments including:

- Arranging a number of 'learning@lunch' sessions which focussed on the risk assessments required post-operatively
- Daily rounds by the head of clinical services to review the risk assessments
- Daily oversight by the nurse in charge to ensure risks were re-assessed and mitigation was taken where appropriate
- Creating a local audit to capture each assessment including MUST, VTE, falls and Waterlow and audit compliance weekly until progress had been identified and sustained.

- NICE guidance (NG89) for March 2018 states that all surgical patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Reassessments for VTE and bleeding should be at the point of consultant review or if their clinical condition changed. Risk assessment for venous thromboembolism (VTE) were completed during the preoperative assessment by nursing staff and on admission to the ward. The ward completed a patient journey audit and compliance to VTE risk assessments was 100% for both October and November 2018. It was not clear if the re-assessment post-operatively was audited through this standard. Between August 2017 and July 2018, 95.5% of patients had a VTE risk assessment completed. There were two reported cases of hospital acquired venous thromboembolism during this time. One was three months post-surgery so was found to be unrelated and the other was 22 days post total hip replacement. The analysis of the incident showed that the VTE risk assessment was completed pre-operatively and was reviewed daily post-operatively.

- We looked at six medical records and we found that the VTE risk assessments were completed correctly for three patients. We discussed this with the nursing staff at the time and they stated that they were not sure of how to complete the risk assessment. We raised this with the head of clinical services who stated that they would put in training immediately. We also saw that this had been raised at the ward provider visit. These visits were routinely completed by Ramsay Health Care UK to each of its hospital locations. The action plan within the September 2018 ward meeting minutes stated that they needed to improve knowledge and awareness around VTE. Following our inspection, we saw an action plan for improving compliance. This included increasing learning through e-learning (as compliance was 40%), and through 'learning@lunch' sessions.

- The National Early Warning Score 2 (NEWS2) was used to identify deteriorating patients in accordance with NICE Clinical Guidance (CG) 50: 'acutely ill adults in hospital: recognising and responding to deterioration' (2007). Staff used the NEWS2 to record routine physiological observations, such as blood pressure, temperature, and heart rate. The NEWS2 prompted staff to take further action where appropriate, such as increasing the frequency of monitoring vital signs and requesting a review from the resident medical officer (RMO). NEWS2 was audited within the medical records audit. October 2018 audit results were 100% for the completion of the NEWS2, but there were inconsistencies with the escalation. For example, for patients who scored a total of five or six in their NEWS2 chart, which required escalation, only 80%, had documented the escalation. It was re-audited in November 2018 with an improved overall compliance of 97% for questions relating to NEWS2 completion. The ward head of clinical services also did ad hoc audits of the NEWS2 and addressed shortfalls with training. This was documented in the head of clinical services ward round book. The September 2018 clinical governance committee meeting mentioned that NEWS2 scoring had improved following the training. During our inspection, we looked at eight patient NEWS2 scores and saw that they had been calculated and escalated accurately.

- The hospital had a small blood fridge in theatres where they kept three units of blood for emergency purposes. They also had a service level agreement with a local acute trust for obtaining blood products. In an emergency, the blood in the fridge on site would be used first and they would consider stopping all surgery in other theatres to ensure patient safety. The risk register stated that there was a risk that the blood might not be supplied in time during an emergency haemorrhage situation. Staff said that in November, a patient had required blood products whilst in theatre and they had obtained this from the acute trust within 25 minutes of the request. Therefore, they felt that the responsiveness was good.
- Information was available to help staff identify patients who may become septic. Sepsis is a serious complication of an infection. The service followed guidance from the sepsis trust, such as the use of the sepsis six tool. This is the name given to a bundle of medical interventions designed to reduce the death rates in patients withsepsis. The sepsis six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis. The ward had made a 'sepsis box', which contained equipment for staff to access quickly. Patients suspected of having sepsis would be transferred to the local NHS hospital for ongoing monitoring and treatment. There were also other emergency boxes on site for assisting in an emergency such as a 'hypobox' on the ward and an emergency transfer bag in theatre recovery. The hypobox would be used if a patient had dangerously low blood sugars to administer sugar to the patient quickly and the emergency transfer bag included items needed to assist in the transfer of a patient to an NHS trust.
- Staff were supported by a RMO if a patient's health deteriorated. The RMO was on duty 24 hours a day and was available on site to attend any emergencies. The hospital had a transfer agreement in place with the local acute trust should a patient require a higher level of care. Staff could contact consultants by telephone 24 hours a day for advice or to raise concerns about patient care. The RMO and staff stated that consultants were responsive and supportive. In an emergency, staff called an ambulance and patients were transferred to the emergency department. There had been four unplanned patient transfers to the local NHS trust from August 2017 to July 2018.
- The hospital held a '10@10' meeting where all departments were represented at a daily meeting with the senior management team. They highlighted who was part of the emergency team throughout the day, specifically airway, chest compressions, scribe and the lead. The meeting notes showed that the RMO was always the lead.
- The hospital used the 'five steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. We observed staff follow the WHO checklist and there was no distraction during the process. The theatre staff completed safety checks before, during, and after surgery and demonstrated a good understanding of the procedure. The service audited WHO checklist compliance by observing five patients every month through their theatre journey. Compliance to the WHO checklist throughout the year was consistently above 94%. The most recent audits were 94% and 100% in October and November 2018. Some of the audits showed elements of challenge. For example, the August 2018 audit showed that during the WHO checklist, one consultant tried to leave prior to the debriefing. They were requested to stay by a theatre member of staff until it was completed, which they did. The sustained good compliance with the WHO checklist was discussed in both the MAC meeting and theatre team meeting in September 2018. It was recognised by Ramsay UK that Pinehill were engaged with it and there was high awareness within the theatre team.
- The theatres had a 'list safety officer' who was responsible for ensuring all equipment was available, staffing levels were correct, implants used were right and any changes to the lists were updated in a timely manner. However, changes to the list were not reprinted on different coloured paper; this is best practice and ensures staff were aware of changes made.
- The hospital had implemented the Ramsay UK speaking up for safety programme called 'Safety CODE'. This was an initiative that encouraged and empowered staff to challenge anyone, including senior colleagues, who may be putting patients at risk with their behaviour. We saw

posters for this in all areas. Some staff had completing training on this and stated that they felt confident to raise any concerns with safety. One staff member gave us an example of where they challenged a consultant and they then came to a mutual agreement for the patient.

- There was a safety board outside theatres which detailed the coordinators for the day. This included the advanced life support (ALS) provider, fire marshall on shift and the list safety officers.
- National Safety Standards for Invasive Procedures (NatSSIPs) were available in the theatre department. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). Theatre staff were aware of national and local safety standards. Theatre had updated all their standard operating procedures and their theatre operational policy following the introduction of NatSSIPs and ensured that they were localised for their department. For example, they had introduced a list safety officer to ensure the smooth and efficient running of the operating list as per the Ramsay policy updated following NatSSIPs.
- The surgical service complied with the Association for Perioperative Practice (AfPP) guidance for assessing and responding to patient risk for all surgical areas. This included ward admission, anaesthesia, surgery, and recovery. There were sufficient staff on duty during the patient's surgical procedure, which included surgeons, anaesthetists, and operating department practitioners. This was in line with AfPP guidance, which meant the service had assessed the risk to patient's undergoing surgery.
- Each patient room and bathroom had emergency call bells to be used to alert staff when urgent assistance was required. These were tested daily to ensure they were fit for purpose. The emergency call bells were linked up to a number of emergency bleeps. The RMO, head of clinical services and the most senior clinician in the ward and theatre areas carried these.
- Patients with known allergies wore a coloured wristband, which acted as an alert to staff providing care and treatment. Allergies were documented in the patient's notes.
- Patients were given the ward telephone number to ring in the event of any issues or to ask questions. Telephone enquiries were documented and filed in the patient's notes and further appointments were made if required. For example, if they needed a wound check they were seen in the outpatient department the next day.
- Nursing handovers occurred three times a day and included discussions around patient needs, medication, present condition and the plan for discharge. If patients needed transfer to another facility, the staff would use the 'situation, background, assessment, recommendation' (SBAR) approach, and document in the patient's records. No patients needed transfer during our inspection so we were unable to observe this in practice.
- Resuscitation was a standing agenda item on the clinical governance committee. For example, in September's meeting, they discussed the new nurse call system and a standard operating procedure that was due to be issued which including daily testing.

Nursing and support staffing

- **The service generally had enough staff with the right qualifications, skills, training and experience. However, at night there were occasions when additional wards were opened without minimum staffing levels being achieved. We were not assured that staffing levels were always safe at night when a second ward area was opened.**
- Staffing and skill mix during the day were planned so that patients received safe care and treatment. The service did not use a safer nursing care tool to measure patient acuity as all patients were of similar dependency due to the hospital only admitting patients with ASA1 or ASA2. Staff shifts were planned by looking at the daily activity. This included the number of theatre cases booked and whether they were major or minor procedures. This helped to assess the correct number of nurses required for each shift.
- The hospital held a projection meeting on a Tuesday, which looked at the following two weeks activity within theatres and the wards. The head of clinical services, theatre manager, senior ward sisters, lead for theatre bookings and, at times, the hospital director attended

this. This allowed managers to review staffing levels and theatre start times and flex up and down in line with patient numbers and the acuity of patients planned for admission.

- The ward used a ratio of 1:7 for planning staffing levels. They used an electronic roster management system to effectively manage the rota and staffing requirements. This allowed managers to manage sickness absence, annual leave and allocation of shifts. Planned staffing for the wards during the day were three registered nurses, including the senior sister to coordinate, and two health care assistants (HCA). At night, two registered nurses were required and there were no HCA's on the night shift. The day surgery unit (DSU) was staffed by two registered nurses, the ward sister and a HCA during the day. Staff told us that at times, additional beds on DSU or the second floor were required to open overnight if there were no beds available on the main first floor ward. The hospital director and head of clinical services told us that only low risk patients would be cared for in the additional areas. Staff told us that there were usually two or three patients overnight in these areas, and that this would usually be staffed with just one additional trained nurse. The two nurses from the first-floor ward would offer support to this nurse if required, but otherwise they would work alone. Three nurses we spoke with, talked to us about overnight staffing. They all told us that they felt using only one nurse in the additional area was unsafe. We saw in September 2018 ward staff meeting minutes there was an action to follow up from the July 2018 team meeting related to overnight staffing. The minutes stated that staff found it very challenging to take breaks when the second floor was open. The action had been marked as complete due to the second floor being closed for refurbishment, although there was no evidence of action plans for the staffing issues raised or acknowledgement of staff concerns about overnight staffing levels. One staff nurse told us that they had been on the night shift by themselves on the second-floor ward with a patient who had undergone a joint replacement. This meant that if the patient required assistance of more than one nurse, for example, to be assisted to the toilet/commode, then the nurse had to rely on the floor one nurses being available to assist. This would leave patients on floor one under the supervision of only one nurse. The patients on the first-floor ward were post-operative patients of a higher dependency than those on the second floor or DSU. If one of the two nurses on the first-floor ward was called away to help the lone nurse in the additional area, this would leave up to 13 patients with only one nurse for support. If one nurse was called away to a medical emergency these patients could be left with inadequate support for a significant length of time, which would be a risk to their safe care. We asked if overnight staffing was on the risk register and found that it was not, however, the senior sister added this to the risk register at the time of the inspection.We raised overnight staffing concerns with the head of clinical services and hospital director at the time of the inspection who initially told us that there would always allocate two nurses to staff any additional areas opened overnight. The head of clinical services did go on to say later, that there may be an occasional time where there was only one nurse allocated to an additional bed area overnight, but they would be supporting only one low risk patient. We were not assured that staffing levels overnight in extra areas were always safe so we asked for additional information following our inspection. The data provided for overnight staffing showed that, from September 2018 to October 2018, when an additional area was opened, on eight out of nine occasions there was only one member of staff allocated to the additional area. On these eight occasions, rosters showed that there were only three nurses on shift overnight across the hospital. This meant that the additional area was only staffed with one nurse, as there were always two staff allocated to the main ward. There were between one and four patients overnight, on the nine occasions when the additional area was open. On seven out of the nine occasions, there were two or more patients in the additional area overnight.The hospital provided a risk assessment dated September 2017 that stated if patient activity exceeded five patients on the additional floor, a second member of staff would be rostered to work. However, we did not see any occasions during the reporting period when there were more than four patients in the additional areas overnight. We discussed with senior leaders our concerns that patient's care needs may be unable to be fully met where nurses were working alone. We expressed concerns about safety of patients due to the chance that the nurse working alone may find it difficult to summon assistance. We also raised concerns that staff had told us it felt unsafe to work alone in the

additional areas. The hospital director told us that risk assessments were completed before and after each additional area was opened and that the integrated nurse call system helped mitigate any risk. We asked to see the risk assessments and the hospital director told us that the risk assessments undertaken had not been documented as they were part of the day to day decision making process during the 10@10 meeting. The hospital director also told us that there were escalation processes in place, which would mitigate any risks associated with staffing. These included, that the RMO and Senior Nurse on call would be asked to attend site urgently in the event of an emergency. Additionally the senior manager on call would be contacted. The hospital director told us that the escalation processes had never been required or instigated since they were introduced in September 2016.

- Although there is no national standard for minimal staffing levels in independent hospitals, on review of the information provided, we were not assured that staffing levels when additional areas were opened overnight, could always meet patient needs and were therefore potentially not always safe.
- The operating department used guidance set out by the Association for Perioperative Practice (AfPP) in 2015 related to safe staffing levels; 'Safe Staffing Levels for the Peri-operative Environment as a staffing tool (2015)'. Theatre staffing levels were also based on nationally recognised guidelines such as the Association of Anaesthetists of Great Britain and Ireland (AAGBI) and the British Anaesthetic Recovery Nurses Association (BARNA). Staff in theatre each day included an operating department practitioner (ODP), three 'scrub' registered nurses and a health care assistant (HCA).
- The theatre department had one full time equivalent (FTE) scrub nurse and one ODP posts vacant. They had employed two apprentice nurses who were training at present and were continuing to recruit. The staff turnover was high at 53% for nursing staff and 41% for ODPs and HCA's. The theatre manager stated that recruitment and retention was the biggest risk to the department.
- There were no vacancies within the ward areas at the time of our inspection.
- Bank and agency nurses were usually regular staff who were familiar with the hospital. Staff were recruited from specific agencies with which the hospital had a preferred provider arrangement. This ensured that these staff met key requirements such as having completed mandatory training. New agency staff received an orientation of the service, which included access to, and the location of emergency equipment and fire exits. The theatre manager also stated that any new agency staff worked alongside senior staff.
- The average agency use for the wards from January 2018 to November 2018 was 9.6%. The average theatre agency usage from January 2018 to September 2018 was 8.8%. Managers stated that recruitment was a challenge and at times they relied on bank and agency staff. This was identified as being an issue due to the hospital's location, as it was close to London where salaries included London weighting allowance.
- The sickness rate was between 3.4% and 7.9% for all clinical staff in the wards and theatres.
- Senior staff confirmed they maintained a focus on recruitment and retention activities across the surgical service. Staffing levels and recruitment was included on the local risk register.
- The hospital reported registered nurse staffing vacancies in theatres and inpatients. There were no vacancies for health care assistants for inpatients, although there were vacancies in theatre for operating department practitioners and health care assistants. There were no vacancies for registered nurses or health care assistants in outpatients. Any gaps in staffing were covered through use of bank and agency staff. The use of bank and agency staff, across inpatients, theatres and outpatients, as a share of total staffing, was between 2.5% and 50.1% during the reporting period from July 2017 to June 2018. There were no unfilled shifts during this period.
- The hospital used an electronic rostering management system to manage rotas, staffing requirements, skill mix and senior cover. The electronic roster allowed managers to manage allocation of shifts through review of staffing levels each day to flex up and down in line with patient numbers and the acuity of patients planned for admission. In addition, medical records (including the pre-op assessment records) were used to

ensure adequate staffing levels to meet the acuity and dependency of patients. The ward area used the current Royal College of Nursing staffing guide of a nurse to patient ratio of 1:6.

Medical staffing

- **The service had enough medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment all the time.**
- Patient care was consultant led. All consultants provided a 24-hour on-call cover for patients post-operatively and were within a 30 minutes' drive time of the hospital when off site. All consultants were employed through practicing privileges. Practicing privileges were granted to doctors who treated patients on behalf of an organisation, without being directly employed by that organisation. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS.
- Consultants had a responsibility to ensure suitable arrangements were made with another approved practitioner to provide cover if they were not available, for example when they were on holiday.
- There was an up to date out of hours on call list for consultants. Most consultants worked in speciality groups and provided cover for one another. Staff told us that the on-call rota worked effectively and consultants were accessible when required.
- Anaesthetists were expected to be available for 48 hours after performing surgery in case a patient, whom they had anaesthetised, became unwell. Anaesthetists also provided cover for each other and the ward teams were aware of a rota to refer to if required.
- Register medical officers (RMOs) were employed through an agency, who submitted a file including evidence of pre-employment training before the arrival of each RMO. This was reviewed and signed-off by the head of clinical services and usually the Medical Advisory Committee (MAC) chairperson. RMO's worked a rota of one week off and one week on, 24 hours a day, which was coordinated through the agency. There was a procedure in place if the RMO required relief from their shift. The RMO stated that they were rarely contacted overnight. The RMO had received induction training. Their duties included monitoring patients in the wards, prescribing medications, cannulation, taking blood samples and responding to emergencies.
- The RMO said they felt supported by the ward staff and medical teams and they could contact the consultant or anaesthetist responsible for a particular patient if further advice or support was needed. The RMO attended the nurse handover daily.
- The hospital maintained a medical advisory committee (MAC) whose responsibilities included ensuring any new consultant was only granted practising privileges if deemed competent and safe to practice. The decision to allow practising privileges was agreed at the MAC meeting which met bi-monthly. We reviewed MAC meeting minutes and saw that consultants practising privileges were discussed. It was a requirement of the Ramsay practising privileges policy that consultants remain available both by telephone and, if required, in person or arranged appropriate alternative named cover if they were unavailable. This was to ensure that a consultant was always available to provide advice or review patients when there were inpatients in the hospital.
- There were 163 consultants working under practising privileges at the hospital; none were directly employed by Pinehill. Practising privileges consultants were fully regulated by the appropriate professional body and worked under the 'Facility rules' and the Ramsay policies. Consultant practice was reviewed and monitored by the hospital. Consultants wishing to apply for practising privileges were required to complete pre-employment checks in order to confirm that they were fit to practise in the role. Details were then passed to the central Ramsay Health credentialing committee who kept a central database of all consultants with practising privileges. Documentation relating to practising privileges was reviewed on an annual basis. In addition, the Hospital Director held a weekly meeting with his personal assistant (PA) to review any outstanding credentialing concerns or requests for updated information to ensure appropriate assurances were provided. If assurances could not be provided, practicing privileges would be suspended. No staff had their practising privileges removed during the reporting

period. During inspection we reviewed the files of five consultants with practising privileges at the hospital and saw that all included the evidence required in line with the facility rules document.

Records

- **Staff kept appropriate records of patients' care and treatment.** Records were clear, up-to-date and easily available to all staff providing care. However, not all risk assessments were reviewed and recorded post-operatively.
- The hospital used a paper-based system for recording patient care and treatment. These were stored securely to protect confidential patient information in each area we inspected. NHS patient's records were available for patients whose treatment was funded by the NHS.
- We looked at eight sets of patient's records, including two from the day surgery unit, and saw that they were generally legible, up to date, and stored securely.
- The service completed a monthly and quarterly audit of medical records. Data submitted showed between 79% and 99% overall compliance with criteria across all services in the hospital. At the quarterly audit, any section that was below 80% was re-audited monthly. Each audit included a list of any actions identified for improvement.
- Clear pathway documents were used throughout the patient journey. Risk assessments were completed from the start of the patient's journey in pre-operative assessment through to admission on the wards. Risk assessments included VTE, nutrition, pressure care, falls, moving and handling and infection control risk. The risk assessments however, were not always completed post-operatively when a patient's condition had changed.
- There were surgical pathways in place; part of the pathway included preoperative assessments. The assessments were carried out in line with NICE guidance. These guidelines were in use within the clinic. We reviewed a sample of these and found that they were completed thoroughly.
- Patient records had stickers, which identified the equipment used, and the serial codes used for implants, for example replacement hip joints. This enabled patients to be tracked and equipment identified if a problem became apparent later.
- Nursing staff sent discharge summary letters to GP's following a patient's discharge. This gave details of the operation performed and any medication required as a continuation of their care. Consultant contact details were provided to GP's so they could contact them for further advice if required.
- Healthcare assistants (HCAs) on the ward completed and recorded intentional care rounding. Intentional care rounding is a structured process with staff carrying out regular checks with individual patients at set intervals. For example, we observed HCAs visiting patients to check that call bells and drinks were within reach and asked if the patient was comfortable or in any pain. We saw these were documented in the patients' records reviewed.
- There was a medical records management policy in place at the hospital which was a Ramsay Healthcare UK group policy.

Medicines

- **The service prescribed, gave, and recorded medicines well. Patients received the right medication at the right dose at the right time.**
- The hospital had an onsite pharmacy. This was open Monday to Friday 0830 to 1800. A clinical pharmacist from the local NHS trust was on-call 24-hours a day, seven days a week to advise and support staff as needed. In addition, the registered medical officer (RMO) and nurse in charge, could access stock items from the pharmacy in an emergency. Stock was accessed using a dual key system and code, to check and sign medications out against the prescription. Medicines for patients to take home were stored in a specific cupboard on the ward. These had to be checked by the RMO and the nurse before dispensing.
- The hospital employed a pharmacist and pharmacy technician who provided a full outpatient dispensing service daily. Additionally, there was a dedicated ward pharmacist for four hours each day to provide medicine reconciliation, screening, TTO dispensing and patient

counselling for their discharge medicines. Staff stated that the pharmacy team were very helpful and visible in the ward area. A team of pharmacy technicians also managed the procurement and supply of medicine stocks. Out of hours emergency cover was provided by the on-call pharmacist at the local Trust.

- Staff followed procedures for the safe administration of medicines in line with guidance from the Nursing and Midwifery Council, safe medicines management. Staff had good knowledge of safe medicines management and had access to the hospital's medicines management policy on the intranet. The policy covered obtaining, recording, using, administration, and disposal of medicines.
- The consultants used their local NHS trust antibiotic prescribing guidelines in line with national guidelines. The medication charts had a specific antibiotic prescribing section, which only allowed an antibiotic to be prescribed for three days, and then prompted a review. The nursing staff stated that since these had been implemented, they were able to get antibiotics reviewed more promptly.
- The pharmacy department completed regular audits and acted upon the results. There was a monthly medicines reconciliation audit, medicines management audit, medicines prescribing audit and a controlled drugs audit. These audits generally scored well. However, there were some compliance issues with the monthly medicines reconciliation audit. Results provided by the hospital prior to our inspection showed that there had been a consistent decrease in compliance from 96% in July 2018 to 77% in September 2018. The reason for the decrease in compliance was attributed to a new medication chart being implemented. We reviewed six medicine charts, and saw that all medications were correctly prescribed, administered, and that there was evidence of medicine reconciliation.
- Medicines, including controlled drugs (CDs), were stored safely and securely in theatres and on the wards. No medication was left unattended whilst we were observing in theatre. Staff carried out twice daily checks on CDs and medication stocks to ensure medicines were reconciled appropriately. These checks had recently increased from daily to twice daily on the wards due to an incident in November 2018. There had been no further problems reported.
- The controlled drug keys for theatre were kept in a safe overnight when the theatre was closed and a log was kept for this. This log was not completed for the month of December 2018. The key code for the CD key safe was changed monthly.
- Staff monitored and recorded temperatures of fridges used to store medicines and of the ambient room temperature in the clean utility rooms where other medicines were stored. We reviewed fridge temperature record checks. These showed that fridge temperatures were checked daily to ensure they were in line with the correct temperature range. Medicines that required storage at temperatures below 8°C were appropriately stored in medicine fridges. Staff knew what to do if fridges were out of temperature range. We saw however, that the ambient room temperature for the clean utility room was measuring at a maximum of 65°C and no action had been taken. This was raised immediately with the nurse in charge who escalated it appropriately.
- Emergency medications were stored in secure containers on the resuscitation trolleys. These were all in date. There was a poster in each clinical area, which listed where all the emergency medicines were stored within the hospital. Staff said that they found this helpful.
- All medication checked was in date. Patients own medications were collected on admission, stored in numbered plastic storage containers and locked away in the clinical room.
- The pharmacist worked in collaboration with the clinical team to provide training and ensure that medicines were managed well. They held a monthly 'learning@lunch' where they talked about recent incidents or did training on certain topics. The pre-operative nurse had attended one centred on antibiotics and had learnt that people could grow out of antibiotic allergies.
- There was no piped oxygen in nine out of the eleven rooms on the ward. This meant that there were a number of oxygen cylinders kept on the ward. They were all stored safely and were checked daily. Staff did not

feel that the lack of piped oxygen was a risk to the patients as all patients were ASA1 and ASA2 and were only transferred back from recovery once they were stable.

- Anaesthetic drugs were drawn up in syringes and prepared ready for use on the next patient. All syringes were labelled as per hospital policy.
- Surgery was the main service inspected and this medicines information also relates to other services.
- There were eight medication incidents reported between April and June 2018 and 10 medication related incidents between July and September 2018. We saw that following investigation of incidents, the pharmacy team provided education, advice and support to staff to reduce the likelihood of further incidents. These were shared with staff on a monthly feedback through a shared learning newsletter completed by the head of clinical services.
- There was oversight of all activity related to medicines management through the clinical governance committee structure. Medicines related incidents and audits were standing agenda items for these meetings.

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.** Managers investigated incidents and shared lessons learned with the whole team. When things went wrong, staff apologised and gave patients honest information and suitable support.
- Staff were aware of the process for reporting any identified risks and incidents. Incidents were logged on the hospital's electronic reporting system. Staff told us they were encouraged to report incidents. Staff could discuss incidents they had reported and gave examples of how they received feedback, for example, if a medication error occurred where a nurse had signed for a medication without administering it. All staff were reminded to only sign for medication once it had been administered.
- The service had several methods to ensure lessons learned from incidents were shared and disseminated. Examples included:
  - The head of clinical services completed a monthly 'incident feedback shared learning' report which detailed every incident within the hospital and identified trends. These reports were shared on the notice boards and most staff reported that they received feedback from incidents.
  - Information was shared with staff through a closed group within a social media platform. This system enabled staff to access information from their mobile phones.
  - Team meetings and daily handovers were used to share information and learning.
- There had been 190 clinical incidents reported from August 2017 to July 2018 by theatres and the wards. Each incident had been reported and investigated in accordance with the service's procedure for incident management. There was an incident in theatre where blood transfusion was given without being signed for by two people. This was highlighted as an incident, discussed in the theatre team meeting in detail, further blood transfusion training had been added, and all agency staff were to be trained.
- Reported incidents were reviewed and investigated by the ward and theatre managers. Serious incidents were investigated by staff with the appropriate level of seniority, such as the head of clinical services. Lessons were learned from serious incidents and changes were made to the service. One of the serious incidents reported met the criteria for a never event, as during an orthopaedic surgical procedure an incorrect sized prosthesis was implanted. We saw that the never event had been fully investigated. During the root cause analysis contributory factors were identified and the lessons learnt, recommendations for future practise and an action plan were documented. Implementation and monitoring of the actions was over seen by the head of clinical services. In addition, actions were monitored and updated at the clinical governance and medical advisory committees and the theatre departmental meetings.
- Serious clinical events were a standing agenda item on the clinical governance committee meetings. In September 2018, they discussed that the numbers of incidents were decreasing and most of them had resulted in no harm.

- Most staff across all disciplines were aware of their responsibilities regarding duty of candour, and the process was applied in accordance with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities). For independent providers, the duty came into force on 1 April 2015. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. We looked at two serious incidents and there was evidence of understanding of the duty of candour. The consultants involved spoke to the patients as soon as they became aware of the incident and apologised. Patients were also formally written to as the regulation required.
- The head of clinical services told us that a log was kept of when DOC had been considered and documentation of when it had been applied. The log was shared occasionally with Heads of Department for discussion to maintain awareness of the DOC process.
- Any patient deaths were reported via the clinical governance committee and the MAC. There had been two deaths between August 2017 and July 2018.
- The hospital had a policy for incident reporting, which was a Ramsay Healthcare UK group policy. There was a system for reporting and managing incidents which all staff had access to. The system scored incidents from one to four according to severity, with one being the most severe and four being the least severe. All incidents were reviewed by the hospital director and head of clinical services. Incidents scoring level one or two were also escalated to the corporate team for review. Heads of departments were responsible for completing incident investigations, which they received training to do during their induction.
- The head of clinical services kept a tracker of all incidents reported, which was used to produce a monthly report of numbers of incidents by severity and department. We saw that themes and trends of incidents were produced and actions required or taken were listed. The report was fed back to heads of departments each month for discussion at team meetings and sharing of learning.
- The head of clinical services told us that the hospital tried to close incidents within a month, unless they were complex. However, incidents would not be closed until there was evidence of full investigation, completion of actions and sharing of learning.
- There were a total of 412 incidents reported by the hospital from July 2017 to June 2018. There were 286 clinical incidents, and 126 non-clinical incidents. The clinical incidents were categorised by level of patient harm. There were 245 incidents of no harm, 35 of low harm, five of moderate harm, none of severe harm, and one death.
- Hospital data showed that from July 2017 to June 2018 there were three incidents reported which met the criteria for serious incidents. We saw that these were all investigated through a root cause analysis process and actions taken to prevent reoccurrence. All of these incidents were reviewed by the local CCG serious incident review panel and had been closed.

Safety Thermometer (or equivalent)

- **The service collected safety monitoring results but the results were not always shared with staff and patients.**
- Staff were not aware if the safety thermometer was done at Pinehill.
- Pinehill Hospital was compliant with the reporting guidelines in relation to the NHS Safety Thermometer. They had started submitting the data in October 2018. Areas identified for reporting included:
  - Venous thromboembolism (VTE) (a blood clot in the vein)
  - Falls
  - Catheter related urinary tract infection
  - Pressure ulcers by category
- 94% of patients in October 2018 were found to have had harm free care, with 0.5% of patients having had a new venous thromboembolism (VTE) and less than 1.5% having had a fall. However, due to the small number and low intensity needs of patients, with more than 80% of their patients being day cases, this data was not utilised to identify trends. The service used incidents to look further into any trends.

- Staff carried out risk assessment for VTE in accordance with National Institute for Health and Care Excellence (NICE) guidelines, but these were not always completed in full. VTEs are blood clots that can form in a vein and have the potential to cause severe harm to patients. Records showed that VTE screening rates were 95.5% between August 2017 and July 2018. During the inspection, we looked at six medical records and we found that VTE screening was completed for three patients. There was one incidence of deep vein thrombosis in the reporting period.
- The hospital gathered patient information such as hospital acquired infections and reviewed these through its clinical governance processes. We did not see this displayed in the hospital. However, information provided by the hospital showed clear information about overall incidence of MRSA, which is a bacterium, which causes infections in different parts of the body, and C. difficile, which is a bacterium that is one of the most common causes of infection of the colon. From August 2017 to July 2018, there had been no incidents of MRSA, Escherichia coli (a type of bacteria that normally live in the intestines of people and animals) or C. difficile.

Are surgery services effective?

Good

Our rating of effective stayed the same. We rated it as **good.**

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other preferences.
- The service made sure staff were competent for their roles**.** Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness.** Managers checked to make sure staff followed guidance.
- There was a local audit programme for the hospital, which was set corporately by the Ramsay Health Care UK Group. The programme ensured different aspects of care and treatment were checked during each audit. Audits included medical records, infection prevention and WHO safer surgical checklists. The audits were based on national guidelines for example, the medical records audit referenced Ramsay policies which used national guidelines to set standards. The local audit programme was not up to date at the time of the inspection. We were informed that this was due to the ward manager leaving at short notice.
- The service used evidence-based guidance and quality standards to inform the delivery of care and treatment. For example, the pre-operative assessment clinic assessed patients in accordance with National Institute for Heath and Care Excellence NG45 'Routine pre-operative tests for elective surgery' (2016) and guidelines from the Joint British Diabetes Society for the 'management of adults with diabetes undergoing surgery and elective procedures' (2016).
- The theatre manager had recently completed an audit of the anaesthetic forms to check their compliance with national guidance. They found some areas where they needed to improve the forms to comply with the guidelines and subsequently updated them. They were also looking to be rolled out for use across Ramsay UK.
- Staff followed guidance regarding the recording and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central

database; we saw evidence of this in the notes. Relevant paperwork was carried out at time of the insertion and inputted into the National Joint Register (NJR) by theatre staff within 24 hours of the procedure. The hospital had received an award from the NJR for the quality of the data input.

- The surgical departments participated in relevant local and national audits, which were based on national guidance, standards and legislation, including NICE, the Royal College of Surgeons, and the Health and Safety Executive. For example, the audit of Patient Reported Outcome Measures (PROMS) and National Joint Registry (NJR).
- Findings from clinical audits and any new national guidelines were reviewed during routine clinical governance committee meetings (CGCM). These meetings were held every two months and were attended by the head of clinical services, a number of consultants and heads of department.
- Policies seen were up to date and contained current national guidelines and relevant evidence. Any updated policies were discussed in CGCM and departmental team meetings.
- Staff on the wards and theatres used enhanced care and recovery pathways, which were in line with national guidance. This included for example, integrated care pathways specific for hip or knee replacements and a day case pathway under general anaesthetic. The day case pathway included the predicted American Society of Anaesthesiologists (ASA) scoring. Consultations, assessments, care planning and treatment were carried out in line with recognised general professional guidelines. A review of medical records and discussions with the clinicians on duty confirmed this during our inspection.
- Audit in the hospital was well embedded with standards clearly identified and communicated where improvements were required. It was completed with a team approach in which all departments actively engaged. The hospital participated in an annual corporate Ramsay clinical audit schedule and used the findings to develop local clinical audit programmes.
- All consultants had access to the Private Healthcare Information Network (PHIN). This data was used to benchmark against local and national patient outcome results. Consultants were encouraged to monitor their own PHIN data and performance to identify trends to hospital senior leaders and the wider health economy. This enabled effective comparison with data available from NHS and other private providers to assist with information transparency and patient choice. Pinehill hospital had been submitting data to PHIN on a monthly basis, since 2016. Data submitted included admitted patient care (APC) episode data, and a range of clinical key performance indicators, such as unplanned returns to theatre, unplanned readmissions, unplanned external transfers, unexpected mortality, surgical site infections, PROMs data and patient satisfaction data. The hospital used data submitted to PHIN to run reports, such as monitoring procedures by volume per consultant, average length of stay, patient satisfaction scores, response rates and PROMs health gain data, in order to improve patient experience and quality care.

Nutrition and hydration

- **Staff gave patients enough food and drink to meet their needs and improve their health.** The service made adjustments for patients' religious, cultural and other preferences.
- Patient's nutrition and hydration needs were assessed monitored and recorded by using the Malnutrition Universal Screening Tool (MUST). This was in line with NICE guidance QS15 statement 10: 'Physical and psychological needs' (2012). During our inspection, we observed MUST assessments were completed on admission. These were not routinely updated; however, the low intensity needs of the patients did not require it, as they tended to stay less than three days after surgery. Staff used fluid balance charts to monitor patients' fluid intake.
- Patients waiting for surgery were kept 'nil by mouth' in accordance with national safety guidance to reduce the risks of aspiration during general anaesthesia. Patients attending for elective surgery were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing Admission times were staggered so that patients were fasted for the minimum amount of time.

- Patients who were recovering from surgery, had jugs of water within reach. These were regularly refilled. Staff completed hourly care rounds for each patient and checked whether they had a drink.
- Patients experiencing nausea or vomiting were prescribed antiemetic medicine (a drug effective against vomiting and nausea). Patients were given antiemetics intravenously in the recovery area if they complained of nausea post-operatively.
- There was a variety of hot food options available, and we were told that if any patients had a specific request, this could be provided. This encouraged patients to eat and ensured their nutritional needs were met.
- The Patient-Led Assessment of the Care Environment (PLACE) audit results for 2018 showed a score of 85.1% for the ward food score. This had decreased since the 2017 score of 91% and was worse than the Ramsay average score of 95.6%. However, all the patients we spoke with said the food was good and they had lots of choice; one said it was "always excellent". All the patients enjoyed their meals and had sufficient food to meet their daily requirements. One patient said that the menu was adjusted to allow for their appetite following their operation.
- The PLACE audit results for 2018 showed that patients were not assisted to sit out of bed for their meals, were not offered the chance to wash their hands before meals, and packaging wasn't removed from food prior to serving. The service had provided an action plan, which said that further awareness was needed and this had been discussed at team meetings.
- All private day case patients were offered a cup of tea and a sandwich after their operation prior to going home. However, since June 2018, NHS day case patients were only offered a cup of tea and biscuits. This meant that there was a differentiation in care between NHS and private patients. However, staff said that they would request a sandwich for a patient if they felt it was required.
- There were concerns raised in 2017 by the Environmental Health Officer about food safety. This led to an improvement notice being issued for immediate response. Following improvement actions taken by the hospital, the rating had improved from one star to five stars.
- There was a service level agreement with the local NHS trust for a dietician to visit if needed. This was routine for patients who had undergone colorectal surgery, but was available for any other advice or support needs.

Pain relief

- **Staff assessed and monitored patients regularly to see if they were in pain.** They gave additional pain relief to ease pain.
- Patients were assessed for their preferred post-operative pain relief in the pre-assessment clinic. Staff would discuss the patient's level of pain and discomfort as part of their assessment. This assessment would continue once the patient was admitted to the ward/day surgery unit prior to their procedure. We overheard a nurse asking a patient about their pain post-operatively.
- The surgical care pathway used, prompted staff to assess, record and manage pain effectively. Patient's records showed that pain had been assessed using the pain scale within the NEWS2 charts and via the hourly care rounds. Our review of eight patient's records found the assessment system was being used appropriately and that pain scores were recorded regularly. There was also clear documentation around the use of patient controlled analgesia (PCA). This is when a patient could administer his or her own pain relief using a button via a machine.
- Patients told us staff effectively managed their pain. For example, one patient said, "they were in pain after they had walked and the staff were understanding and increased their pain medication and put in more support to assist in their care".

Patient outcomes

- **Managers monitored the effectiveness of care and treatment and used the findings to improve them.** They compared local results with those of other services to learn from them.
- The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. Clinical audit and risk assessments were carried out to facilitate this.

The hospital participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) programme, and the National Joint Registry (NJR).

- The service had an 86.9% pre-operative participation rate for PROMS and 74.8% post-operative participation rate. These were both above the England average. The service had good participation with PROMS in comparison to other independent hospitals in the area.
- All patients apart from one, who had a total knee replacement, reported an overall health gain and no one reported their health worsening. One patient out of 91 reported worsened health following a total hip replacement, all other patients reported improved health. This was better than the England average and when compared to other independent hospitals within the region. These results were discussed at the November 2018 clinical head of department meeting. The service was looking to complete PROMS for carpal tunnel and spinal surgery as the number of these operations they performed were increasing. They would participate once they completed more than 100 of these types of operations per year.
- The hospital participated in the NJR and benchmarked itself against other Ramsay hospitals. They submitted data for 174 hip replacements and 147 knee replacements in the submission year 2017 to 2018. This meant that patients were being consented for the national joint registry and ensured traceability of their joint. The service had a serious incident relating to a joint and wrong implant insertion. This was alerted by the NJR and not by the team inputting the information. This triggered a root cause analysis (RCA) which identified that the information was not put onto the NJR in a timely manner and there was a lack of knowledge from the inputter about the joint information. Actions from the RCA included ensuring that the administrator inputted the joint information onto the register within 24 hours of the patient's procedure and further training on the NJR was required for the administrative staff.
- The hospital also participated in the breast implant register. This ensured that information about patient's implants was recorded confidentially on a national database. This enabled implants to be traced in the event of a product recall or other safety concern.
- There were five unplanned returns to the operating theatre from August 2017 to July 2018. The hospital had four unplanned transfers to the local NHS trust within the same reporting period. This was better than our previous inspection where there were 14 unplanned transfers. All incidents of unplanned transfer were entered onto their electronic reporting systems and analysed for trends by the management and governance team. These were all discussed in detail at the clinical governance committee. No trends were identified in any of the meeting minutes reviewed.
- The hospital reported seven unplanned readmissions, to either an acute hospital or Pinehill, within 28 days of discharge from August 2017 to July 2018. Unplanned readmissions were reported as incidents on the hospital's electronic reporting system. The service looked at trends for readmission. There were four patients readmitted from June 2018 to November 2018 for infection; this was the most common reason for readmission.
- The service took part in the collection of data for the private patient reported outcomes. This covered, hip, knee and hernia surgery. Private patients having this surgery had their data sent to the Private Healthcare Information Network (PHIN). Data collected included unplanned return to theatres, unplanned readmissions and surgical site infections.
- Infection rates were collected and reported and were found to be low. The service had recorded 17 surgical site infections out of 3,209 procedures within the reporting period. This was an overall infection rate of 0.03%. The managers had a good understanding of the infections and discussed them in the clinical governance committee meetings.
- The hospital benchmarked itself against local independent hospitals as well as all Ramsay hospitals nationally. Recently, they had an internal Ramsay audit where they identified Pinehill as having the best performing theatre within the company when measured against AfPP standards for perioperative practice. Hospital results of patient outcomes were compared with those of Ramsay Healthcare UK and nationally with the NHS as a whole to benchmark the hospital's

performance. Hospital results of patient outcomes were compared with those of Ramsay Healthcare UK and nationally with the NHS as a whole to benchmark the hospital's performance.

Competent staff

- **The service made sure staff were competent for their roles.** Managers appraised staff's work performance and held supervision meetings with them to provide support, and monitor the effectiveness of the service.
- All new hospital staff attended a corporate induction and had a local orientation to their department. Dependant on their role, some new staff were classed as being supernumerary for a period and this allowed them to understand their new environment before having full responsibility for their role. For example, ward nurses were classed as supernumerary for the first two weeks of their employment. We spoke to two new members of staff on the ward. They stated that the induction was good and they felt supported to complete their competencies. One received all their induction paperwork and welcome pack before they started so felt well-informed before arriving on the ward. A student nurse said that they had a good induction period and had been offered good opportunities to develop whilst working on the ward. For example, they had been to pre-operative assessment and theatre as well as working on the ward.
- New staff completed a variety of mandatory and role specific training through an e-learning system and face-to-face training. Most of this training was provided on site for example, the senior sisters could provide intravenous training and blood transfusion training for all staff.
- Staff had annual appraisals and most staff on the wards and theatres had completed an appraisal in the last 12 months. Data provided showed that on the wards, 92% of nurses and 100% of HCAs had received an appraisal during the reporting period (August 2017 to July 2018). In theatres, 100% of nurses and 92% of HCAs had received an appraisal during the reporting period.
- Staff told us that they found the appraisal system helpful and could identify any training or development needs through this process. Managers discussed competencies and training needs with staff at the appraisal meeting. For example, one theatre staff member was going on a recovery course to extend their skills. This training need was identified through the appraisal process.
- Poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education, clinical supervision and one-to-one meetings with their managers. At each one-to-one, the managers reviewed the annual objectives and created actions to help the staff achieve these objectives by their annual appraisal date. We saw examples of these one-to-one meetings with actions in place for further support. Staff said that they felt very supported by their managers.
- Competencies were required for each role, and these were recorded in a specific booklet. Competencies included drug administration, wound care and use of ward equipment. We saw evidence of these completed competencies for staff in theatres and on the ward.
- A ward operational audit was completed quarterly, which included checking of agency staff competency. The July 2018 audit showed that the agency staff credentials were not signed off prior to commencement and they did not have an induction. There was an action plan in place to make improvements and the October 2018 audit showed that 100% of agency staff were signed off prior to commencement and completed an induction.
- Surgical procedures were carried out by a team of consultant surgeons and anaesthetists who were employed by other organisations such as the NHS and worked at the hospital under practising privileges. Their annual appraisals were carried out with their employer. It was the responsibility of the registered manager, with advice from medical advisory committee (MAC) to ensure consultants were skilled, competent and experienced to perform the procedures they undertook.
- RMOs had their competencies assessed, and mandatory training provided and updated by the external agency provider. They worked against guidelines and a handbook to ensure they were working within their

sphere of knowledge. A clinical mentor supported them from an external agency who could be contacted for telephone advice when needed. They also had a face-to-face meeting twice a year.

- Hospital data showed that in the previous year, between 84% and 100% of staff in different staff groups had received an annual appraisal. Five staff groups had a 100% rate of completion of annual appraisal (registered nurses in outpatients, theatres and inpatients, ODP registered staff and health care assistants in theatres, and health care assistants in outpatients). The remaining two staff groups had completion rates of 88% (for inpatient health care assistants) and 85% (for 'other staff').
- Staff had access to the Ramsay Academy, which was part of the organisation's learning and development department. The Academy offered opportunities for additional, non-mandatory training and staff development. The academy produced an annual calendar of events for which staff could apply through a formal process. Academy training sessions were free of charge for staff to attend. Staff were also able to apply for funding to attend external training sessions. There was a process for staff to apply for funding through the senior leadership team who could approve applications. The human resources (HR) coordinator at the hospital kept a log of any additional training that staff attended, which could be viewed on a shared drive by the senior leadership team.
- The hospital's HR coordinator oversaw all recruitment processes on site. There were processes in place to ensure that all pre-employment checks were completed and recorded. This included checks on employment history, qualifications and professional registrations to ensure that staff were suitably qualified for the roles applied for.

Multidisciplinary working

- **Staff worked together as a team to benefit patients.** Doctors, nurses and other healthcare professionals supported each other to provide good care.
- There was good multidisciplinary working, and communication between the staff in theatres and on the wards. Staff told us they had a good working relationship with consultants and the RMO. The pharmacists were present on the ward daily and the staff said that they were approachable and supported them well with medications.
- We saw evidence of team communication across all services. The hospital had set up a '10@10' meeting. This took place at 10am every morning. It was attended by the senior management team and a representative from each department, including theatre, ward, pharmacy, outpatients, the catering department and patient services. All staff contributed to provide an overview of the hospitals activity. This included sickness, staffing levels, cancellations for theatre, patient admissions, any medical alerts, complaints, incidents and risks. Staff on call for emergencies were highlighted. Compliments and complaints were also discussed. Any relevant information was taken back to each department and cascaded to the team.
- Patient records showed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.
- The service had links with the local NHS trust. For example, nurse specialists from the local trust were available to attend the ward to provide advice. For example, nurses who were specialists in stoma care. A stoma is an opening in the body following the removal of part of the bowel. The specialist nurse attended a patient with a stoma daily following surgery to ensure that they had the care they needed.
- Information about the treatment a patient had received during their stay in the hospital was communicated to the referring GP when they were discharged from the service by letter.

Seven-day services

- **The surgical service provided a seven-day service.**
- The hospital only undertook elective surgery, and operations were planned in advance. The exception to this was if a patient was required to return to theatre due to complications following a procedure.
- There was an on-call rota for theatre staff for out of hour's requirements. A weekly on call rota was circulated, including details for all clinical areas and an on-call member of the senior leadership team.

- Consultants were on call seven days a week for patients under their care. Patients were seen daily by their consultant, including weekends.
- The RMO and ward staff had a list of contacts for all the consultants and anaesthetists for each patient and told us they could be easily contacted when needed. Anaesthetists were available via an on-call rota if a patient needed to return to theatre. The RMO provided out of hours medical cover for the wards 24 hours a day, seven days a week.
- A senior nurse was always available for advice and support during working hours. Furthermore, the management team operated a 24-hour, seven days a week on-call rota system where staff could access them for advice and support as needed.
- The ward accommodated overnight patients seven days a week and ward staffing levels were suitably maintained most of the time during out of hours and weekends.
- The pharmacy was open Monday to Friday from 0830 to 1800. In the event of patients requiring medications out of hours, the RMO and a registered nurse went to the pharmacy department and checked out the medications in accordance with the hospital medications policy. On call pharmacy advice was provided by a pharmacist at the local NHS trust.
- There was a small pathology laboratory onsite, which enabled enable basic blood testing to be carried out seven days a week.
- The physiotherapy department was staffed Monday to Sunday. The weekend service was provided on a rota and was only able to support inpatients. There was no physiotherapy on call cover out of hours.

Health promotion

- **Staff supported patients to manage their own health, care and well-being and to maximise their independence following surgery.**
- Patients attended pre-operative assessment appointments where their fitness for surgery was checked. They complete a medical questionnaire, which asked if they wanted advice regarding stopping smoking, vaping or losing weight. The nurse provided this advice if the patients required it or referred the patients on to other appropriate services.
- Patients having elective surgery were provided with a booklet of advice about their hospital stay. The booklet also contained some health promotion guidance including dietary advice, smoking cessation and alcohol consumption. Leaflets were available regarding referrals for assistance with smoking cessation.
- The physiotherapy staff saw patients who were to undergo orthopaedic surgery. These appointments provided health promotion opportunities, including how to maintain mobility by performing certain exercises.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.** They followed the service policy and procedures when a patient could not give consent.
- Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients.
- Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act (MCA) 2005. There was an effective consent policy for staff to follow. This outlined that consultants should seek consent from patients undergoing surgery during the initial consultation process and again on the ward during admission before the procedure. We saw from patient records that this had been obtained in agreement with the policy. We saw completed and signed consent forms during the inspection and observed consent being obtained for one patient prior to their surgical procedure.
- Patients were given information about their procedure both verbally and written to make an informed decision about their procedure. Patients said doctors fully explained their treatment and additional information could be provided if required.
- We were told that patients who were booked for cosmetic surgery were given a two-week cooling off

period before undergoing the procedure in case they wanted to change their mind. This was in line with national guidance. There were no cosmetic surgery patients on the ward at the time of the inspection.

- Staff told us the majority of admitted patients had the capacity to make their decisions. Patients that lacked capacity were identified during the pre-operative assessment process to determine whether they could be admitted for treatment at the hospital. Where patients could not provide informed consent, the staff would make decisions in the best interests of the patients, involving the patient's representatives and other healthcare professionals.
- Staff were aware of the legal requirements of the MCA and Deprivation of Liberties Safeguards (DoLS). There was an up to date policy regarding the MCA and DoLS. Staff were aware of where to access this.
- All staff received MCA and DoLS training within their safeguarding level 2 training. Staff were above 96% compliance in both wards and theatres for this at the time of inspection.
- Mental Capacity Act (MCA), and Deprivation of Liberties (DOLS) training compliance across the hospital was 97%
- Consent audits were part of the hospital medical records audits which were completed on 30 sets of records each month. Data provided by the hospital showed good compliance with consent standards used in the audit.
- There were corporate Ramsay Healthcare UK policies and procedures used by the hospital for consent to treatment, mental capacity and deprivation of liberty safeguards.

Are surgery services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We observed staff to be caring and compassionate with patients and their relatives throughout our inspection. Staff promoted privacy, and patients were treated with dignity and respect. Staff spent time with patients, and interacted with them during tasks and clinical interventions. We saw staff talking to patients, explaining what was happening and what actions were being taken or planned. Staff responded compassionately to pain and discomfort in a timely way.
- The service submitted data to the Friends and Family Test (FFT). This was a method used to capture NHS patient's perceptions of the care they received and how likely they were to recommend the service to their friends and family. The service had a response rate of 28% from May 2018 to July 2018. Which was an average of 86 responses per month. Scores were 100% of patients recommending the hospital for all specialities apart from Urology, which was 89%. Comments from patients who completed the FFT were 'all staff were very welcoming, I was looked after very well' and 'excellent care given throughout. All staff friendly, kind and considerate and put a very anxious patient at ease". Patients told us they would be happy for their friends and family to come to the hospital for treatment. FFT responses were displayed in the ward areas for patients and staff to read.
- All patients were given a discharge bag when discharge from the ward, which had a FFT or "we value your opinion" card in to complete. Staff invited patients to complete these prior to being discharged. In October 2018, the service had seen an increase in their responses and they felt this was due to the introduction of the discharge bags. There were a total of 449 responses for October 2018.
- The ward displayed many 'thank you' cards, which staff had received from patients and relatives. Comments from the cards included:

- "thank you so much for all your care and professional attention during my recent stay"
- "a big thank you to the wonderful nursing and catering team. Each one of you was so caring and attentive to me and my needs.
- "I want to thank you all so much for how safe you made me feel when not feeling on top of my game"

- Staff mainly spoke with patients discreetly to maintain confidentiality. There were two rooms, which had two bed spaces in them and were separated by a curtain with little room between them. We observed an anaesthetist discussing an anaesthetic with the patient. The patient was hard of hearing, which meant that the level of discussion was easily audible to the patient and visitors in the next bed.
- Pinehill scored 88.9% in the PLACE 2018 audit for privacy and dignity. This had improved since 2017 and was above the Ramsay average for 2018 of 87.6%.
- Once patients were in the recovery room curtains were closed to ensure privacy and dignity.
- We spoke with five patients. All the patients thought staff were kind and caring and said they could not fault the service. All the patients told us that they had received fantastic care and had had a positive experience during their stay at the hospital.
- As part of our inspection process we sent the hospital comments cards and boxes for patients to leave anonymous feedback about services. We received 103 completed comments cards from two boxes left; one in the outpatient department and one on the ward. Feedback on the cards was overwhelmingly positive with patients saying that they were treated with dignity and respect, and that they would recommend the hospital for treatment. Staff were described as friendly, helpful, polite, caring and knowledgeable.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff told us that they had time to spend with patients to reassure them and provide emotional support.
- Patients and those close to them received support to help them cope emotionally with their care and treatment. Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "it is comforting for their husband that she is in such good hands." Patients also said that staff were "brilliant" and "friendly."
- Pre-admission assessments included consideration of patient's emotional well-being.
- We observed patients in the anaesthetic room and saw staff were supportive to patients with any anxieties. Staff were reassuring and maintained a calm environment.
- Patients had a named nurse who looked after them during each shift. The named nurse ensured they were available for their patients to voice any concerns or anxieties.
- The hospital had Wi-Fi so that patients could keep in contact with their friends and relatives.

Understanding and involvement of patients and those close to them

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients told us that nurses explained what they were doing, and asked for permission and agreement first. Patients said medical staff explained plans for their treatment and provided opportunities to ask questions, this included family members when required. Patients told us they were given choices regarding their treatment options at their pre-operative assessment. Family members were encouraged to attend the appointment to ensure they were aware of any post-operative care that might be required at home. Physiotherapists discussed post-operative care needs with patients and relatives to ensure a smooth and safe discharge home.
- Patients told us that staff clearly explained the risks and benefits of treatment to them before admission.
- All patients were complimentary about the way they had been treated by staff. We observed most staff introduce themselves to patients, and they explained to patients and their relatives about the care and treatment options.
- Patients, who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

- Staff recognised when patients and those close to them needed additional support to enable them to be involved in their care and treatment. Staff said they had systems in place to identify the communication needs of patients, which included access to language interpreters, specialist advice or advocates when required. We were informed about a patient who suffered from severe motor skill loss and had been admitted for a hip operation. They were unable to use the remote control in their room. A member of staff brought in a voice activated remote system from their own home and set it up for her to be able to watch television. We saw a thank you letter from this patient who was thrilled at how caring this individual had been during their stay.

Are surgery services responsive?

Good

Our rating of responsive stayed the same. We rated it as **good.**

- The service took into account patients' individual needs**.**
- Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.
- The service planned and provided services in a way that met the needs of the local people.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Service delivery to meet the needs of local people

- **The service planned and provided services in a way that met the needs of the local people.**
- The services provided reflected the needs of the population they served and they ensured flexibility, choice and continuity of care. A variety of surgical procedures were available within the service, including cosmetic surgery, general surgery and endoscopy.
- The hospital was committed to providing surgery to private patients as well as providing services for NHS patients through agreements with the local commissioners. All patients were treated equally whether self-funded, through insurance schemes, or through the NHS.
- The facilities and premises were appropriate for the services that were delivered. There were eleven inpatient bedrooms, two rooms were two-bedded, and a separate day surgery unit with six beds and six trolleys. There was a second floor with further bedrooms but this was closed at the time of inspection. Investment had been approved to improve the facilities on the second floor in the hospital including new flooring, furniture and re-plastering. The hospital had three main theatres, all with laminar flow and a minor procedure/endoscopy suite; this ensured that planned services could be delivered to patients.
- The theatres were mainly open Monday to Friday 8am to 6pm and every other Saturday until mid-afternoon. The service could operate until 9pm during the week, which provided patients and consultants with increased flexibility. Theatre lists for elective surgery were planned with the theatre manager and with the bookings team. These lists were reviewed two weeks in advance at the Tuesday projection meeting. This helped to ensure operating lists were utilised effectively and patient choices were accommodated wherever possible. They also discussed the numbers of expected patients to ensure there were sufficient bed spaces and staff allocated within the ward areas. Staff told us that the head of clinical services had oversight daily of the staffing numbers.
- The service only received planned admissions. Patients' specific needs such as learning disabilities, other disabilities or mental capacity issues were identified at pre-assessment, to ensure appropriate arrangements were made to meet individual needs prior to admission.
- There was written information available about most types of planned treatment. Information included details of their planned length of stay, after care in hospital and at home, following discharge, to ensure an optimal outcome from their treatment. Patients we spoke with confirmed they were given a choice of appointment times and could schedule procedures at a time convenient to them.

- The hospital had service level agreements with a local acute hospital to provide extra services they were unable to supply themselves. This included blood products and critical care services.
- The hospital senior leadership team had facilitated a programme of ongoing refurbishment works to clinical areas to improve the environment and ensure premises were suitable to meet local patient's needs. There had been installation of secure access across the hospital to improve security and limit access to patient areas. Refurbishment works across the hospital have included redecoration, replacement of hand wash sinks and removal of carpets in clinical areas in order to improve the patient experience and reduce the potential for risk of infection.
- Plans had been submitted to the local council for planning permission to extend the hospital car park as this is something that patients have regularly complained about. As part of these plans the hospital have negotiated with a local school to request access for works vehicles through the school land, in exchange for financial support from the hospital towards school improvements.
- The hospital worked with several local commissioning bodies to provide treatment to NHS funded patients in the local area. The hospital director met regularly with the local CCG contract manager to seek feedback on services and ascertain if there were any changes needed to meet the needs of the local patient population. Pinehill employed an extensive resource that surveyed the health needs of the local community. There was an NHS team at the hospital who developed services as requested by local GPs, for example, direct access gastroscopy.

Meeting people's individual needs

- **The service took into account patients' individual needs.**
- Reasonable adjustments were made to consider the needs of different people on the grounds of religion, disability, gender, or preference.
- Patients with mobility difficulties had access to the wards from a lift. The corridors were wide, which meant there was easy access for wheelchairs.
- The service had access to interpreting services for patients whose first language was not English. A telephone line was available and face-to-face interpretation services could be obtained if required. There was also a list of staff members in the hospital who could speak different languages who were happy to translate if needed. Nursing staff said that if a patient could not speak English, they would let the family stay post-operatively if needed.
- Patients who had complex needs had their discharges planned in advance. In the pre-operative assessment, patients were asked about their home situation. We saw evidence in the notes of nurses arranging extra support for a patient's discharge by arranging social care at home.
- Staff answered call bells promptly; patients also told us that nursing staff responded quickly to their needs, for example to help them to the toilet. Relatives' needs were considered and they were offered food and drinks when they visited patients.
- Staff provided information leaflets for a range of conditions and to support care given. These were written in English but could be obtained in other languages.
- The service was looking at improving the patient experience for people with motor or mobility issues. They were looking at trialling a new voice activated nurse call system. This was to assist patients who found it difficult to press the nurse call button. The new system could be calibrated to individual needs and integrated into the existing call system.
- Clinical staff underwent dementia training as part of their mandatory training. The compliance was 100% for all theatre teams, 100% complaint for the ward nurses and 93% for the Healthcare Assistants.
- All patients who were over the age of 74 had a dementia screening assessment completed in their pre-operative assessment. If this was found to be positive, the nurse would feed this back to the patients GP and they would decide about the best place for the patient to receive their care. A dementia link nurse had set up a dementia memory box. This was available on the ward and contained items to prompt memories for patients living with dementia. Staff had access to 'This is me' booklets if required. The PLACE audit for 2018 achieved a score of

81% for dementia. This was above the Ramsay average of 80%. The hospital decided not to make all the recommended improvements to the areas. For example, changing the colour of toilet seats, rails and flush to a different colour to the walls (as contrasting colours can help patients with dementia more easily identify key features and facilities). The hospital completed a risk assessment for this and made the decision to not change these due to the low numbers of patients diagnosed with dementia seen on the ward.

- The dementia link nurse was also the learning disabilities link nurse. They provided ad hoc training sessions on learning disability on the ward for staff on topics such as speaking in easy language and using purple folders to highlight the patients once on the ward. We were told that not all patients with learning disabilities were flagged in advance as some came through direct access. This was when a GP could book a diagnostic endoscopic procedure directly and therefore they did not come through the pre-assessment process. This meant that the link nurse could not find out what adjustments they might need. For example, putting them first on the list or speaking to them beforehand to offer some reassurance.
- Equality Impact Assessments and PLACE audits were carried out and reviewed regularly to ensure equal access to appropriate facilities.
- The catering team were able to respond to individual nutritional needs and requirements for religious or cultural needs. The operations manager told us how the hospital had been able to support a patient who was not eating due to a dislike of the hospital food. He explained that the chef had gone to speak to the patient in order to identify their preferences and provide food that they wanted to eat.
- The operations manager explained that he wanted patients to have a positive experience at the hospital, and would respond to individual issues wherever possible. For example, he supported a patient who was struggling to access the hospital internet by personally visiting them to set up Wi-fi on their phone and tablet.
- The hospital provided access to multi-faith chaplaincy services for any patient or visitor who requested it.
- There was a hearing loop installed for hearing impaired visitors.

Access and flow

- **Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.**
- The hospital's admission policy ensured that patients received a pre-operative assessment. All patients were assessed which meant patients could be identified as being safe for surgery, which helped to avoid any unnecessary cancellations. Patients with co-existing conditions were identified during this process and then given further tests, for example blood tests, or diagnostic imaging. Patients with multiple illnesses, giving them an ASA grade above two were declined for surgery at Pinehill. Anaesthetic clinics had been established to respond to the increased complexity of patients being treated, with the aim of avoiding cancelled operations and providing an improved service. These were held weekly on a Wednesday between1600 and 1800.
- Pre-operative assessment clinics were open Monday to Friday from 0900 until 1700. There were no clinics available in the evenings or at weekends. Staff said that there was no need for this at present but they would be able to offer an appointment in the evening if this suited the patient better.
- The ward area on the first floor was open seven days a week for 24 hours a day. The day surgery unit and second floor ward were open depending on patient need. The number of admissions and planned treatments reduced at weekends with the theatre department opening every other Saturday.
- Patients had timely access to initial assessment and treatment and the service mostly met national targets for access to treatment. The referral to treatment time (RTT) was used for tracking times to treatment for NHS patients. 100% of patients were seen within 52 weeks (RTT) and over 95% of patients in the last six months were seen within 18 weeks. In October 2018, 95.2% of patients who needed admitting to the hospital were seen within 18 weeks. The average waiting time for completed pathways for admitted patients was 10 weeks. The maximum waiting time was 39.6 weeks. This was better than the England average for NHS patients.

There was no formal mechanism similar to the RTT for the private patients, however, there were no waiting lists and patients were generally seen within one to two weeks from their referral.

- The NHS patients were referred to the service by their GP via the NHS referrals system. The service screened these referrals to ensure that they were appropriate for the facilities within the hospital. Patients were given a choice of dates for their procedures.
- The service monitored the number of cancellations and procedures were only delayed or cancelled when necessary. Any patients who were cancelled were rebooked as quickly as possible. The total number of procedures cancelled for non-clinical reasons in the reporting period was 149. 100% of these patients were offered a date within 28 days of the cancellation. Cancellations were discussed within the clinical governance committee meetings and actions for improvements were put in place. The reduction in cancellations on the day was one of the clinical priorities for 2018/19.
- A "list" safety officer's role had been embedded to improve the flow within theatres. Their role was to manage the theatres list, and equipment needs. They were identifiable through the wearing of a red hat. We observed theatres completing a brief where all equipment needs were discussed. This helped to reduce any delays in theatre due to unavailability of equipment. The theatres managed the utilisation daily which meant that theatres rarely ran over their scheduled running time. The service reported five cancellations within 2018 as a result of the theatre overrunning. The managers had a weekly projection meeting which looked at the list utilisations and this helped to reduce overruns and cancellations.
- The service managed their theatre utilisation. The theatre manager received a monthly report regarding their utilisation called the theatre timing pack. They used this to review theatre efficiency and surgical speciality efficiency. In November, theatres achieved 71.2% for scheduled utilisation. This was productive use of operating time. The managers used this information to schedule the theatre lists more efficiently. The report also provided information about each surgical speciality. For example, in November 2018, the ophthalmic surgery list had the highest utilisation at 85.2% and direct access gastroscopy clinic was 53.4% utilisation. This gave managers an insight into the specialities which were growing and those that needed further support.
- The hospital monitored numbers of patients who were readmitted within 28 days of being discharged. The number of unplanned readmissions within 28 days of discharge from 2017/18 was 13 and the number of patients who returned to theatre in this reporting period was eight.
- Discharge planning started at the pre-operative assessment stage. Length of the patient's expected stay was discussed and this helped patients plan for any additional support required at home.
- Patient's records showed staff had completed discharge checklists, which covered areas such as medication, communication provided to the patient and other healthcare professionals, for example, GPs. This ensured patients were discharged in a planned and organised manner. However, the patient satisfaction survey and patient complaints highlighted that discharges were an area where improvements were needed. The service had developed a number of actions including:
  - Discussing expected length of stay at pre-operative assessments.
  - Giving out of discharge bags. These included information about the discharge, patient satisfaction survey, complaints leaflet, information about how to prevent an infection and phone numbers to call if the patient had a concern.
  - Printing pre-written discharge checklist stickers as a prompt for staff to use when discharging a patient.
  - Completing an advance notification form for patients who had any risks. This form was sent to the ward prior to admission. It detailed any allergies and if the patient had any risks such as high body mass index (BMI), diabetes, needle phobia or a disability.
- The head of clinical services had also commenced daily ward rounds to review each patient and assist with discharge planning where needed. We saw evidence in the head of clinical services book of prompting staff to consider a complex patient discharge and offering support to the staff. There was a standard operating

procedure for discharging a patient. It provided a step-by-step guide for staff on how to appropriately discharge a patient and the relevant information they needed to give the patient.

- The service provided an on-call theatre team who were called to attend any emergency readmissions to theatre. Additionally, in the event of a patient deteriorating and requiring higher levels of care, the patient was transferred to the local NHS trust via ambulance.
- The hospital offered services in a timely manner and sought to minimise wait times. Monthly diagnostics waiting times and activity reports were submitted and referral to treatment times for surgery (RTT) were monitored. To monitor and prevent 18-week RTT breaches, Ramsay head office sent each hospital a weekly elective wait monitoring report to complete and return. Any patients that were approaching breach, had steps taken to expedite their admission dates. The hospital also submitted data to the secondary uses service (SUS) to enable commissioners to monitor wait times.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.**
- Information on how to raise complaints and concerns was displayed in the areas we inspected. There was a clear process in place for dealing with complaints. Staff were aware of the complaints procedure. Clinical staff told us they always tried to resolve any issues or complaints at the time they were raised. If this was not possible, patients could be referred to the nurse in charge in the first instance.
- Patients were aware of how to make a complaint. They said the complaints procedure was in the folder in their room and among the aftercare literature they were given.
- We looked at the complaints tracker for 2018 and saw that 13 complaints were related to the surgery service. All complaints had been logged and investigated in accordance with the hospital's complaints policy. Seven out of the 13 complaints had been resolved within the hospital's complaints policy timescales. Those that were not, were due to the complexity of the complaint. However, we did see evidence that the complainant had been kept up to date regularly with progress.
- Lessons learned were discussed within the departments at their team meetings and via a monthly lessons learned newsletter. For example, a patient was unhappy that they had received no contact regarding a feedback form that was completed. The meeting minutes showed that all staff were asked to highlight any feedback forms where the patient had potential concerns. This allowed the senior leadership team to contact the patient immediately to resolve any issues.
- Staff could give examples of complaints and what they had learned from them. A member of staff on the day surgery unit stated that their main theme of complaints was that patients felt they were being rushed to be discharged post-surgery. Staff felt that this was exacerbated due to the second-floor ward closure resulting in a reduction of beds. Staff said that they tried to keep patients informed about timings as well as the turnaround times within the unit.
- All staff were encouraged to deal with concerns as they were raised, in an attempt to achieve an early resolution. If they were unable to do so, staff involved their line manager to attempt to resolve the issue as it presents. All complaints were logged on to the hospital's reporting system and were delegated to the appropriate person to investigate. The departmental manager investigated any complaints about their service with support from the head of clinical services. The head of clinical services or hospital director completed a written response to complainants where appropriate. All complainants were offered a written response, but for some patients who raised a minor complainant verbally it was possible to resolve the concerns over the telephone. All complaints, whether made in writing or verbally, were logged on a complaints tracker by the head of clinical services. The hospital had reported 64 complaints in the reporting period from August 2017 to July 2018. None of these complaints had been referred to the ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- The hospital adhered to a management of patient complaints policy which was a Ramsay Healthcare UK corporate group policy. The hospital director had overall

responsibility for managing and responding to complaints with the support of the head of clinical services. The Hospital PA provided administrative support for the complaints process. There were information leaflets available to patients detailing how to make a formal complaint. The policy stated that an acknowledgement letter should be sent to any complainants within 2 days of receipt of a formal written complaint. A copy of the complaints procedure information leaflet was also sent to the patient at this time. The hospital had a target time of 20 working days to provide a full written response to complainants. The hospital director told us that the 20 working days timeframe could be difficult to achieve when investigating a highly complex medical complaint that required input from various parties including consultants.Although, every effort was made to achieve the target timescale, if the investigation was still ongoing after the 20 working days had elapsed, the patient was written to again and informed of the delay and when they could expect to receive the full response.

- The formal letter of response to a complaint provided the hospital directors contact details and offered the patient the opportunity to meet with the general manager to discuss the outcome of their complaint in person, should they be dissatisfied with the outcome or the complaints' process. In the response letter patients were additionally advised that the investigation into their complaint would be closed if no further response was received. Patients were given the opportunity to escalate the complaint to a second or third stage should the complainant not be satisfied with the outcome. Any complaints that could not be resolved at local level within the hospital were escalated to the corporate team.
- Complaints were reviewed weekly by the hospital director, head of clinical services and PA to ensure good progress in relation to investigation and resolution. They were then further reviewed formally at the heads of department meetings and clinical governance committee meetings, with any relevant information being shared further to the Medical Advisory Committee meetings. The head of clinical services provided a monthly report to all departments related to the complaints and feedback received identifying all lessons learnt and actions taken/required. This was then disseminated by the departmental managers to staff via team meetings. There was also a national Ramsay wide reporting committee structure where complaints were shared and lessons learned.
- Data provided by the hospital showed that during the reporting period, no complaints were referred to the Ombudsman or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Average response time for complaints, according to the complaints tracker, between April and September 2018 was 23.6 days. Of 37 complaints listed on the log, 11 had exceeded the 20 working days response target. The three top themes for complaints were concerns regarding outcomes of care, fees, and cancelled appointments. The tracker showed that written letters, and apologies had been sent to complainants, and where appropriate refunds of items such as travel costs and a blood test. The tracker documented that learning had been shared with teams and we saw copies of the 'patient satisfaction, outcomes and complaints shared learning reports' produced monthly by the head of clinical services, which summarised all complaints received that month, including actions taken and learning to be shared. An example of an action taken in response to complaints made was that a sign was erected at reception asking patients to return to reception if they have not been called within 20 minutes; this was in response to a concern raised about excess wait times to be seen for a clinic appointment in the outpatient department.

Are surgery services well-led?

Good

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

We rated the service as good for well-led because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

- The service systematically improved service quality and safeguarded standards of care by creating an environment for clinical care to flourish**.**
- The service had a vision for what it wanted to achieve and workable plans to turn into action, which it developed with staff and patients.
- The service engaged well with patients, staff, and the public to plan and manage appropriate services, and collaborated with partner organisations effectively.

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The service had a clear management structure in place with defining lines of responsibility and accountability. There was a head of department who reported to the head of clinical services.
- Managers in the service stated that the head of clinical services was very visible and they felt very well supported.
- All grades of staff in the service told us that they felt departmental managers were approachable. Departmental managers worked clinically and provided clinical cover for sickness when required. The ward and theatre staff worked together effectively. A number of clinical staff had worked in the organisation for over 10 years. They told us they had stayed in the organisation for a long time because of the team they worked with.
- There had been a number of changes at departmental management level within the past year. For example, there had been two ward managers during the previous year. Staff on the ward felt that this had not had a huge impact on their day-to-day work as the senior sisters and senior leadership team were so supportive.
- Staff were motivated and positive about their work, and described all members of the senior management team as approachable and visible. They told us there was a friendly and open culture.
- A leadership development programme was available for staff to attend. At the time of our inspection, not all of the clinical managers in the surgical service had attended this training. However, we were told that the senior sisters were finishing current courses and then they would attend the leadership course. The head of clinical services had been promoted from theatre manager and was in the process of completing an 'aspiring leaders' training programme.
- The ward and theatre managers held team meetings, which kept their staff informed. They were held on an ad hoc basis and not routinely done monthly. An action from their provider visit seen in the September 2018 ward team meeting minutes was to have more regular and consistent team meetings. We requested the most up to date meeting minutes following our inspection and these were September 2018 for both the wards and theatres.
- Staff we met with, were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.
- There was a poster displayed in each department labelled "guess who?" and it had information about leaders within the hospital and their contact details. It included the senior leadership team, safeguarding lead, mental capacity link nurse, information governance lead and the resuscitation lead.
- The hospital was part of the Ramsay Health Care UK organisation, being one of 30 Ramsay hospitals in the UK. The hospital senior management team reported into the corporate leads and were supported through a network of regional and national leads and specialists. Leaders confirmed that corporate support was readily available, and that there were effective working relationships.
- The hospital senior leadership team consisted of a hospital director, head of clinical services, an operations manager and a finance manager. The hospital had gone through significant changes within the senior leadership team over the previous eighteen months. At the time of inspection there was a stable and committed senior leadership team in place. The hospital director, head of clinical services and operations manager had been in post for approximately one year prior to the inspection. The finance manager had worked at the hospital for over five years and had regional finance responsibility for several Ramsay hospital sites. All of the senior leadership team had worked within the Ramsay

Healthcare UK group for several years. All the senior leadership team had completed a level of management training, accessed through the Ramsay academy or external courses. We were assured that senior leaders had the skills, knowledge and experience that they required.

- Appointment to senior leadership team posts was done through the corporate team and we saw that robust recruitment processes and appropriate checks of qualifications and experience were in place and were recorded in staff personal files.
- The senior leadership team all described positive working relationships and there were processes in place for the team to work together effectively. The team met together regularly on an informal basis as their offices were in close proximity. In addition, they had monthly formal senior leadership team meetings. The hospital told us that these monthly meetings were not always minuted although they followed a set agenda. Going forwards there was a plan for the meetings to be minuted routinely. There was a senior leadership team closed social media group set up to facilitate communication between the team. Members of the senior leadership team described joint decision making through mutual respect for each other's opinions and working towards a single goal of patient safety.
- There were clear lines of accountability and responsibility. The hospital director explained that he had overall accountability and responsibility for making decisions at the hospital. He was supported in his role by the rest of the senior leadership team who all reported directly to him. The hospital director reported the corporate chief operating officer but also received support from the Ramsay group clinical director and local cluster manager. Each member of the senior leadership team had heads of departments who managed groups of clinical or non-clinical services, and reported directly to the leads.
- There were embedded processes in place for the senior leadership team to work with the Medical Advisory Committee (MAC). The MAC received information from the clinical governance committee alongside reports from the hospital director and head of clinical services which they reviewed alongside applications for practising privileges, practise restrictions or extension to scope of practise requests. All members of the senior leadership team regularly attended the MAC meetings.
- Members of the senior leadership team told us that they did daily walk rounds of their areas. The hospital director told us that visibility was an important part of his role. Staff reported that leads were visible and engaged, maintaining regular contact through informal and formal processes. The head of clinical services chaired a daily '10@10' meeting which other members of the senior leadership team and all heads of departments attended. This was a brief meeting to review a range of hospital wide issues including activity, any major concerns, staffing, maintenance and complaints, to ensure that all leads across the hospital were up to date with any issues and that appropriate support and any actions required were in place. This demonstrated an inclusive and effective approach to leadership at all levels across the hospital.
- There were leadership development opportunities within the hospital. All heads of departments completed a level of leadership training during their induction and had access to further funded leadership training programmes such as 'Aspiring Leaders' and 'Leadership excellence through awareness and practise (LEAP)' once in post.

Vision and strategy

- **The service had a vision for what it wanted to achieve and workable plans to turn into action, which it developed with staff and patients.**
- The hospital's vision was to be committed to being a leading provider of health care services by delivering safe care with high quality outcomes for patients.
- The service did not have a defined strategy relating to surgery but the service was included in the hospital's overall strategy, which outlined the composition and function of the service. The strategy was displayed in clinical areas.
- Staff understood their role, what was expected from them and had an understanding of the service's vision. Theatre had created their own mission statement, "we will deliver safe and effective patient focussed care. We will always aim for best practice, and incorporate the

Ramsay values every day. We will strive to be open and honest with each other and feel supported in challenging unsafe practices and behaviour. We will always treat all staff and patients how we would like our family members to be treated."

- There was a corporate Ramsay Healthcare UK five-year strategy. There were five key elements to the strategy which were:
  - Hospital will be expanded into out of hospital care
  - Enhancing the core operating model
  - Accelerating projects and new partnerships
  - Reaching beyond traditional models
  - Thinking big and getting to scale.
- The hospital had developed a clinical strategy based on the Ramsay corporate strategy. We found that the clinical strategy was not robust and that it lacked detail. There were no measurable objectives set out in the strategy which meant that progress against achievement of the strategy could not be demonstrated. The hospital director recognised that the strategy needed further development. The strategic priories identified were:
  - 'Our patients- provide best practice care to ensure patient safety and satisfaction'
  - 'Our Staff – support and develop our most important resource and provide a safe and rewarding workplace'
  - 'Our future – develop strong and effective partnerships to meet the community health needs'
  - 'Our stakeholders – develop strong and effective partnerships'.
- The hospital had a vision which was that it was 'committed to being a leading provider of health care services by delivering safe care with high quality outcomes for patients'. Whilst the vision was published, it was not clear if all staff were familiar with the vision or if staff had been involved with its development.
- The hospital set out a list of strategic priorities which were to provide best practise care, support and develop staff, and to develop strong and effective partnerships. The clinical strategy referred to using the seven pillars of clinical governance and an audit cycle of setting standards, measuring practise, comparing results, implementing change and re-auditing, in order to achieve the priorities. However, there was no detail behind the strategy to indicate how these actions would be implemented.
- Staff understood the organisation's values, which were embedded in the hospital's working practises. The hospital had a staff awards system which was related to the organisations values. Staff were nominated for an award if they had demonstrated one of the values throughout their work. A different value was chosen each quarter and the senior leadership team chose winners from the applications submitted. The Ramsay values were also used in the appraisal process.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- The service had a caring culture. Staff told us that they enjoyed working in the department and felt supported by their departmental managers. Department managers told us that they had an open-door policy and that they were proud of their staff and their departments. All staff told us that they remained in their job because they liked their teams and they were described as a "family".
- The head of clinical services in the service held regular meetings with department managers. They felt that this kept them well informed. They discussed the risk register, staffing levels and any feedback from audits and meetings. The managers in turn held meetings with their staff groups. Staff felt that they were kept up-to-date and were made aware of changes needed within practice.
- All areas had their own closed social media groups in order to share information and learning. Staff said they liked this way of communicating as they felt informed and kept up to date with ward information without it being intrusive.
- The hospital culture encouraged openness and honesty. Processes and procedures were in place to meet the duty of candour. When incidents had caused harm, the duty of candour was applied in accordance with the regulation. Staff confirmed there was a culture of

openness and honesty and they felt they could raise concerns without fear of blame. The hospital did not have a freedom to speak up guardian, but all staff said they felt that the senior leadership team and their managers were very approachable and felt they could raise any concerns.

- There was a culture of normalising two-way communication between colleagues to prevent unintended patient harm. Ramsay Healthcare UK had launched a Speaking Up for Safety Programme (SUFS), with all staff and consultants at Pinehill hospital undertaking training to ensure that the Safety 'CODE' model was embedded within the organisation. The model used graded assertive communication to enable and empower staff to respectfully raise issues with colleagues if they were concerned about patient safety. The programme aimed to ensure that all staff felt able to raise safety concerns in a supportive environment and enabled leaders to be accountable and ensure a safety first culture. The programme included assertiveness training for all staff. Staff were very positive about the programme and all levels of staff, including consultants, were aware of it. SUFS champions were identified through the wearing of badges.
- Most staff felt valued and supported to deliver care to the best of their ability. All staff talked about an open and transparent culture within the hospital. Quotes from staff included, "Everyone is always smiling", "Really nice hospital to work in", and "we work well as a team."Staff also confirmed they enjoyed caring for their patients and we observed good interaction during the inspection.
- The staff board within theatre had a "our Pinehill theatre team are great because" section which included comments such as "loyal and flexible staff", "excellent teamwork and support for each other" and "good sense of humour, whole team is treated like a family". Theatre team meeting minutes thanked staff for good engagement and compliance to the safer surgery huddle.
- There was a disclosure of information (whistleblower) policy used in the hospital which was a Ramsay Healthcare UK corporate group policy. The policy provided a procedure for staff to pursue their concerns if they genuinely believed that malpractice or wrongdoing had occurred. However, we saw that this policy was overdue for review since September 2018.
- The hospital director and head of clinical services described the culture within the hospital as open, honest, supportive, positive, healthy and warm. They described staff at all levels working with pride and passion and having a focus on quality of care. Leaders encouraged an open door policy for staff to be able to raise concerns directly with managers and senior leaders.
- The hospital manager worked within a culture of openness and ensured notifications of incidents were submitted to external bodies where appropriate and that there was regular communication about any adverse events or performance concerns with the local clinical commissioning group.
- Within the leadership team they described working together respectfully but with the ability to challenge each other, ask direct questions, and raise concerns in order to get decisions right.
- Ramsay Healthcare UK had a staff code of conduct which was shared with all staff during their induction. The code highlighted expected behaviour and the importance of demonstrating the corporate values. The hospital director and head of clinical services stated they did not hesitate to have honest conversations with staff who did not demonstrate the corporate values. Leaders were keen to address any issues as they arose. However, if concerns about behaviour and performance persisted, disciplinary actions, including dismissal, would be considered where necessary.

Governance

- **The service systematically improved service quality and safeguarded standards of care by creating an environment for clinical care to flourish.**
- There was a clear governance structure in place with committees for medicines management, infection control, and health and safety, which fed into the clinical governance committee. Governance meetings were attended by the heads of department for inpatients and theatres. All committees had terms of reference, which

reflected their role in the hospital, their structure and purpose. We reviewed four sets of governance meeting minutes and saw that they were well attended by the senior management team, heads of department and clinical leads. Standard agenda items for discussion included clinical incidents, complaints, audits and risks. There was evidence of actions taken to address compliance within the surgical service.

- The head of clinical services held meetings with the heads of each department every six to eight weeks. They then also held departmental meetings on the ward and in the theatre departments. Meetings were structured and minuted. We reviewed four team meeting minutes and they all showed discussions around improving the service delivered.
- There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and patient pathways. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Results were shared at relevant meetings such as the hospital clinical governance meetings. Not all audits on the ward were up to date at the time of our inspection due to the unexpected departure of the ward manager.
- The service participated in national audits including the National Joint Registry, Patient Reported Outcome Measures (PROMS), Friends and Family Test and Patient Led Assessment of the Environment (PLACE).
- The hospital had a committee structure which mirrored that of the corporate team. Each committee had terms of reference which were reviewed annually. There were a number of meetings which occurred at regular intervals, and fed up to the corporate committees for review. Reports were prepared by subcommittees such as Health and Safety, Infection Prevention and Control (IPC), and Heads of Department (HOD), which fed into the Hospital Clinical Governance(CG) and Senior Leadership Team (SLT) meetings. The SLT and CG meetings fed into the Hospital Medical Advisory Committee (MAC). Minutes for all these meetings showed that a standardised agenda was used to discuss topics such as, complaints, incidents, audit findings, and risks. Minutes included an action log with named responsible persons and due dates for achievement.
- The hospital committee structure was used to monitor performance and provide assurance of safe practise. There were a range of other systems and processes of accountability which supported delivery of safe and high quality services. These included, regular quality reviews of staffing, issues and risks between the head of clinical services and HODs, the daily 10@10 meetings, daily walk rounds by SLT, and production of trackers and reports for complaints, incidents, health and safety and IPC.
- The MAC worked closely with the SLT and provided recommendations and challenge where appropriate. Part of the MAC remit was to review changes in NICE guidelines Central Alerting system alerts and National Patient Safety alerts, and to make recommendations for any required changes in practise.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected. However, when concerns around overnight staffing levels were raised by staff, there was no evidence that senior leaders took action to address this risk. The ward risk register did not identify overnight staffing as a risk, at the time of inspection.**
- The heads of theatre and wards had recorded identified risks onto a local department risk register and these were up to date. We were informed that staffing overnight on the wards was raised as a risk by the ward staff, however, this was not on their risk register. Following discussion, managers updated it to include this risk during our inspection. Key risks from each department were placed onto the hospital wide corporate risk register.
- The risks and challenges within the departments were displayed on their staff boards and leaders had offered solutions to these where possible. For example, storage within the theatre department was a challenge and therefore they had increased the storage solution in the middle preparatory area and introduced bar coding of equipment.

- There was a plan in place for local safety standards for invasive procedures using the national guidelines. However, staff were unable to tell us the progress the service was making with this.
- The service held a weekly projection meeting where they looked at the following two weeks theatre activity. This enabled them to plan services and staffing and reduce the risk of cancellations. The hospital also held a '10@10' daily meeting for all heads of departments. Staff discussed any staffing issues and unexpected disruptions to services with the senior leadership team.
- Service risks were identified, tracked and reviewed regularly by the hospital leaders at HODS meetings and the health and safety committee. The senior leadership team all had good awareness of the hospital risk register and could describe the current risks.
- There were five risks identified on the current hospital risk register, with a further register of 27 closed risks dating back to January 2014. The service used a standardised risk calculation tool to identify risks, where risks were scored from one (least risk) to 25 (highest risk). These scores were then processed into three risk categories:
  - Yellow- risk scores one to eight. These were held at departmental level.
  - Orange- risk scores nine to 14. These risks were held on the hospital risk register.
  - Red- risk scores 15 to 25. These risks were also held on a corporate risk register.
- There were two red rated, two orange rated and one yellow rated risks identified as current risks on the hospital risk register. The red risks were around supply problems with the current blood transfusion supplier and a lack of availability of up to date equipment maintenance records from the maintenance contractor. The orange risks were around a backlog of building maintenance work and a lack of fire compartmentation protection. The yellow risk related to ageing theatre lights. All risks had risk owners, identified mitigating actions and review dates documented on the risk register. All risks had been reviewed regularly in accordance with the specified frequency of review documented on the register. The register was updated with additional information when risks were reviewed. We saw that risks had been escalated to appropriate committees.
- The hospital participated in a corporate annual audit programme which reviewed performance across departments. Outcomes of audits were used to benchmark performance against other hospitals in the Ramsay Healthcare UK group. Results were also used to produce a focused programme of audit for any areas where standards were not being met. There was participation in national audits and results from these were compared with performance of other providers.Key performance data was used to highlight any outliers in performance, for example, for medication incidents, falls, infections, thrombosis and complaints. Outliers in performance for clinical outcomes were challenged by the corporate team in order to drive improvement. Performance was also monitored by the corporate team through regular reporting of the hospital risk register, complaints and incidents, and by means of a quality report produced by the head of clinical services.
- There were processes in place to ensure that financial governance procedures were followed. These included a monthly review of financial accounts between the finance manager and the hospital director, and review of the accounts in SLT meetings. There was a process of internal and external audit of accounts to provide assurance that accounts kept were accurate and complete.

Managing information

- **The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The service used paper records. Nursing and medical patient records were combined within the same record; this meant that all health care professionals could follow the patient pathway clearly.
- Results of x-rays and blood tests were available electronically, which all relevant staff could access.

- Patient discharge letters were printed and sent to the patent's GP. The service kept a copy and a third copy was given to the patient.
- Staff confirmed they received information in a variety of methods, which included; team meetings, newsletters, notice boards and the closed social media group.
- Notice boards displayed the service's performance such as friends and family test feedback, infection rates and feedback from incidents and complaints.
- Staff across the hospital described IT systems as fit for purpose
- A range of information technology systems were used to monitor quality of care. There was a risk management system where incidents and complaints were recorded. Tracker documents were produced monthly to provide oversight of numbers and trends of incidents and complaints. Electronic systems were used by the senior leadership team to record and analyse a range of key performance data.
- There was an electronic system used for allocation of staffing rotas.
- There was a plan for electronic patient records to be introduced to the hospital from April 2019.
- There were systems in place to ensure that data and notifications were submitted to external bodies as required.

Engagement

- **The service engaged well with patients, staff, and the public to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- Staff reported that there was good engagement from their managers and from the senior leadership team. They said that using the social media group to engage with them means that they always knew what was going on within their area. For example, this was used to inform the staff that their manager had left which meant all staff knew about it at the same time.
- Patient's views and experiences were gathered and acted on to shape and improve the services and culture. Service user feedback was sought in various means, including the Friends and Family Test (FFT), 'we value your opinion' feedback, daily head of clinical services ward rounds and Patient-Led Assessment of the Care Environment (PLACE) audits.
- The head of clinical services did daily ward rounds of the inpatients to gain feedback and where needed, resolve any issues immediately. Patients reported that this was effective and appreciated this support. The head of clinical services documented anything relevant that the patients had said in a diary for staff to see.
- The hospital held a 'tea and cake' morning every quarter for new starters to meet the senior leadership team.
- The head of clinical services was proud of the teams, they said that the staff were really engaging and looked for solutions rather than problems and demonstrated their desire to make improvements.
- Staff at the hospital participated in the Ramsay Healthcare UK group annual staff survey. Staff in the surgical service told us they were not aware of what was being done to make improvements based on the survey results.
- We saw evidence of staff engagement in the form of a 'you said, we did' board displayed outside the staff restaurant. This included "you said that you did not receive awards and recognition for a job well done", "we arranged Christmas parties and a summer ball with subsidised tickets and were arranging a summer barbeque".
- Patient engagement was captured across the hospital through a number of methods, including the NHS friends and family test (FFT), a quality assurance (QA) questionnaire and a written questionnaire leaflet called "we value your opinion". The QA audit was completed by a third party who forwarded results to the senior leads for any actions. Although FFT scores were generally good, an action plan to address lower scores in any area was devised and regularly updated. There was an average 24% response rate to FFT between Feb and July 2018. 99.2% satisfaction rate.
- Patients were invited to participate in yearly PLACE audits.Feedback was used to learn lessons when things went wrong and feedback was reviewed to inform developments in service and improve the physical environment for patients.

- Senior leaders had a strategic aim to seek patient engagement through the setting up of a patient forum for patients to advise on their experiences and views. They had not yet been able to find patients willing to assist but planned to develop this method of patient engagement.
- Patient feedback was obtained throughout the hospital on a daily basis from patients through their words of thanks, appreciation and compliments.Feedback from written complaints and compliments received were seen as an excellent way to improve the services for patients through system and process changes. Leaders saw previous complainants as key contacts for providing information about patient experiences which fell short of expectations.
- The feedback obtained from complaints was reviewed at departmental, Heads of Department and Senior Leadership Team Meetings.Action plans were devised where feedback from patients indicates room for improvement in any aspect of the service delivered.
- The hospital took a leadership approach of transformation through engagement with staff. Leaders encouraged staff to be involved in service improvements and to seek their own solutions to issues in collaboration with heads of departments.
- There was a staff engagement forum at the hospital at which representatives from each department would meet together to identify areas for improvement and change. A member of the senior leadership team (SLT) attended the forums to listen to discussions, but not chair the meeting. The agenda for each forum was set by staff attending. In addition, there were quarterly drop in engagement events where staff could meet with the SLT and tea and cakes with the SLT events for new starters.
- All staff were able to complete the Ramsay staff survey. Pinehill score was benchmarked against Ramsay overall. For the latest survey in July 2018 there was a 98% completion rate by staff at Pinehill hospital. In most of the questions, Pinehill did better overall than other hospitals in the Ramsay group. For example, 84% of Pinehill staff felt that their direct line manager gave them the support they needed to do their job well compared to 76% of Ramsay overall staff. 91% of the staff said they would recommend Ramsay to friends or family who needed care. Key areas for improvement from the last survey, were pay issues and a feeling that senior leaders took limited actions in response to staff views and concerns. In response to findings from the staff survey, leaders developed an action plan. Actions included 'You said, We did' forums, a pay review using 2% of the hospital's budget and linking pay to performance and development, and development of the Pinehill staff engagement forum.
- There were regional clusters in the organisation which leaders from different Ramsay hospitals in the area used to build positive and collaborative working relationships across the corporate group.
- The senior leadership team worked to develop relationships with a range of stakeholders including local acute trusts, consultants, and clinical commissioning groups (CCGs). They worked together to review local contracts, performance, capacity and demand, to shape future delivery of services.

Learning, continuous improvement and innovation

- **The service was committed to improving services. They mostly learned lessons when things went well or wrong, promoting training, research and innovation.**
- During our inspection, we found a number of things that had improved since the previous inspection:
  - The appraisal compliance on the ward had improved and was 92% for nurse and 100% for healthcare assistants.
  - Mandatory training compliance had improved for safeguarding and resuscitation training.
  - All areas were clean and free from dust.
  - All policies seen on inspection were in line with national guidance.
  - Fluid balance charts were fully completed.
- We saw areas of concern that were highlighted in our September 2017 inspection that had not improved. For example:
  - All records were not fully completed. Patient risk assessments were not completed post-operatively. This meant that there was a risk of patients coming to harm whilst on the ward areas.

- There were still high levels of agency being used in theatres due to recruitment and retention issues.

- The head of clinical services was proud of the teams, they said that the staff were really engaged and looked for solutions rather than problems and demonstrated their desire to make improvements.
- The hospital had implemented the "speaking up for safety" programme to support the culture of safety and ensuring high professional standards were maintained throughout the hospital.
- The service showed innovation with trialling a new voice activated nurse call system, which would assist patients who were not able to press the button. We were told that if this was a successful trial that it could be rolled out across the Ramsay group.
- There was a focus on continuous improvement and quality. Leaders were responsive to concerns raised and performance issues and sought to learn from these and used the information to improve services.
- The hospital reported serious incidents and never events to external bodies in accordance with requirements. They used findings or investigations and root cause analyses to identify areas for improvement. Part of the actions in implementing improvements were to shared learning widely with staff to ensure changes in practise.
- Staff used the staff engagement forums to work together to solve problems. Staff were encouraged to suggest solutions to problems and concerns and the staff engagement forum provided an opportunity to discuss issues and recommend improvements to service delivery.
- Examples of some improvements which had been made at the hospital were:
  - A review of anaesthetic charts used in theatre, to improve consistency of documentation. The new chart was planned to be implemented across Ramsay Healthcare UK.
  - Staff had introduced chaperone cards for use in the outpatient department. The cards were handed out to patients by reception staff on arrival with the aim of highlighting a patient's right to a chaperone. This was developed to avoid patients feeling embarrassed to ask for chaperones and to improve their overall experience.
  - Discharge bags had been developed which contained information leaflets, a copy of the GP letter and medications. Patients were given the bags on discharge from the ward and a sticker was placed in their records to document that this had been done. The aim was to ensure that all discharge processes were completed and no elements were omitted in error.
  - Situation, Background, Assessment, Recommendation (SBAR) escalation sheets had been issued to all staff to promote accurate communication between staff and improve patient safety.

Good

Outpatients

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

Information about the service

Pinehill Hospital is operated by Ramsay Health Care UK Ltd. The hospital provides an outpatient service for adults and older people. The hospital discontinued all paediatric services as of September 2018.

The hospital provides an outpatient service for various specialties to both private and NHS patients. The breakdown of activity by speciality is: Orthopaedic 28%, General Surgery 10%, Gynaecology 10%, ENT 10%, Urology 9%, Gastroenterology 7%, Ophthalmology 7%, Anaesthetics 6%, Dermatology 4%, Rheumatology 1%, Plastics 1%, Other 5%.

Pinehill hospital treat NHS funded patients, as well as patients who wish to pay for their own treatment. Outpatient mix: 63% NHS funded, 37% Non-NHS funded.

From August 2017 to July 2018 there were 49,292 (86% of total hospital activity) outpatient attendances.

During the inspection, we visited the outpatients service, physiotherapy service and phlebotomy. We spoke with 23 staff including; allied health professionals, nursing staff, health care assistants, reception staff, medical staff, and senior managers. We spoke with 15 patients. We also reviewed 10 sets of patient records. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Outpatient services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as requires improvement.

Are outpatients services safe?

Good

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

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse. They had training on how to recognise and report abuse and knew how to apply it.
- Systems and procedures were in place to assess, monitor and manage risks to patients.
- Staffing levels were adequate for the service provision.
- Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.
- Arrangements for managing medicines in outpatient services were suitable to ensure patients were kept safe from avoidable harm.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and

shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

- The risks associated with anticipated events and emergency situations were recognised and systems were in place to deal with these.

However:

- Whilst the service generally controlled infection risk well, staff kept themselves, equipment and the premises clean, carpet was present in consultation and treatment rooms in outpatients and physiotherapy, which could be an infection control risk. A standard operating procedure was in place to mitigate the risk, and we saw evidence of regular steam cleaning schedules. A plan was in place to remove all carpeted areas in the future.
- The service had suitable premises and equipment and generally looked after them well. However, not all equipment was within date for safety testing. Electrical safety testing had expired on some equipment meaning that we could not be assured that it was safe for use.

Mandatory training

- **The service provided mandatory training in key skills to all staff and made sure everyone completed it.**
- Staff received effective mandatory training in safety systems, processes, and practices. The hospital delivered a mandatory training programme internally for all staff members, including clinical and non-clinical. Staff attendance was recorded to ensure compliance and the training was delivered on a monthly basis throughout the year.
- Staff told us they had completed mandatory training, which was delivered either face to face or by e-learning. It included topics such as safeguarding for adults, Mental Capacity Act 2005 (MCA) deprivation of liberty safeguards (DoLS), dementia, infection prevention and control, manual handling, emergency management & fire safety, information security, and equality & diversity. A mandatory training matrix was in place which detailed the training course, the frequency of the training and which roles it was applicable to.
- Staff knew how to access mandatory training and told us they could find out when they were next due for an update. Staff spoke positively of mandatory training modules and felt able to access further assistance if required. Staff were confident they would be supported to attend additional training if required.
- The target set by the hospital for staff to complete mandatory training was 95%. Data provided by the hospital showed that as of December 2018, compliance for mandatory training in the outpatient department was achieved for 19 out of 25 modules. Compliance for mandatory training in the physiotherapy department was achieved for 12 out of 25 modules. An overall mandatory training compliance was not provided. However, most staff in outpatients and physiotherapy were up to date with their mandatory training. There was a very small staff sample and only one or two members of staff were not up to date with their mandatory training in a few modules. This is an improvement since our last inspection where compliance with mandatory training was low and we were not assured effective action was taken to address non-completion of mandatory training.
- To encourage staff to remain up to date with their mandatory training, their annual pay review was dependent on them being up to date with their mandatory training.
- During our last inspection, we were not assured that staff could assist in an emergency as compliance with completing basic life support training was low. At this inspection, we found this had improved. Data provided by the hospital showed 100% of staff had completed basic life support training in the outpatient department and all staff, except one, in the physiotherapy department had completed basic life support training.

Safeguarding

- **Staff understood how to protect patients from abuse. They had training on how to recognise and report abuse and knew how to apply it.**

Good

Outpatients

- The hospital had safeguarding policies and procedures available to staff, including details of who to contact in the event of a safeguarding concern. Staff we spoke with understood their responsibilities and were aware of the safeguarding policies and procedures.
- Staff were able to name the safeguarding lead for the organisation. Staff told us that the safeguarding lead was very proactive and always available for help and advice.
- Staff demonstrated a good understanding of safeguarding vulnerable adults at risk.
- We noted there were contact details for the hospital safeguarding lead on display in the staff offices, so staff would know who to contact if they had any concerns.
- Staff could describe what would constitute a safeguarding concern and the action they would take to raise concerns. Staff also showed an awareness and understanding of recognising female genital mutilation (FGM).
- All staff we spoke with told us they had completed safeguarding training for adults. Safeguarding training data showed that as of December 2018, 100% of staff in outpatients and physiotherapy had received safeguarding training levels one and two. The safeguarding level two module included training on the Mental Capacity Act 2005 (MCA), deprivation of liberty safeguards (DoLS), FGM, and Prevent. The hospital had held a number of safeguarding shared learning sessions locally to allow staff a forum to learn from incidents reported.
- Visitors to the hospital were required to sign in and wear a visible identification badge. This made sure patients and staff were protected from unauthorised personnel.
- The hospital had recently installed a secure access across the hospital to improve security and limit access to patient areas.

Cleanliness, infection control and hygiene

- **The service generally controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**
- Effective standards of cleanliness were maintained across outpatient areas, physiotherapy and phlebotomy, with reliable systems in place to prevent healthcare-associated infections.
- The outpatient and physiotherapy departments, including waiting areas, clinical areas, phlebotomy and equipment trolleys, were visibly clean and dust free. Consultation rooms and equipment, including the physiotherapy gym, were tidy and clean. This was an improvement from the last inspection when we were not assured there was an effective system in place to ensure all equipment was cleaned regularly.
- There were specific environmental daily cleaning schedules in place throughout all areas. We were told that domestic staff clean all areas daily, and nursing staff clean between patients. We noted that cleaning schedules were all signed and dated to evidence regular cleaning took place. We saw clean equipment was labelled with dated 'I am clean' stickers so staff knew the items were clean and ready for use.
- Carpet was present in consultation rooms in outpatients and physiotherapy. There was both carpeted and vinyl areas on the floor in the consultation rooms. The patients' examination couch was situated on the vinyl floor area, which mitigated any risk of contamination. The Department of Health (2013) Health Building Notes (HBN) 00-10 regulation consider floors should be washable, and have curved edges to prevent bacterial growth. A standard operating procedure was in place to control the risk. The service level agreement showed that carpets were steam cleaned every three months and we saw evidence of steam cleaning schedules to support this. Staff informed us that nursing staff would be responsible for clearing any spillages such as bodily fluids or blood in the first instance, if this were to occur. Domestic staff would then steam clean the area. Staff told us there were plans in place to remove all carpeted areas in the future in order to reduce the risk of infection.

Good

Outpatients

- Staff had received training about infection, prevention, and control (IPC), and hand hygiene during their initial induction and as part of their mandatory training. Data provided by the hospital showed that as of December 2018, 100% of staff across outpatient services and physiotherapy had completed their IPC training either face to face or through e-learning. This meant we were assured staff had up to date infection prevention and control knowledge.
- Staff in the phlebotomy service were able to describe the correct processes and hand hygiene techniques for taking blood. There were posters in the phlebotomy room reminding staff of the correct process. Additionally, the phlebotomy room was fully compliant with HBN requirements.
- There were reliable systems in place to protect and prevent people from healthcare-associated infections. Data confirmed there had been no cases of hospital acquired MRSA, Methicillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) or E. Coli in the reporting period 1 August 2017 to 1 July 2018.
- Handwashing facilities and hand gel dispensers were available in every treatment and consultation room in the outpatient and physiotherapy departments. Hand washing technique information posters were displayed above sinks.
- Paper towels were readily available in areas where people washed their hands.
- Staff followed the hospital policy regarding hand hygiene and infection control. This included staff being 'arms bare below the elbow'. We did not have the opportunity to observe many occasions of staff hand hygiene, however, of the three consultations we did observe, all followed the hand hygiene protocol.
- Hand gel dispensers were located at the entrance of outpatients' department and physiotherapy unit. Posters were displayed promoting and encouraging hand hygiene for visitors. We observed reception staff asking patients and visitors to apply the hand gel when they booked in at the main outpatient waiting area.
- Hand hygiene audit results from July 2018 showed that there was 100% compliance with hand hygiene techniques for both outpatients and physiotherapy.
- Personal protective equipment (PPE), such as gloves and aprons, were available in sufficient quantities and was readily available in each consulting and treatment room.
- The examination couches seen within the consulting and treatment rooms were clean, intact and made of wipeable materials. This meant the couches could easily be cleaned between patients.
- Disinfectant wipes were available in the outpatients and physiotherapy departments to wipe down treatment couches between patients. We also noted white paper rolls were used on examination couches and changed between patients.
- Although there were no designated waiting areas for patients with communicable or infectious diseases like diarrhoea, tuberculosis or seasonal flu, staff informed us that these patients would be seen in a separate treatment room, which would be deep cleaned after use. Staff told us they would seek advice from the infection control lead to ensure appropriate precautions and actions were taken to minimise the risk of cross-infection.
- Disposable curtains were in use around areas that contained patient treatment couches.These were dated with the date on which they were last changed. We noted that all curtains we checked had been changed, in line with hospital policy.
- All clinical rooms had appropriate facilities for the disposal of clinical waste and sharps. All sharps boxes were clean, were not overfilled and had temporary closures in place to minimise the risk of needle stick injuries. We were assured that sharps were disposed of safely.
- We saw waste was separated and in different coloured bags to signify the different categories of waste. This was in accordance with the Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health (COSHH), health, and safety at work regulations.

- We observed good waste management processes with offensive and hazardous waste bags being readily available and regularly disposed of.
- We noted that there was a biohazard spill kit (containing the relevant equipment to manage blood and other bodily fluid spillages), which was easily accessible and in date. There was a secure area for storage of chemicals in line with control of substances hazardous to health (COSHH) regulations.
- We noted there was a good decontamination process and defined cleaning pathway in place for flexible nasal endoscopes, which were fully compliant with theDepartment of Health (DH) Health Technical Memorandum (HTM) 01-06 part A-E: safe management and decontamination of naso-endoscopes. Naso-endoscopes were appropriately tracked and traced, in line with best practice.

Environment and equipment

- **The service had suitable premises and equipment and generally looked after them well. However, not all equipment was within date for safety testing.**
- A programme of refurbishment had commenced across outpatient areas to improve the environment and increase the potential to prevent the risk of infection. All outpatient consultation rooms and corridor areas had recently been redecorated.
- The outpatient service had 10 individual consulting rooms, two treatment rooms, a dirty utility room and an outpatient waiting area. In addition, there was one room used by phlebotomy which was located near the main outpatient waiting area. All consulting rooms we saw each had a couch area for procedures, appropriate hand wash and hand sanitiser facilities, personal protective equipment dispensers, emergency call bells and chaperone posters on display. All consulting rooms we saw were lockable and were equipped with a desk and chairs for discussions with patients.
- There were sufficient toilets within the department for use by male and female visitors which we saw were clean and regularly inspected for cleanliness. Disabled toilets and baby changing facilities were also provided.
- The physiotherapy department consisted of a gymnasium and four treatment rooms, with the option to turn two cubicle areas in the gym into additional treatment rooms. The department was tidy and well equipped with handwashing and hand sanitisation facilities. There was a reception area by the entrance which was manned by a receptionist and provided a waiting area for patients attending a physiotherapy appointment. All equipment we checked was within its expiry date.
- Over the last 12 months the hospital had installed a secure access across the hospital to improve security and limit access to patient areas.
- During our inspection, we did not see any equipment, such as specialist chairs or couches, for larger patients. However, staff told us bariatric equipment could be obtained from the ward area if required.
- We noted that all patient furniture in both the outpatient department and physiotherapy unit, such as chairs and couches, was in a good state of repair and was compliant with HBN 00-09 (that is it was fully wipeable).
- The maintenance of equipment was completed through a service level agreement. A schedule of work was in place and equipment was assessed annually as safe for use. Most equipment we observed had evidence of safety testing where appropriate. However, we saw a computer screen and computer terminal where this had expired in December 2016. Electrical safety testing on a blood pressure machine we saw had also expired in January 2018. The screen on a machine used for naso-endoscopes had also expired in June 2018. This was raised with staff during our inspection who told us all out of date equipment would be tested for safety.
- Nursing staff told us some of the equipment used in the outpatient department belonged to consultants and remained onsite. Consultants were responsible for ensuring their equipment was maintained. Copies of records evidencing that the equipment had been maintained and calibrated had been received as required and kept with the consultant's practicing privileges. The granting of practising privileges is a well-established process within independent

healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic, in independent private practice, or within the provision of community services.

- There were sharps disposal bins available in all the consultation and rooms and we noted the bins were correctly assembled, labelled, and dated. None of the bins were more than half-full, which reduced the risk of needle-stick injury. This is in accordance with the Department of Health (DH) Health Technical Memorandum (HTM) 07-01: Safe management of healthcare waste.
- There was a service level agreement for the decontamination and maintenance of equipment. Staff reported that equipment was returned to the department promptly, and stated they had sufficient equipment to meet the demands of the service.
- Fire extinguishers were visible and dated. Staff we spoke with explained the evacuation procedure and told us that they regularly attend fire prevention updates.

Resuscitation Equipment

- Adult resuscitation equipment was available in case of an emergency. This was easily accessible by both outpatient and physiotherapy staff.
- The resuscitation trolley was locked and there was evidence of appropriate daily and weekly checks in line with hospital policy. We reviewed records for the last 18 months and noted there were no gaps. All drawers had correct consumables and medicines in accordance with the checklist. We noted consumables were in date and trolleys were clean and dust free. The automatic electrical defibrillator worked and suction equipment was in order.

Assessing and responding to patient risk

- **Systems and procedures were in place to assess, monitor and manage risks to patients.**
- All patients were required to complete a medical history questionnaire prior to their appointment, which included whether they had any known allergies, infection risks and details of medication they were taking. This information was reviewed to ensure potential risks were identified prior to treatment.
- We saw that emergency call bells were located in all consultation and treatment rooms in outpatients and physiotherapy. These sounded an alarm when activated, which triggered a 'crash' response from staff across the hospital so that an unwell or deteriorating patient could receive prompt assistance. Over the last 12 months the hospital had completely upgraded and improved the call bell system to ensure all patients and visitors could request assistance or initiate an emergency response.
- The hospital had a clear pathway and process in place for the assessment of patients who became unwell within the outpatient area. The service always had access to a resident medical officer (RMO) who provided support to the outpatient and physiotherapy staff if a patient became unwell. Staff informed us that if a patient was to deteriorate whilst in the department, the 'Deteriorating Patient Policy' would be followed, which included calling the RMO to assess the patient. Nursing and physiotherapy staff could provide examples of actions taken when a patient had become unwell in the department. This meant in the event of a patient becoming unwell, appropriate action was taken to assess and respond to the patients' needs without putting them at risk of deterioration.
- There was a resuscitation trolley situated in the outpatient department which could be used in an emergency. The physiotherapy department did not have their own but could easily access the one in the outpatient department, as all departments were situated on the ground floor, in close proximity to one another.

Nurse staffing

- **The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- An electronic rostering tool was used across all departments, in line with the corporate rostering policy, to ensure safe staffing levels. The tool enabled managers to effectively manage rotas, staffing requirements, skill mix and senior cover.
- The manager reviewed staffing requirements in advance of clinic sessions held each week. There were

safe staffing levels in the outpatient department with a full establishment of staff in post. Data provided by the hospital showed that there were 4.3 whole time equivalent (WTE) registered nurses in post and 3.1 WTE health care assistants. Hospital data showed that there had been no agency staff use for registered nurses or health care assistants from May to July 2018. The outpatient sister told us that any shortage in staff was covered by regular in-house bank staff who were familiar with the service. This meant patients could be assured that staff were familiar with the service provided and the needs of the patients.

- Data provided by the hospital showed staff sickness in the outpatient department, as of July 2018, was reported at 0% for nursing staff, and 21.6% for health care assistants.
- Data provided by the hospital showed there were no unfilled shifts between May and July 2018. Where additional staffing was required to cover sickness or annual leave, this was generally covered by bank staff.
- We saw evidence of a competency and induction checklist for new, bank and agency staff. All new starters underwent an induction process and worked supernumerary for a minimum of two weeks, to ensure they received adequate support and supervision. The induction process included the completion of competencies and training requirements.
- All professional staff within the outpatient and physiotherapy department were registered with their respective professional bodies and the register was checked as part of the hospital's recruitment process.
- In the physiotherapy department, there was a team of 13 physiotherapists and two physiotherapy technicians, who were led by a physiotherapy manager.

Medical staffing

- **The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.**
- Medical staff practising within the outpatient department had their registration with the General Medical Council (GMC) verified as part of the hospital's recruitment process and monitored weekly by the hospital director. Most consultants employed at the hospital held substantive posts in neighbouring NHS trusts.
- Medical staff were employed within the hospital under practising privileges rules. These staff worked across the outpatient department and inpatient wards. In the outpatient department, medical staff delivered clinics for specialties, which included orthopaedics, general surgery, gynaecology, ENT, urology, gastroenterology, ophthalmology, anaesthetics, dermatology, rheumatology, and plastics.
- Consultants attended the outpatient department on set days at set times. This meant the department knew in advance of which consultant was attending and appropriate staff training could be arranged in advance.
- Consultants were responsible for ensuring arrangements were in place to cover planned leave and any other circumstances.
- The RMO provided a 24 hour a day, seven days a week service on a rotational basis. They could be contacted for medical advice, in the event of an emergency and for patients who required additional medical support.

Records

- **Staff kept appropriate records of patients' care and treatment. Records were clear, up-to-date and available to all staff providing care.**
- We reviewed 10 patient records and noted that all records were clearly written, legible, signed, and dated. In each set of records, the patient's medical history, consent and allergies information was completed. Referral letters, care plans and risk assessments were available, where applicable.
- Patient records in all departments were stored securely in a locked cupboard, in line with legislation.
- Patients medical records were available for their clinic appointments. Data provided by the hospital confirmed that from May to July 2018, less than one percent of patients had been seen in the outpatients without a medical record. Staff were aware of the process to request medical records in the event that they were not available when a patient arrived for their appointment.
- An established process was in place to mitigate risk if a patient attended an appointment and their medical

record was not available. A temporary medical record would be created and an additional set of patient labels would also be printed. Copies of referrals and medical history would be obtained for first appointments from the GP or the referring hospital. For follow up patients, copies of clinic letters would be provided by either the medical secretaries or the NHS office. All available hospital correspondence would then be printed and filed in the temporary medical record. The service had full electronic access to diagnostic results and bloods results if the paper copy was not present in time for an appointment.

- Patient records were managed in line with the corporate medical records policy. Staff we spoke with told us that consultants were encouraged not to remove hospital medical records from the site. Consultants had a responsibility to meet the hospital's regulatory requirements for keeping their private patient notes. All consultants were required to register with the Information Commissioners Office (ICO) and this was checked annually.

Medicines

- **Arrangements for managing medicines in outpatient services were suitable to ensure patients were kept safe from avoidable harm.**
- We found no controlled drugs being stored within outpatients or physiotherapy. A controlled substance is generally a drug or chemical whose manufacture, possession, or use is regulated by a government, such as illicitly used drugs or prescription medications that are designated a Controlled Drug in the United Kingdom.
- The outpatients' department had appropriate lockable storage facilities for medicines. During our last inspection, we found the keys to medicine cupboards were not stored in accordance with national guidance as unauthorised members of staff had access to the cupboard where the keys were kept. At this inspection, we found the process for storing keys to the medicines cupboard had improved and only authorised staff had access.
- During our last inspection, we found blank prescription pads were not stored securely and robust monitoring systems were not in place to ensure that all prescriptions were accounted for. We noted during this inspection the process had improved. Blank prescriptions, both private and NHS, were stored securely and systems were in place to monitor the use of prescriptions. The service kept a log of each prescription for audit and tracking purposes. The process for management of prescriptions was safe.
- Hospital pharmacy opening times were Monday to Friday, 8.30am until 6pm. The pharmacy team provided a full outpatient dispensing service daily. Out of hours cover was provided by an on-call pharmacist at a neighbouring NHS trust.
- All the medicines we inspected were within their expiry dates and records showed that the fridge temperatures were maintained within the required temperature for the safe storage of medicines, between 2 and 8°C. We saw that fridge temperatures were monitored daily and recorded.
- All medicine cupboards and fridges were clean and tidy. The medicines refrigerators were kept locked.
- We saw evidence that room temperatures were monitored and were below the recommended 25°C. Staff told us that if the room temperature reached above 25°C, pharmacy would be contacted and the incident would be recorded on the risk register. This meant medicines were stored in a safe manner.
- There were robust systems in place to ensure that medicines were safely managed and accounted for. Pharmacy staff regularly checked stock levels and had processes to monitor expiry dates.
- For our detailed findings on medicines please see the Safe section in the surgery report

Incidents

- **The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**
- There had been no never events reported for outpatients or physiotherapy from August 2017 to July 2018. Never events are serious patient safety incidents that should not happen if healthcare providers follow

national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

- Data provided by the hospital showed there had been no serious incidents reported for outpatient services in the period from December 2017 to November 2018.
- During the period from July 2017 to June 2018, there were 63 clinical incidents and 12 non-clinical incidents reported within outpatients. All clinical and non-clinical incidents were reviewed monthly, categorised into trends for learning and reported on within the monthly 'Incident Feedback and Shared Learning Report'.
- Actions to improve these were discussed at clinical governance committee meetings and departmental meetings. There were no incidents reported which had resulted in patient harm.
- There was an electronic reporting system in place to allow staff to report incidents. There was a positive incident reporting culture in the department; all staff we spoke with had received training and were encouraged to report incidents. Staff knew how to access the system and their responsibilities to report incidents. Staff told us they were provided with feedback after reporting an incident and that learning from incidents was shared across areas through staff meetings, daily huddles, monthly reports and emails. Staff we spoke with in the outpatient and physiotherapy department told us information was shared through the monthly 'Incident Feedback and Shared Learning Report', which included lessons learned from incidents and action plans.
- All staff could give examples of when they have or would need to report an incident.
- When things went wrong, staff apologised and gave patients honest information and suitable support. Staff were aware of the duty of candour regulation and described how they applied the principles by being open and honest with patients at all times and admitted any mistakes. Staff could give us examples of where they had used this in practice or instances where they would use it. We spoke with the outpatient sister who gave us an example of how duty of candour principles were applied following an incident, where a clinic was cancelled, requiring patients to come back to the hospital to attend a re-scheduled clinic. They explained to patients what had happened and apologised. 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our last inspection, most staff we spoke with were unaware of what duty of candour meant. We therefore saw an improvement in staff knowledge during this inspection.

Emergency awareness and training

- The hospital had a business continuity plan in place which was reviewed annually. Staff could access this through the hospital intranet. Staff we spoke with were aware of the plan, and understood their responsibilities in the event of an emergency or major incident.
- Staff we spoke with gave an example of procedures followed during a power outage earlier in the year.
- There were emergency call alarms in the consulting and treatment rooms in the outpatient and physiotherapy departments. The emergency bleep holders were automatically alerted when an alarm was raised. Staff would use the emergency call alarms to summon assistance as needed.
- All staff we spoke with said they received regular fire safety awareness training.
- Data provided by the hospital showed 100% of outpatient and physiotherapy staff had received major incident training. Most staff in the outpatient department (92%), and 89% of physiotherapy staff were up to date with fire evacuation training.

Are outpatients services effective?

Not sufficient evidence to rate

The effective domain for outpatient and physiotherapy services was inspected; however, this domain is not currently rated.

Good

Outpatients

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- There was a regular audit programme for all departments across the hospital.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held regular meetings with them to provide support and monitor the effectiveness of the service. Staff we spoke with confirmed they had completed all mandatory training and competency assessments.
- Staff were supported to complete additional training and development.
- Staff in different teams worked together to benefit patients. Doctors, nurses and other healthcare professionals, supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

Evidence-based care and treatment

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.**
- Specialties within outpatient services delivered care and treatment in line with the National Institute for Health and Care Excellence (NICE) and national guidelines, where appropriate. Policies were up to date and assessed to ensure they did not discriminate based on race, nationality, gender, religion or belief, sexual orientation or age. Staff in outpatients and physiotherapy had a good awareness of policies and procedures. They could give us examples of how to find policies and when they had used them.
- There was a regular audit programme for all departments across the hospital, which outpatients and physiotherapy participated in. This included, but was not limited to, audit of health records, focused operational audits, infection prevention and control, hand hygiene, medicines management, environmental, cleaning schedules, and decontamination. We saw that there was good compliance with completion of these audits and that there were action plans in place.

Nutrition and hydration

- Patients who attended clinic appointments were not generally in the department for long periods of time, therefore beverages and food were not provided.
- Water dispensers were available in waiting areas in both the outpatient and physiotherapy department.
- Staff we spoke with told us that patients were able to have diet and fluids if needed, and snacks could be provided to diabetic patients.

Pain relief

- Pain relief was not routinely administered within the service as patients attended for a short period and usually took analgesia before attendance if required. Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care, or the resident medical officer would prescribe analgesia if necessary. Local anaesthetic was administered to patients undergoing minor surgery.
- The hospital provided pain management clinics for patients referred with musculoskeletal based pain. These clinics were run by a pain consultant who had achieved competencies and experience in pain medicine. Patients could be referred for physiotherapy services, as needed.
- Patients we spoke with had not required pain relief during their attendance at the outpatient department.

- We observed a consultation in outpatients between a patient and a doctor where the patient's experience of pain was discussed and appropriately managed.

Patient outcomes

- **The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**
- The outpatient and physiotherapy departments contributed to the hospital's corporate audit programme. This included, but was not limited to, audits of patient health records, operational audits, infection prevention and control, hand hygiene, and medicines management.

Competent staff

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held regular meetings with them to provide support and monitor the effectiveness of the service.**
- Staff were competent and trained to carry out their roles, in order to meet the needs of patients They were supported to undertake training to enhance their knowledge and skills. Staff we spoke with confirmed they had completed all mandatory training and competency assessments.
- The outpatient manager and physiotherapy manager kept records of the mandatory training staff completed.
- Throughout the service, we saw that staff received training to support the delivery of care and meet individual's developmental needs. Senior managers were able to complete an institute of management and leadership course (ILM), if they so wished.
- All hospital staff were supported to complete additional training available through the provider's corporate academy. A health care assistant we spoke with was completing a nurse degree apprenticeship scheme, which would lead to registration as a qualified nurse. The heads of departments were able to undertake a number of management courses which enabled them to be more effective within their roles. They told us that there were no restrictions on study leave or eLearning.
- Staff told us they had records of the training they received which described the level of competency they had achieved. All staff we spoke with had a competency file.
- Staff told us they were supported and encouraged to develop. They said they were supported by their supervisors and managers and received regular reviews and appraisals.
- Outpatient and physiotherapy staff told us they received an annual appraisal, in addition to six-month reviews. This process was used to identify any learning needs for the next year. Evidence showed that at the time of inspection, outpatient and physiotherapy departments were on target and all staff had received an appraisal. Data received from the hospital confirmed that 100% of physiotherapy staff and 100% of outpatient staff had received an appraisal.

Multidisciplinary working

- **Staff in different teams worked together to benefit patients. Doctors, nurses and other healthcare professionals, supported each other to provide good care.**
- Staff we spoke with felt they had good working relationships with other colleagues, including consultants. For example, physiotherapy staff told us they worked closely with pre-assessment colleagues, the pain consultant and orthopaedic consultants so patients received a timely and streamlined service.
- Medical and nursing staff reported good working relationships with neighbouring NHS trusts.
- There was a strong multi-disciplinary team (MDT) approach across all the areas we visited. Staff of all disciplines, clinical and non-clinical, worked alongside each other throughout the hospital. We observed good collaborative working and communication amongst all members of the MDT. Staff reported that they worked well as a team.
- Managers and senior staff in both the outpatient and physiotherapy department held regular staff meetings.

All members of the multidisciplinary team attended and staff reported that the meetings were a good method to communicate important information to the team.

- Each of the departments were represented at a daily 10@10 meeting, during which time any concerns, challenges or concerns about patient care, treatment or satisfaction were escalated and discussed.
- The service had hosted a number of masterclass events at local venues; including hotels, conference centres and local GP surgeries. These sessions were educational in nature and presented by specialist consultants enabling best practice to be shared with a multi-disciplinary approach.

Seven-day services

- The outpatient department offered appointments 8am to 9pm Monday to Friday, and 8am to 1pm on Saturdays. This enabled patients to attend the hospital at a time that suited them.
- Staff confirmed that when the outpatient department was closed and patients had any queries, for example regarding wound management, the RMO would be called to advise. The RMO provided a 24 hour a day, seven days a week service on a rotational basis.
- The physiotherapy department was staffed Monday to Friday 7.30am to 8pm. In addition, there was a weekend rota to provide support to inpatients.

Health promotion

- We noted there were various information leaflets available in the main waiting areas for both the outpatient and physiotherapy departments. This included, but was not limited to, 'Knee Replacement Surgery' and 'Monitoring Surgical Wounds for Infection'.

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

- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.**
- There was a hospital policy to ensure that staff were meeting their responsibilities under the MCA and Deprivation of Liberty Safeguards (DoLS). Staff said they had had training in MCA and DoLS as part of their mandatory training.
- Data provided by the hospital showed 100% of staff in both the outpatient and physiotherapy departments were up to date with training in mental capacity, including deprivation of liberty safeguards.
- Staff in outpatients and physiotherapy told us they rarely encountered patients living with dementia or who lacked capacity. However, they were able to describe the process they would follow if they suspected a patient lacked capacity, and knew who to contact for further support or advice on this. Data provided by the hospital showed 100% of staff were up to date with training in dementia in both the outpatient and physiotherapy departments.
- The hospital had an up to date policy regarding consent, which staff could access through the hospital intranet. Nursing, therapy and medical staff understood their roles and responsibilities regarding consent and were aware of how to obtain consent from patients. Consent training was delivered through a competency based system. Data provided from the hospital showed there were eight registered nurses working within the outpatient department who had all completed their registered nurse competency document, which included consent.
- Patient records we reviewed contained evidence of appropriate consent, where required.
- Patients told us that staff were very good at explaining what was happening to them before asking for consent to carry out examinations or procedures. All patients we spoke with felt their care and treatment was fully explained, and that they were given enough time to ask questions if they were not clear about any aspect of their treatment. They described having treatment options explained so that they were informed to make their own decisions.

Good

Outpatients

Are outpatients services caring?

Good

Our rating of caring stayed the same. We rated it as **good.**

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Patients were treated with dignity, respect and kindness during all interactions with staff.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment. They were communicated with and received information in a way that they could understand.

Compassionate care

- **Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.**
- We spoke with 15 patients during our inspection and all spoke highly of the care and compassion they were shown by all the staff they encountered during their time in the hospital.
- Feedback from patients confirmed that staff treated them well and with kindness. One patient described a consultant as “Amazing. He is very professional, extremely caring and wants the best for you”. A patient with a phobia of confined spaces described the support she received when going for a scan: “the staff kept me calm and were brilliant”.
- The reception area was very open meaning that conversations could easily be overheard. Although patients mentioned this, they also pointed out that reception staff were careful not to discuss anything personal. There was also a sign on the desk requesting patients respect the privacy of others.
- Chaperones were available. On arrival, patients were given a form on a clipboard to fill in and a card offering the chaperone service was attached. We saw clear signs in the consultation rooms advising patients of their right to request a chaperone during appointments.
- We observed caring and positive interactions with patients during their consultations.Discussions and examinations took place in the consultation rooms to ensure privacy. Nursing and medical staff used curtains around the examination couch and patients were covered up when sensitive examinations took place.
- Staff introduced themselves and took time to interact in a considerate and sensitive manner.
- Staff were friendly and helpful and responded sympathetically to queries in a timely and appropriate way.
- The hospital obtained patient feedback through the Friends and Family Test (FFT), which allowed patients to state whether they would recommend the service and give feedback on their experiences. Between February and July 2018 scores ranged from 98% to 100% for outpatient services, but response rates were low, ranging from 18% to 33%.
- There were cards in reception with the website address encouraging patients to leave feedback on their experience at the hospital.

Emotional support

- **Staff provided emotional support to patients to minimise their distress.**
- Staff throughout the department understood the need for emotional support. We spoke with patients and relatives who all felt that their emotional wellbeing was cared for. Patients we spoke with said that they had received good emotional support and felt that they been given ample time in which to ask questions.
- Written information was provided to patients which helped explain their condition and treatment plan. However, there was no access to communication aids such as easy read materials.
- Patients were given contact details and encouraged to contact the service if they had questions following a consultation.
- Staff had ‘dealing with difficult patients training’ to help them support a patient if they became distressed.

Understanding and involvement of patients and those close to them

Good

Outpatients

- **Staff involved patients and those close to them in decisions about their care and treatment.**
- Patients we spoke with said that they had received good information about their care and treatment and had been involved in decisions about their care. One said, “staff are reassuring and make sure you are comfortable and know what is happening next”.
- Following their appointment, any future appointments were arranged with the patient by reception before they left.
- Patients we spoke with told us medical and nursing staff explained their care and they were offered choices and options about the timing of their treatment. Patients and relatives told us they felt able to ask questions and medical staff provided them with the information they needed to address any concerns. One patient said, “they are really good at making sure you understand what’s involved and give contact numbers in case you have questions after”.
- We observed good interactions between staff and patients at a gym class in the physiotherapy department. They discussed treatments and involved patients with their ongoing plan.
- Staff recognised when patients needed additional support to help them understand and ask relevant questions about their care and treatment. Staff had telephone access to language interpreters if they were required, and interpreters could attend appointments when booked in advance.

Are outpatients services responsive?

Good

Our rating of responsive stayed the same.We rated it as **good.**

- The outpatient and physiotherapy departments planned and developed services to meet the needs of the local population for both private and NHS patients.
- The importance of flexibility, choice and continuity of care was reflected in the service.
- The service took account of patients’ individual needs.
- Reasonable adjustments were made for patients who found it difficult to access the service.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to treat and discharge patients were in line with good practice.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Service delivery to meet the needs of local people

- **The outpatient and physiotherapy departments planned and developed services to meet the needs of the local population for both private and NHS patients.**
- Patients attending the hospital outpatient department were a mix of privately funded (37%) and NHS funded (63%) patients. The local clinical commissioning group (CCG) set criteria within their contract for NHS patients’ attendance at the hospital. This meant that local commissioners were involved in the planning of local services.
- The hospital director met regularly with the local CCG to seek feedback on services and determine if there were any changes needed to meet the needs of the local patient population.
- The outpatient department was open 8am until 9pm Monday to Friday, and on a Saturday morning. The physiotherapy department was open 7.30am to 8pm Monday to Friday. Evening and weekend appointments allowed patients access to healthcare that suited their circumstances.
- There was an on-site phlebotomy service open from 8am until 6pm Monday to Friday.
- The outpatient department was clearly signposted from the entrance of the hospital and was a short walk from the main reception on the ground floor. This meant that the department was easily accessible for all patients. The physiotherapy department was also easily accessible and clearly signposted.
- The outpatient and physiotherapy environments were appropriate and patient centred. The main outpatient area was spacious and comfortable. Each department had its own waiting and reception areas. All areas had

appropriate facilities to meet the needs of adult patients awaiting appointments. This included adequate and comfortable seating, access to bathrooms, water dispensers and reading material.

- Car parking facilities were available at no charge, which patients reported to be busy at times.
- Appointments were available in the evenings and on the weekend to be convenient to all. Patients were given quick access to appointments; choice of appointments and cancellations were kept to a minimum. Where there were specific patient needs identified, this was communicated to all relevant clinical departments through the advance notification form to allow for planning.
- The physiotherapy service had extended opening times to enable patients to access the service during evenings.
- Equality impact assessments and annual patient-led assessments of the care environment (PLACE) audits were carried out and reviewed regularly to ensure equal access to facilities. Patients were involved in PLACE audits. Staff felt it was essential to involve their regular users in the services provided to ensure they were constantly looking at ways to improve the quality of care provided.

Meeting people's individual needs

- **The service took account of patients' individual needs.**
- Patients with mobility difficulties had easy access to the waiting area and consulting rooms as both physiotherapy and outpatient departments were located on the ground floor. The corridors were wide which meant there was easy access for wheelchair users.
- Staff we spoke with had an awareness of patients with complex needs and those patients who may require additional support. Staff told us that patients with complex needs, learning difficulties and dementia did not attend the hospital very often.
- Staff we spoke with told us patients who became unwell whilst waiting to be seen were brought to the attention of medical staff or resident medical officer.
- The hospital had access to multi-faith chaplaincy services for any patient or visitor who may request it.
- We saw that the hospital had installed a hearing loop at the main reception desk for patients with hearing difficulties.
- The hospital had access to a telephone interpretation service if a patient required assistance with translation.
- There were arrangements in place to ensure patients who were self-funding were aware of fees payable. Staff told us they would provide quotes and costs, and ensured that patients understood the costs involved. Lists of fees were openly displayed in consultation and treatment rooms. Leaflets were available which gave an explanation to the pricing structure for self-funding and insured patients and advice for whom to contact if patients had any questions.
- General information leaflets relating to services provided, including complaints, were also available in the waiting areas.
- Written information on medical conditions and procedures was available and accessible throughout the department.
- There were water dispensers in all waiting areas in the outpatient and physiotherapy services. Hot drinks and food could be purchased from the hospital restaurant.

Access and flow

- **People could access the service when they needed it. Waiting times from referral to treatment and arrangements to treat and discharge patients were in line with good practice.**
- The hospital had a contractual target to meet for referral to treatment (RTT) times. This was to treat 95% of patients on non-admitted pathways, within 18 weeks of referral. Hospital data showed that as of October 2018, 99.6% of patients started non-admitted treatment within 18 weeks of their referral, which meant the hospital met the contractual target of 95%.
- The hospital also exceeded the national target of patients on incomplete pathways who were seen

within 18 weeks. Hospital data showed that as of October 2018, 99.2% of patients waited 18 weeks or less to be seen; this exceeded the hospital target of 92%.

- The hospital reported that they had not received any fines for breaching of RTT targets in the last 12-month period.
- Patients we spoke with told us that they had not had any significant wait for their outpatient appointment.
- We noted the clinics to be running on time and patients did not have to wait long once they had arrived in the department. Staff told us they would inform patients if clinics were running late.
- The hospital had very low 'did not attend' (DNA) rates. All patients who missed their appointment were followed up and offered a second appointment, if appropriate.

Learning from complaints and concerns

- **The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.**
- The hospital had a clear process in place for dealing with complaints. There was a complaints policy in place, which was due for review in November 2019. Staff we spoke with were aware of the complaints procedure and informed us that they tried to resolve any patient concerns immediately to prevent the concerns escalating to a complaint. Staff understood the principles of duty of candour and could describe them. We saw complaints leaflets, on how to make a complaint, were available to patients in the waiting areas.
- The themes and trends of the complaints were reviewed by the clinical governance committee and medical advisory committee on a regular basis. Lessons learned from complaints were discussed at departmental meetings to offer staff the opportunity to reflect on the complaint and collectively discuss where improvements could be made. We reviewed departmental meeting minutes and saw that complaints were discussed.
- Patients we spoke with were aware of how to make a complaint, but told us that they were happy with the service they had received.
- The outpatient and physiotherapy department received 20 complaints from December 2017 to November 2018. No complaints had been referred to Parliamentary and Health Service Ombudsman (PHSO) or the Independent Healthcare Sector Complaints Adjudication Service (ISCAS).
- Themes from complaints included dissatisfaction with staff behaviour, cancellation of appointments, complaints about administration, dissatisfaction with service, and complaints about charges and invoicing. We saw that the hospital had responded to complaints in a timely manner, and appropriately investigated complaints and apologised to all patients involved. All complaints received on a monthly basis were shared with the team through monthly feedback reports to share learning.
- Leaflets on how to complain were throughout all areas of the outpatient and physiotherapy service.

Are outpatients services well-led?

Good

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

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. There were named and experienced departmental leads for outpatients and physiotherapy services. Each lead was passionate about the service they led and worked well with the team of staff in their department.
- The hospital had a vision for what it wanted to achieve and workable plans to turn it into action. The hospital set a five-year strategy and vision from 2018 to 2021. All staff we spoke with were aware of the vision for the hospital, and understood their role in achieving it.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

Good

Outpatients

- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. People who used outpatient and physiotherapy services were actively engaged and involved when planning services. Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided.
- The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.

Leadership

- **Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.**
- The hospital had gone through significant changes within the senior leadership team over the last eighteen months. Staff told us that they felt there was good leadership within the service and the organisation, which they felt had improved in recent years. There were named and experienced departmental leads for outpatients and physiotherapy services. Each lead was passionate about the service they led and worked well with the team of staff in their department.
- Staff members were given the opportunity to engage with the senior management team and felt supported and listened to.
- Staff within the outpatient and physiotherapy department spoke positively about their local leadership and told us they felt valued and respected.
- All staff we spoke with were aware of the senior leadership team and said they were approachable, visible and supportive and leaders were positive, proud of the hospital and motivated staff.
- The service supported staff to develop leadership and management skills, with courses available for all levels of staff.
- Many staff had worked at the hospital for a long time and reported that their direct line managers were supportive and kept them informed of day to day running of the departments.

Vision and strategy

- **The hospital had a vision for what it wanted to achieve and workable plans to turn it into action, which staff in the service understood.**
- The hospital had a five-year vision and strategy from 2018-2021. All staff we spoke with in the outpatients and physiotherapy departments were aware of the vision for the hospital and understood their role in achieving it. The hospital's vision and strategy was cascaded to teams through departmental meetings and newsletters. There was no department specific vision or strategy.

Culture

- **Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.**
- All staff we spoke with felt they could be open with colleagues and managers and felt they could raise concerns and would be listened to. Staff said any inappropriate behaviour would be dealt with immediately.
- Managers encouraged learning and a culture of openness and transparency. They operated an 'open door policy' and encouraged staff to raise concerns directly with them. We saw senior leaders were visible throughout the departments. Staff told us this was a normal daily occurrence. We observed positive, friendly and caring interactions between them and local staff.

Governance

- **The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.**
- The service had clear governance systems in place. Regular meetings were held through which

governance issues were addressed. The meetings included the medical advisory committee (MAC), heads of department (HoD) meeting, and clinical governance committee meetings.

- Clinical governance committee meetings were held every other month. This committee had an overview of governance risk and quality issues for all departments. Senior managers from outpatients and physiotherapy attended these meetings..
- There was a systematic programme of internal audit for all departments across the hospital, which outpatients and physiotherapy participated in.This included, but was not limited to, audit of health records, infection prevention and control, hand hygiene, medicines management, environmental, cleaning schedules, and decontamination. Audits were completed regularly according to the audit schedule and results were shared at relevant meetings. We saw that there was good compliance with completion of these audits and that there were action plans in place.

Managing risks, issues and performance

- **The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.**
- The heads of department met monthly and the minutes showed items discussed included risks, finance, staffing, new legislation/policies, significant events, complaints, audit results, and key departmental feedback. Information from these meetings was shared back with staff in the departments.
- Heads of departments managed departmental risk registers. Risks documented on the outpatients and physiotherapy risk registers reflected what staff had told us. Governance and risk performance was discussed through the committee meeting structure.

Managing information

- **Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way.**
- The outpatient services sister confirmed that consultants could access diagnostic results electronically. This prevented delays in potential decisions and enabled the consultant to review this information prior to seeing the patient.
- Computers were available in the outpatients and physiotherapy departments. All staff had secure, personal login details and had access to email and all hospital IT systems.

Engagement

- **The service engaged well with patients, staff, and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.**
- People who used outpatient and physiotherapy services were actively engaged and involved when planning services. Patients were regularly asked to complete satisfaction surveys on the quality of care and service provided. The hospital also gathered patient opinion from the friends and family test (FFT) and patient led assessment of the care environment (PLACE) audit. Patient feedback forms were displayed in all areas of the service, which encouraged patients to leave feedback. Departments used the results of the survey to improve the service. It was clear that the department recognised the value of public engagement.
- Staff told us that managers at all levels were approachable and that they felt comfortable to raise any concerns with them.
- Staff told us they had regular team meetings. Information was shared with staff in a variety of ways, such as face-to-face, email, newsletters/bulletins, and noticeboards.
- Staff spoke highly of the opportunities for training and development offered by the hospital.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things went well or wrong, promoting training and innovation.**
- There was a culture of continuous staff development across the departments. A health care assistant we

spoke with was completing a nurse degree apprenticeship scheme, which would lead to registration as a qualified nurse. The heads of departments were able to undertake a number of management courses which enabled them to be more effective within their roles This demonstrated the hospital's commitment to continuous staff learning and improvement.

- The physiotherapy manager told us they had recently made some improvements to services. They had introduced an upper limb rehabilitation service as well as promoting women's health activities.
- During our last inspection, we saw there were plans to expand outpatients' services and purchase a static MRI, in order to meet increasing patient demand. At this inspection, we found although these plans had not progressed, the hospital were still planning to increase the capacity in the outpatients' department.
- The hospital had set up a pathway for a fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues. Staff accessed the service through the return to work interview with their line manager or if supported by a GP or occupational health referral.
- The service had also recently introduced a range of mental health support initiatives for staff. Support included, but was not restricted to; stress management courses, mindfulness courses, counselling services including sleep counselling and mental health first aid training.

Good

Diagnostic imaging

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

Information about the service

Pinehill Hospital is operated by Ramsay Health Care UK Ltd. The hospital provides a diagnostic imaging service for adults and older people. The hospital discontinued all paediatric services as of September 2018.

The hospital has an imaging department with x-ray, ultrasound, dental orthopantomogram (OPG) (an x-ray machine that allows a panoramic view of the lower face, displaying all the teeth of the upper and lower jaw), and a digital mammography. There are also two image intensifiers used within theatres. A mobile computerised tomography (CT) unit is at the hospital site weekly and a mobile magnetic resonance imaging (MRI) scanner six times a week according to patient needs. CT scans produce cross-sectional images of specific areas, an MRI uses strong magnetic fields and radio waves to generate images of the organs in the body while an image intensifier increases the intensity of available light in an optical system to allow use under low-light. CT and MRI services were provided by Ramsay Diagnostic Imaging and not by Pinehill hospital, therefore they were not inspected.

We carried out an unannounced inspection on 4 December 2018.

During the inspection, we visited the radiology service. We spoke with eight staff including; radiographers, health care assistants, reception staff, medical staff, and senior managers. We spoke with three patients and one relative. We also reviewed seven sets of patient records. Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

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

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

Are diagnostic imaging services safe?

Good

Our rating of safe stayed the same. We rated it as **good.**

- The service provided mandatory training in key skills to all staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service had suitable premises and systems in place to ensure equipment was well looked after.
- The service generally controlled infection risk well. Staff usually kept themselves, equipment and the premises clean. They generally used control measures to prevent the spread of infection. Although the premises and environments were kept clean, we saw that hand hygiene was not always maintained.
- Staff assessed risks to patients so they were supported to stay safe.

Good

Diagnostic imaging

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment
- The service had enough diagnostic imaging staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.
- Staff kept appropriate records of patients' care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- The service planned for emergencies and staff understood their roles if one should happen.

However:

- Although the service gave, and recorded administered medicines well, we did not find processes in place for the monitoring of medicines stored within the service.

Mandatory training

- The service provided mandatory training in key skills to all staff. There were processes in place to monitor compliance and ensure everyone completed it.
- The October 2016 inspection highlighted training as an area of concern. The development and training of staff was included in the hospital's quality improvement action plan 2018/19. The service had implemented processes to ensure staff were up to date with their mandatory training. During the inspection, records seen identified that all staff within the diagnostic service had completed their mandatory training.
- The service provided mandatory training courses in key skills to staff, which included "face to face" and "e-learning" training modules. Mandatory training topics covered key areas such as basic life support, manual handling, health and safety and infection control. The training figures for radiology showed 100% compliance.
- All staff undertook mandatory annual e-learning and practical training sessions for infection prevention and the consultant microbiologist provided bi-annual in-house training.
- Heads of departments were able to view all staff members compliance on the hospital's electronic training system, which detailed all their staff's training. This meant they could review all staff members training needs and discuss any non-compliance within the department.
- The consultant radiologists working for the hospital under practising privileges, did not receive mandatory training from the service. They received training from their substantive place of employment and Pinehill hospital kept a record of their completed training.

Safeguarding

- Staff understood how to protect patients from abuse and knew how to recognise and report abuse.
- Safeguarding adults and children's policies were in place and up to date. They reflected relevant legislation and local requirements, including the contact details of the local safeguarding boards. Contact numbers for making safeguarding referrals were also displayed throughout the service.
- The October 2016 inspection identified that not all staff had completed their safeguarding training. During this inspection, the data seen (December 2018) showed that 100% of staff had completed their training within diagnostics. Staff spoken with were aware of safeguarding procedures but confirmed they had limited experience of managing concerns due to the brief contact with patients, their relatives or carer. Staff told us that if they were concerned about a patient, they would contact the head of department or head of clinical services for advice. Senior management confirmed they had arranged additional training to ensure staff were more confident with the processes and procedures regarding safeguarding.
- Prevent is one of the arms of the government's anti-terrorism strategy. It addresses the need for staff to raise their concerns about individuals being drawn towards radicalisation. Prevent training formed part of the wider safeguarding agenda and encouraged staff to view a patient's vulnerability as they would any

other safeguarding issue. Training figures across the diagnostic service showed that 83% of radiographers and 100% of health care assistants had completed Prevent training as of December 2018.

- Staff undertook female genital mutilation (FGM) training alongside their level 2 adult safeguarding training and 100% of staff had completed this training as of December 2018. However, not all staff spoken with had good awareness of female genital mutilation (FGM). FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. Staff said that should they have any concerns they would contact the head of department or clinical services.
- Full details of training compliance across the hospital can be found within the surgery report.

Cleanliness, infection control and hygiene

- The service generally controlled infection risk well. Staff usually kept themselves, equipment and the premises clean. They generally used control measures to prevent the spread of infection. Although the premises and environments were kept clean, we saw that hand hygiene was not always maintained.
- The hospital's infection control processes were coordinated and led by the infection prevention and control (IPC) nurse. The IPC committee comprised of a consultant microbiologist, IPC lead, head of clinical services, pharmacy link and theatre manager. The minutes identified representation by the imaging service. Meetings were held quarterly and provided the hospital with infection prevention advice and guidance in conjunction with Ramsay Health Care infection prevention and control policies and procedures and national guidance.
- All members of staff were required to undertake a skin surveillance which included having their hands inspected. Skin surveillance was carried out by all heads of departments with a visual inspection carried out by the IPC nurse at mandatory training days annually. The annual Pinehill infection prevention and control committee report for 2017/18 showed 100% compliance with hand hygiene.
- A network of specialist nurses and infection control link nurses operated across the Ramsay organisation to support clinical practice. Pinehill hospital had infection prevention and control (IPC) link nurses in all departments which enabled them to take ownership and identify any actions needed.
- Infections were reported onto the hospital's electronic system which was reviewed quarterly at the prevention meeting and clinical governance meetings.
- Root cause analyses were carried out on all serious cases of infection according to the criteria outlined in the Health Care Acquired Infection (HCAI) Surveillance Policy IPC-14 (2015).
- We saw the results of the infection prevention and control environmental audit for July 2018 which incorporated the radiology department. The audit provided assurance that cleanliness standards were maintained with any problems identified and addressed. Results were fed back to the heads of departments at the end of the audit so they could implement any actions as required. The audit showed that the radiology area and the process for secure storage and transmitting of patient archiving and communication system (PACS), had achieved 99% overall.
- The November 2018 hand hygiene audits of individual staff entering the radiology ultrasound room and x-ray screen room showed the service had achieved 98% compliance. Staff said that any identified areas of concern were discussed with them during the audit. However, during the inspection we found inconsistencies across the radiographers in the use of hand hygiene techniques after patient contact. We found no issues with medical staff and observed doctors using hand gel after each patient contact. This was brought to the attention of senior staff who confirmed they would address this during their daily huddle.
- Equipment was cleaned after each use to ensure it was ready for the next patient. We saw completed cleaning schedules which included; ultrasound probes and machine and the patient couch. We observed, during the inspection, the ultrasound being cleaned after each procedure and the couch was prepared for the next patient with clean paper.

Good

Diagnostic imaging

- The hospital had implemented new hand hygiene dispensers and bus stop hand gel stations which we saw in place in the imaging service. Hand gel dispensers were located in the waiting area with visible signage to encourage staff and visitors to use them. During the inspection, we did not observe any patient or visitor use the hand gel dispensers and staff did not encourage visitors in their use.
- Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.
- Domestic cleaning was completed by the hospital housekeeping staff who prioritised high risk areas. For example, inpatient and treatment areas were prioritised over office areas. Senior staff were happy with the level of service they received. We saw completed cleaning schedules for the radiology service with no issues or concerns identified.

Environment and equipment

- The service had suitable premises and equipment and looked after them well.
- The hospital had access to a mobile computed tomography (CT) and magnetic resonance imaging (MRI) scanner. A CT scan uses computer processed combinations of many x-rays to create pictures of your organs, bones and other tissues while an MRI uses magnets, radio waves and a computer to make detailed pictures inside your body. The CT and MRI do not form part of this inspection as they were provided by an external company.
- Regular planned preventative maintenance was carried out on all equipment being used at Pinehill Hospital, which ensured the equipment being used was safe for use. The hospital management team reviewed equipment, planned replacements and upgrades during quality and business review meetings. The equipment replacement programme had approved the following for the imaging service:
- Ultrasound probe for radiology (January 2018)
- Ultrasound couch to expand breast service (August 2018)
- Upgrade of ultrasound to expand the breast service (August 2018)
- Access to the imaging department was through the hospital's main entrance, which had ramped access. All diagnostic imaging services were delivered on the ground floor of the building with its own waiting area.
- The imaging department had access to an x-ray room which was used for general x-rays and fluoroscopy (an x-ray that obtains moving images of a body part) investigations, an ultrasound scanning room, a digital mammography room and a orthopantomogram (OPG) room. An orthopantomogram is an x-ray machine that allows a panoramic view of the lower face, displaying all the teeth of the upper and lower jaw.
- Patients attending the department reported initially to the reception area where they were asked to wait in the waiting area. A member of the diagnostic team would then call the patient into the department for their investigation.
- We saw evidence that quality assurance testing was completed at regular intervals in line with the Institute of Physics and Medical Engineering (IPEM). We saw the annual report for 2017 with no issues or concerns identified. The 2018 annual review had just been undertaken and the hospital was waiting the full report.
- The service accessed the resuscitation trolley located in the outpatient's department. The service had its own anaphylaxis (an acute allergic reaction) box which staff could access when required in an emergency which we found to be well equipped and maintained with daily checks recorded.
- We saw that all imaging rooms were clearly signposted with "do not enter" warning lights to ensure that staff or patients did not enter rooms whilst imaging was taking place. This was in line with the Medicines and Healthcare Products Regulatory Agency (MHRA) guidance for access.
- Local rules as required under Ionising Radiation Regulations 2017 (IRR17) required employers to keep exposure to ionising radiation dosage as low as reasonably practicable. The purpose of the local rules was to assist the radiation protection supervisor in instructing staff in radiation protection, and, in the event of an accident, to provide a clear reference to prepared contingency plans.

Good

Diagnostic imaging

- The radiology department displayed the local diagnostic reference levels (DRLs) for the most common examinations in each modality and the upper level dose at which further investigation was required. Instructions for operators on actions to take was included.
- We saw staff had access to appropriate personal protection equipment (PPE), including lead gowns and neck shields. The radiology department had clear guidelines on which specialised PPE should be used for specific procedures. PPE was routinely checked to ensure they were not damaged. Staff also wore radiation exposure devices which were analysed to ensure that staff were not over exposed. We were told that the head of department was looking at alternative methods of capturing consultant exposure as they worked across other sites and data collection was therefore not always appropriate to this service.
- The service stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health. We saw evidence of up to date COSHH risk assessments to support staff's exposure to hazardous substances.

Assessing and responding to patient risk

- Staff assessed risks to patients so they were supported to stay safe.
- We saw policies in place to support staff in their role in responding to patient risk. For example; the head of department had updated files in line with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 17) procedures as well as standard operating procedures as required under the regulations.
- The service had designated radiation protection supervisors (RPS) which was in line with Regulation (4) of the Ionising Radiation Regulations 2017 (IRR17). The RPS's role was to ensure the service's adherence to safe working practices and advise on what actions to take in an emergency.
- All staff wore radiation badges to monitor any occupational doses. The service was compliant with the assessment and the recording of radiation doses as recommended under Regulation 35 of IRR17.
- Senior staff from radiology attended the daily "10@10" meeting which provided the opportunity to discuss any concerns which included for example; planned activities, staffing issues and any equipment or maintenance concerns. We observed feedback from the meeting being discussed at the daily staff huddle which ensured staff could assess and respond to patient risk as appropriate. The daily huddle meetings were recorded which meant staff who were not on duty could read the information so they could catch up on any identified concerns or actions required.
- Most patients attending the imaging department were fit and mobile. Those patients that were unwell, were usually inpatients and accompanied by a ward nurse, and if necessary the registered medical officer (RMO). Therefore, staff did not routinely assess risk, other than that posed by the investigation itself.
- Imaging staff were aware of the need to risk assess patients prior to the requested investigation and knew how to escalate any concerns they may have. There were standardised processes to assess risk used within each modality, based on national guidance.
- Investigations were requested using a paper referral system, which was signed by the consultant, and detailed the patient's demographics and outlined the investigation requested. This referral card was used by imaging staff to confirm the patient's identity when attending for the investigation.
- Referrals were reviewed by imaging staff to ensure that the correct procedure was being requested. To safeguard the patient a search was completed of the database to identify if the investigation had been completed at an alternative location. This process prevented patients being exposed to radiation unnecessarily.
- We saw patients were asked to confirm identity prior to an investigation being completed. Information relating to the patient's name, address, date of birth and expected investigation was discussed between the patient and the member of staff looking after the patient. The service used a "pause and check" system for radiology investigations which was in line with the Society and College of Radiographers. Staff used the pause and check system in line with the World Health Organisation (WHO) surgical safety checklist, which

enabled the identification of any risks, for example, allergies, antibiotic prophylaxis (a treatment given or action taken to prevent disease) and site marking to be reviewed prior to the investigation.

- There were processes in place for the assessment of patients who may be pregnant. Radiotherapy during pregnancy might cause harm to the developing foetus. We saw a checklist which was used to assess any potentially pregnant patient prior to the investigation being completed.
- Patients attending the imaging service were required to complete an extensive checklist prior to the investigation to ensure that all risks had been identified to reduce any potential consequential harm.
- Staff checked that patients, who required a contrast media, were not allergic to any substances prior to administering the medicine. Contrast media is used to increase the differences of structures or fluid within the body. Contrast media was administered by the consultant responsible for the investigation.
- Following completion of the investigations, the image was reported on by either a radiologist or the referring clinician. For example; x-rays, were sent to the referring consultant for review, ultrasound scans were completed by a consultant and MRI scans were reported on by the radiologist. The service had designated reporting staff each day which meant that there was not a delay in the implementation of treatment following the investigation.

Radiology staffing

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.
- The hospital had an electronic rostering management system that enabled managers to effectively manage rotas, staffing requirements, skill mix and senior cover within the service. The imaging service ensured they had appropriately trained radiology staff to maintain patient safety. The level of skill mix within the service was made up of 63% trained staff and 37% technicians.
- The imaging service had four staff on daily who flexed their time to cover the needs of patients attending the service. Staff confirmed they could call on the services of the registered medical officer when required. Bank radiographers used were regular staff who were familiar with the service. This ensured that staff met key requirements such as having completed mandatory training.
- See additional information under this sub-heading in the Surgery Report section.

Medical staffing

- The service had enough medical staff with the right qualification, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment most of the time.
- There were no medical staff employed directly by the service, with all medical staff working under practising privileges. All medical staff carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Medical staff new to the hospital received a formal induction, and could work under practising privileges only for their scope of practice covered within their NHS work. Details of medical staff working at the hospital can be found in the surgery report.
- There was a small group of radiologists working within the service to facilitate reporting on images. These were regular staff, who attended the hospital on set days according to their availability. Staff told us that if their specialist knowledge was required, they could be contacted directly.

Records

- Staff keep appropriate records of patients' care and treatment. Records were kept in locked cupboards to maintain confidentiality.
- The radiology records audit for November 2018 showed the service had achieved an overall score of 99%. The audit was based on 20 to 30 records, dependent on the category which included; referral information 100%, MRI patient safety 90%, the review of records using ionising radiation 100%, and contrast media and medicine management 100%. We noted that the service reviewed the "referral form contraindications completed by the referrer" scored 60% (12 from 20 records) for the MRI patient safety section. The service reviewed this section to ensure

that patient records were being completed appropriately. The identified action stated for the radiology manager to escalate any non-completion of contra-indications section of referral to ensure improved compliance. This had a due date of January 2019.

- Diagnostic images were archived using an electronic database and were password protected to prevent unauthorised access. Images could be shared with external systems if necessary. This was particularly useful for when a specialist opinion was required.
- We looked at seven patient records which we found to be well maintained. Entries were dated and signed by the appropriate staff member which included details of all investigations and their findings.
- The service could access the image exchange portal (IEP) for the safe and secure transfer of images. The picture archiving and communication system (PACS) held images across a national network. The service could "blue-light" any request to receive prioritisation of information if required.
- Throughout the department, care was taken to ensure that computer screens were not accessible or in view of unauthorised persons. Computers were locked when not in use.

Medicines

- The service gave, and recorded administered medicines well. However, we did not find processes in place for the monitoring of medicines stored within the service.
- The imaging department used a small number of medicines for investigations. These were largely contrast media. We saw that these were stored in locked cupboards within the x-ray room. We were told that when medicines were taken to the visiting mobile CT/MRI scanner, staff checked them out and in when they were brought back to the department.
- Consultants were responsible for the prescribing and administering of all medicines for patients attending the service. This meant that no imaging staff were responsible for the administration of medicines.
- During the inspection we found medicines were in date with the exception of one item which was dated August 2018. This was brought to the attention of the manager who confirmed they would dispose of the medicine appropriately. We asked about medicines stock rotation and replacement, and it was unclear who oversaw the management of stock used within the radiology department. In addition, there was no evidence of input by the pharmacy department to support medicines management in the service.
- For our detailed findings on medicines please see the Safe section in the [main service] report.

Incidents

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- There was a Ramsay Health Care UK group policy for incident reporting, which was in date. The policy identified individual's responsibilities for reporting and investigating incidents. Staff described when they would report an incident and the process used. Staff had access to the electronic reporting system.
- Incidents had been identified as an area of development in the quality improvement action plan for 2018/19. This included improving the systems in place to provide feedback to all staff related to patient incidents, trends and any learning. We observed a staff huddle and noted that incidents and shared learning were included. Staff spoken with confirmed they received regular feedback on incidents across the hospital which may impact on the service.
- Service data showed that there were no never events or serious incidents reported in the diagnostics department. There had been 83 clinical incidents and 30 non-clinical incidents attributed to the outpatients and diagnostic imaging services for the period August 2017 to July 2018. The incident feedback shared learning group reviewed and discussed all incidents across the hospital and we saw that 21 incidents were attributed to the radiology service from May 2018 to August 2018. The identified themes for the imaging service included delay with scan/test results and information governance breaches. We saw an incident report regarding an information governance breach which included the actions, for example; discussion in

daily huddle to highlight concerns to all staff and the review of screening processes and procedures. Staff confirmed they had implemented an additional checking system to ensure that all picture archiving and communication system (PACS) (a system to store and digitally transmit electronic images and clinically-relevant reports) were accounted for and had the correct information attached.

- There had been three ionising radiation incidents from August 2017 to July 2018. These were under the threshold for external reporting. However, all incidents or near miss incidents involving radiation were reported on the hospital's incident reporting system. These were categorised as 'IRMER' incidents for the purpose of data collection and monitoring of trends. The hospital had an agreement that all incidents, where the patient had received an exposure to radiation in error, were reported to the radiation protection advisor. Senior staff explained and demonstrated the processes in place regarding any radiation incidents.
- From November 2014, providers were required to comply with the Duty of Candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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 the person. Most staff spoken with understood their responsibilities regarding the duty of candour legislation. They said they were open and honest with patients and applied this to all their interactions. Staff said they would discuss any identified concerns with the patient and provide a full apology.

Safety Alerts

- The service planned for emergencies and staff understood their roles if one should happen.
- National patient safety alerts when received were circulated by e-mail or hard copy to each head of department who confirmed any action undertaken and signed off once completed. On completion the central alerting system database was updated. The hospital confirmed they were up to date with all safety alerts.
- Staff spoken with informed us they had participated in a recent emergency scenario which involved the reaction of a patient to contrast media. They outlined the action taken and the shared learning which included notifying administration staff who could direct the appropriate staff to the relevant location.

Are diagnostic imaging services effective?

Not sufficient evidence to rate

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously inspected but not rated.

We currently do not rate effective for Diagnostic Services.

- Staff in services provided care and treatment based on national guidance and evidence of this effectiveness.
- Patients had access to a drink when visiting the service and staff managed patient's pain effectively.
- The service made sure staff were competent for their roles.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff generally understood their roles and responsibilities under the Mental Health Act (MHA) 1983, the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- The service monitored the effectiveness of care and treatment, however, they did not consistently use findings of audits to improve services. We did not always see action plans in place where the service did

not meet the hospital's audit requirements which meant that we could not be assured there were processes in place to oversee the shortfall in compliance.

Evidence-based care and treatment

- The service provided care and treatment based on national guidance and evidence of its effectiveness.
- The October 2016 inspection found copies of guidelines and policies were out of date. During this inspection, we saw up to date policies, and procedures and that protocols were in place to manage patients safely. Policies were referenced against national guidance to ensure care and treatment was delivered in line with legislation, standards and evidence based guidance.
- The service worked to the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 17) and guidelines from the National Institute of Care Excellence (NICE), the Royal College of Radiologists (RCR), the Society of Radiographers and other national bodies. This included all specialities within the diagnostics.
- The service had a defined audit schedule and audits were completed regularly. These covered topics such as record keeping and care of the environment. The hospital could benchmark the results from the audits with other hospitals within the Ramsay Health Care group. However, most staff were unaware of the results for their area and could not tell us about measures the service had undertaken to improve any poor compliance.

Nutrition and hydration

- Patients had access to a drink when visiting the service.
- Patients were provided with clear instructions in their preparation letter about the amount of fluid to drink prior to attending the imaging department. If patients had to fast, they had access to a water fountain in reception to quench their thirst after their procedure.
- See information under this sub-heading in the surgery report section

Pain relief

- The service managed patients' pain effectively.
- Staff asked patients if they were comfortable during their ultrasound scans, however no formal pain level monitoring was undertaken as the procedures were pain free.
- See information under this sub-heading in the surgery report section.

Patient outcomes

- The service monitored the effectiveness of care and treatment, however, they did not consistently use findings of audits to develop action plans and improve services. This meant that we could not be assured there were processes in place to oversee any shortfall in compliance with audit standards.
- The hospital had an annual clinical audit programme which included the radiology service. Areas covered included the medical records and observations of the service. The radiology observation audit for August 2018 had an overall score of 89% which was rated amber in the hospital RAG (red, amber and green) scoring system. We saw the action plan which was due for completion in December 2018 which included:
  - A folder to be created for meeting minutes with staff sign off sheets. During the inspection, senior staff were aware of the shortfall in team meetings and had commenced their first meeting in October 2018.
  - Image quality to become embedded within ongoing development and feedback discussions.
  - Radiology manager to review storage and look for suitable alternatives where stores did not meet requirements. We did not find any issues or concerns with storage facilities during the inspection.
  - Action plans from audits to be shared with the radiology team to increase awareness and compliance. However, during the inspection, we were not assured that there were processes and procedures in place for the sharing of action plans with the radiology team.

- Radiology Manager to review process for recording did not attend (DNA's) and turnaround times to ensure assurance that the department was meeting targets. During the inspection the radiology manager was aware of DNA figures and confirmed the service was working on processes to record turnaround time.

- We saw the results of the November 2018 dosing audit. The audit was conducted by the radiation protection advisor body which confirmed the service had passed in all areas which included for example the x-ray and fluoroscopy rooms. The evidence provided with the audit demonstrated that the tests were reliable, consistent and appropriate to the level of risk.
- The radiation protection advisers (RPA) report from May 2018 to November 2018 identified areas which required attention such as advice on practical implementation of the new regulations (IRR17) and the Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17). During the inspection, we found staff had good awareness of the regulations and could describe processes in place which included the new reporting guidance. Radiation protection and laser safety were discussed as part of the health and safety committee meeting. Further to this any radiation or laser incidents would be also discussed through clinical governance and medical advisory committee meetings. There had been no serious radiation incidents in the last 12 months.
- The non-radiologist reported imaging audit for September 2018 based on 10 randomly selected patient records where a radiologist report is not required had an overall score of 53%. For example, we saw that the "consultant recorded comment stating images evaluated" scored 30% and was rated red in accordance with the hospital's RAG (red, amber, green) system. The audit had a section for the action plan which had not been completed. This meant that we could not be assured there were processes in place to address the shortfalls in compliance.
- The clinical governance committee meeting minutes for September 2018 identified a concern with the new MRI request forms not being completed by consultants. Senior management confirmed they oversaw the completion of these forms to ensure they were providing the appropriate service to patients. During the inspection we saw the MRI review audit regarding compliance in the use of the form. This was rated red in accordance with the hospital's RAG (red, amber, green) system. The records seen showed there had been improvement from July 2018 (35%) to November 2018 (60%). However, we did not see an action plan stating how the service was going to improve compliance.
- The service had adapted the World Health Organisation (WHO) surgical safety checklist for the imaging service. This was used for every patient undergoing radiological interventions. We saw the WHO checklist audit for October and November 2018 which identified 100% compliance. As evidence of good practice, we saw that all patient's WHO checklist forms, once completed, were scanned into the individual patient's records being saved on the radiology information system.
- A proportion of Pinehill Hospital income from April 2017 to March 2018 was conditional on achieving quality improvement and innovation goals, through the commissioning for quality and innovation (CQUIN) payment framework. The hospital participated in two CQUINs which were:
  - Staff health and well-being with the aim of improving staff morale and motivation through a healthier and happier workforce while improving the quality of patient care delivered.
  - Sign up to safety campaign to reduce avoidable harms to patients by 50% over three years.
- The Ramsay CQUIN for 2017/18 identified that the hospital had achieved 75% of its CQUIN by quarter four (January to March 2018) with the aim of meeting 100% for 2018/19. During the inspection staff confirmed that their health and well-being was discussed during their appraisal and that morale had improved across the hospital. Staff were aware of the sign up to safety campaign and felt it was a positive way forward.
- See information under this sub-heading in the Surgery Report section.

Competent staff

Good

Diagnostic imaging

- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- The head of department monitored staff's ability and poor or variable staff performance was identified through complaints, incidents, feedback and appraisal. Staff were supported to reflect, improve and develop their practice through education and one to one meetings with their managers.
- Staff had attended additional training relevant to their role. The 2017/18 training data showed that members of staff within the radiology services had attended both local and external courses and well as courses provided by the Ramsay academy. These included; dealing with difficult people, effective leadership skills and automated external defibrillator (AED) training. AED training ensured staff had the necessary skills needed to respond to an emergency until medical services arrived.
- All staff administering radiation were appropriately trained to do so. Those staff that were not formally trained in radiation administration were adequately supervised in accordance with legislation set out under IR(ME)R.
- We saw evidence that all radiographers had in date health care professional (HCPC). registration This was in line with the society of radiographers' recommendation that radiology service managers ensured all staff were appropriately registered. Training specific to their registration was reviewed during staff appraisals, along with any development plans.
- Senior staff had attended a mental health first aid training course in January 2018. Staff said that due to the success of the training, the hospital was looking to build this into an annual refresher course.
- The quality improvement action plan 2018/19 had identified processes in place for staff to request approval for external training and courses with training being approved specific to individual's development plans and scopes of practice. Staff confirmed there was good access to additional training and found the hospital very proactive in encouraging staff to attend additional training.
- The quality improvement action plan 2018/19 identified that a review of all staff competencies was underway, with a review date of October 2018, to ensure staff had been assessed and were competent in their role. The heads of department confirmed they had assessed staff to ensure they were competent in their role.

Appraisal

- All staff members received an annual appraisal. This enabled senior staff to review each staff's individual needs and ensured staff members had adequate development to support their role. Any additional training needs were discussed as part of the appraisal process and learning needs agreed with timescales. Data seen during the inspection showed that 100% of staff had received their annual appraisal.
- The head of department monitored staff's ability and provided on-site training if necessary, using appraisals and supervision to support and develop staff.Staff spoken with confirmed they had received their appraisal which they found beneficial and supported them in their role.
- Staff told us they received a comprehensive induction when they commenced work at the hospital. This included a hospital wide induction and local induction. The local induction included; orientation to the area and local competencies. The hospital wide induction included; information governance, infection prevention and control and fire safety. Staff said they found the inductions helpful.

Multidisciplinary working

- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- We saw that the imaging team worked closely with the visiting consultants. Multidisciplinary team (MDT) meetings were not undertaken within radiology. A radiologist attended the medical advisory committee and local departmental meetings. MDT meetings occurred at the local acute hospital trust and were not minuted by the service. These were not attended by a member from the hospital's radiology department and feedback was on a "need to know" basis.

Good

Diagnostic imaging

- Staff told us that they could contact their peers working across the Ramsay hospital group for support and advice when required. Heads of departments would meet to share ideas and work together on consistent approaches to the delivery of care across the Ramsay group.
- For detailed findings on multidisciplinary working please see the effective section of the surgery report.

Seven-day services

- There was a six-day service provided by the imaging service.
- The imaging department opening hours were Monday to Friday 8:30am to 5pm. The hospital had a service level agreement with an external company who provided computed tomography (CT) and magnetic resonance imaging (MRI) services. We saw this was in date and was due for review in July 2019. Computed tomography (CT) scans were available every Friday 8am to 8pm and magnetic resonance imaging (MRI) every weekday Monday to Thursday and Saturday 8am to 8pm. A CT is a combination of many x-ray measurements taken from different angles to produce a cross-sectional image of specific areas while an MRI uses magnetic fields and radio waves to generate images of the organs in the body.
- Pinehill Hospital also provided a referral ultrasound scanning service, digital fluoroscopy/contrast studies, mammography and plain film service, which were available Monday to Friday 9am to 5pm.
- There was an on-call rota for the on-call radiologists and radiographers for out of hour's x-ray requirements. A weekly on call rota was circulated, including details for all clinical areas and an on-call member of the senior leadership team. Each department had a consultant directory which included contact details. Consultant details could also be accessed electronically on the hospital's shared drive.
- The resident medical officer (RMO) was available seven days a week.

Health promotion

- See information under this sub-heading in the surgery report section.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood their roles and responsibilities under the Mental Health Act 1983, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). They knew how to support patients who lacked the capacity to make decisions about their care.
- DoLS protects people who are not able to make decisions and who are being cared for in hospital or in care homes. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
- The hospital had an up to date policy regarding the Mental Capacity Act 2005 (MCA) and deprivation of liberty safeguards (DoLS). Staff could access this on the hospital intranet.
- Patients attending the imaging department were required to give consent for their procedure. This was usually in the form of verbal consent for investigations such as x-rays. Patients attending for invasive procedures were consented by the responsible consultant. This could be written consent, depending on the investigation completed.
- The consultant responsible for the procedure would obtain consent from the patient prior to an invasive investigation following a detailed account of the investigation process. We did not see any of these procedures during the inspection, and therefore we are unable to confirm practice completed.
- The consent audit for November 2018 showed the service had achieved 100% compliance. Examples of areas covered included; details correctly completed on the consent form, all risk described in a language that the patient could understand and patient had signed and dated.
- See information under this sub-heading in the surgery report section.

Are diagnostic imaging services caring?

Good

Diagnostic imaging

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

Our rating of caring stayed the same. We rated it as **good.**

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment

Compassionate care

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We observed staff caring for patients with compassion and understanding. We saw that all staff introduced themselves to patients, giving details of their name and ensuring that they knew what they were attending the department for.
- Staff promoted privacy, and patients were treated with dignity and respect. Patients were called from the waiting room and staff used this time to talk to patients and put them at ease. We observed staff talking to patients in a respectful and considerate way. For example, we saw staff responded compassionately to a patient's emotional distress when presenting to the service.
- Pinehill Hospital utilised patient surveys to gather data from patients about their experience and satisfaction with the services they have received. Although, the 2017/18 quality report identified that 100% of patient were satisfied with their radiographer, this was based on one response only. Staff said they did not routinely ask patients to provide feedback during their visit to the department and we saw no evidence of feedback forms for patients, their relatives of friends to complete.
- Patients told us they would be happy for their friends and family to come to the hospital for treatment.

Emotional support

- Staff provided emotional support to patients to minimise their distress.
- Staff showed awareness of the emotional and social impact that a person's care, treatment or condition could have on their well-being. Staff understood the emotional stress of patients having a procedure.
- Imaging staff were not routinely involved with providing support for specific illnesses, but could refer patients to their consultant or the head of clinical services if they felt that additional support was required.
- Patients said staff quickly responded to their needs and talked openly with them and discussed any concerns. One patient said, "staff are brilliant, I can't fault them" and another said staff were "very approachable and "available to answer questions."

Understanding and involvement of patients and those close to them

- Staff involved patients and those close to them in decisions about their care and treatment.
- Patients said they felt involved with decisions about their care and treatment and had been asked for permission and agreement first which meant that the views and preferences of patients were considered. Staff could give advice regarding investigation reporting and explained that they would need to see the referring consultant for further information.
- Patients and relatives confirmed they had been given the opportunity to speak with the radiologist looking after them. Patients said the radiologist had "explained everything" and that they were fully aware of what was happening. All patients were complimentary about the way they had been treated by staff. We observed most staff introduced themselves to patients, and explained to patients and their relatives about the care and treatment options.

Good

Diagnostic imaging

- Patients who were paying for their treatment privately, told us that the costs and payment methods available had been discussed with them before their admission.

Are diagnostic imaging services responsive?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously rated as good.

Our rating of responsive stayed the same. We rated it as **good.**

- The hospital planned and provided services in a way that met the needs of local people.
- Services were planned to consider the individual needs of patients. Adjustments were made for patients living with a physical disability.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

However:

- Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure. However, the service could not provide us with the turnaround figures for time taken from procedure to reporting to assure us they were meeting their targets.

Service delivery to meet the needs of local people

- The service planned and provided services in a way that met the needs of local people.
- Patients attending the hospital imaging services were a mix of privately funded and NHS funded patients (these patients had chosen the hospital as a location for their appointment through the NHS e-referral service). This meant that there were several patients who attended the service for an investigation without a private consultation.
- The local clinical commissioning group (CCG) set criteria within their contract for NHS patient's attendance at the hospital. This meant that local commissioners were involved in the planning of local services.
- Pinehill Hospital had successfully worked alongside the clinical commissioning group to set up a direct access pathway for musculoskeletal (MSK) MRI for Hertfordshire GPs which was overseen by the radiology department. The pathway allowed GPs to directly refer to the radiology department. There was an agreement that all scans would be performed within the agreed six weeks. The hospital informed us that one patient had not met the six-week target but this was not identifiable on the waiting list information provided for October 2018.
- The hospital informed us they had met their six-week target with the exception of one patient. However, the waiting list information provided for October 2018 did not identify how many of the 47 patients referred were on the MSK pathway.
- For plain films, appointments could be offered as early as the day of referral. For other procedures, depending on the preparation and speciality, an appointment would be offered within the next two days.
- Where possible, the service provided imaging appointments in conjunction with the patient's outpatient consultant appointment. For example, the service had created a one-stop shop for urology which meant that patients attending for a review had their x-ray and consultant appointment at the same time thus preventing patients attending the hospital on numerous occasions.
- See information under this sub-heading in the surgery report section.

Meeting people's individual needs

- The service took account of patients' individual needs.
- The waiting room had two changing room for the x-ray and ultrasound room which enabled patient's privacy whilst changing. Patients could get changed and sit in the waiting room until they were called into the scanning room. Patients were seen one at a time, which prevented waiting for appointments in gowns and promoted dignity.

Good

Diagnostic imaging

- The service could access face to face and telephone interpreting for spoken languages, translation services (including braille) and British Sign Language interpreters. Staff knew how to access the translation services when required. Staff also had access to a list of staff who spoke a second language other than English.
- Patients told us that they were given detailed explanations about their admission and treatment as well as written information. Staff confirmed that written information could be obtained in other languages if required.
- Staff confirmed that they were usually unaware if the patient attending the clinic had mental health needs or other additional needs such as a learning disability or dementia. Staff explained that should a patient become anxious or restless during a procedure they would use distraction and de-escalation techniques to calm patients.
- The main waiting area had reading material to occupy patients whilst they waited for their appointment. There was a clock so patients could keep track of time.
- The waiting area was large enough to accommodate wheelchairs. We were told that when patients required a wheelchair or assistance to mobilise, staff would assist them into the imaging room from the main waiting area.
- There were patient toilets located within the department. These were suitable for use of patients who had reduced mobility and required mobility aids or wheelchairs.
- Patients attending the imaging department from the inpatient ward were required to be brought to the area by wheelchair. We saw that porters or nursing staff accompanied patients to prevent any delays in returning to the ward.

Access and flow

- **Patients could access the service when they needed and there was minimal waiting time for patients to receive their procedure.**
- Patients attending the department as an outpatient reported initially to the main reception area where they were asked to wait in the waiting area. A member of the diagnostic team would then call the patient for their investigation. Inpatients were called to the department when a suitable time slot became available.
- X-rays and ultrasound reporting was completed by the referring radiologist. All ultrasound investigations were completed by a radiologist. This meant that most of reporting was completed at the time of the investigation (hot reporting).
- Patients who did not attend (DNA) was a factor which contributed to the overall number of cancellations on the day. To alleviate the problem, the hospital had started calling each patient the evening prior to their scheduled appointment. We saw the results from January to November 2018 which showed the following for DNAs, abandoned activities and cancellations. This was based on 10,415 total activity resulting in 11.25% of non-activity.
  - 104 patients did not attend their appointment
  - 24 activities were abandoned
  - 458 cancellations
- The hospital informed us that target turnaround times (time taken from procedure to reporting) for private patients were within 48 hours and NHS cases within seven working days. However, the service could not provide us with the turnaround data which meant we could not be assured they were meeting their targets.

Learning from complaints and concerns

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.
- Complaints had been identified as an area of improvement on the quality improvement action plan for 2018/19. This included improving systems in place to provide feedback to all staff related to patient incidents, trends and any learning. Staff were aware of the policy for the management of complaints which was accessible on the hospital's intranet.
- Patients spoken with told us they hadn't had a reason to complain during their visit, but they would feel confident in raising a concern or complaint if necessary. Staff said that if a patient raised a concern or wanted to make a complaint they would try to

resolve it locally to prevent escalation. Where this was not possible the complaint was referred to the head of department or manager. However, it was unclear if staff informed managers of patient complaints resolved during their visit, which meant that we could not be assured that all complaints were identified and recorded.

- A total of 71 complaints have been received at Pinehill hospital from December 2017 to November 2018. Only three of these related to complaints about the radiology service or department. Two related to the lateness of reporting and another regarding fees payable. We saw the action taken and lessons learnt which included ensuring staff inform patients of the expected reporting time. Radiographers spoken with confirmed they were aware of the process of informing patients regarding reporting times which meant there were systems in place for the cascading of shared learning across the service.
- See information under this sub-heading in the surgery report section.

Are diagnostic imaging services well-led?

Good

Diagnostic services were previously inspected as part of the Outpatient and Diagnostic services. This is the first inspection, where core services have been separated. Outpatients and Diagnostic services were previously inspected but not rated.

Our rating of well-led stayed the same.We rated it as **good.**

- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- The service used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Services had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation.

However:

- Staff were not aware of the service's performance and we saw no information on display within the staff room to support this.

Leadership

- The service had managers with the right skills and abilities to run a service providing high-quality sustainable care.
- The diagnostic service had appointed a new radiology manager within the last 12 months who had awareness of the IRMER regulations ensuring the service followed best practice and was safe at all times.
- There was clear leadership within the team with the head of department (HoD) being also one of the two radiation protection supervisors within the service. The HoD worked clinically as part of the team in addition to completing management tasks and duties. Staff spoke positively about the leadership of the team and hospital.
- Staff said the executive director and head of clinical services were well respected, visible, supportive and always available when required.
- Staff said they enjoyed working in the department and felt supported by their departmental manager who was accessible and had an open-door policy. The departmental manager spoke with pride about the work and care their staff delivered daily. Many clinical staff working in the imaging service had worked in the organisation for over 10 years. They told us they had stayed in the organisation for a long time because of the team they worked with.
- We were told that senior leaders frequently visited the department and were approachable and would listen to any concerns raised.

Good

Diagnostic imaging

- Staff we met with were welcoming, friendly and helpful. It was evident that staff cared about the services they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care to their patients.
- See information under this sub-heading in the surgery report section.

Vision and strategy

- The hospital had a vision and strategy for what it wanted to achieve and workable plans to turn it into action developed.
- Staff were aware that there was a hospital vision and strategy, although did not refer to it directly. Staff referred to changes within the service which were aligned to the vision and strategy. For example, the reconfiguration and expansion of the services were aligned to the five-year strategy.
- See information under this sub-heading in the surgery report section.

Culture

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff we spoke with reported a good culture. Staff felt supported by their colleagues, manager and head of clinical services. They told us they were proud to work within the hospital. Staff said their line manager looked after them well. We also observed positive and supportive interactions between staff and the manager. The manager described having an open-door policy where any member of staff could see them privately. This was confirmed by staff spoken with who felt they could address any concerns with their manager.
- Staff felt valued and supported to deliver care to the best of their ability. Openness and honesty was encouraged at all levels and staff said they felt able to discuss and escalate concerns without fear of retribution. When incidents had caused harm the duty of candour was applied in accordance with the regulation.
- All staff were enthusiastic about their jobs and the team in which they worked. Staff told us that it was a "great place to work." Quotes from staff included, "the hospital is a great place to work" and "we work well as a team," "everyone is friendly", "I love working for the hospital" and "we work well as a team."Staff also confirmed they enjoyed dealing with their patients and we observed good interaction during the inspection.
- Staff felt supported in their work and there were opportunities to develop their skills and competencies, which was encouraged by senior staff.Staff felt listened to and said they worked well as a team.
- The manager confirmed that team meetings were inconsistent with only one held in January 2018 and the next one in October 2018. However, staff attended daily huddles which were recorded and provided up to date information to staff. Senior staff confirmed they were aware of the shortfall in team meetings and were looking at ways to address this.
- The hospital had launched the "speaking up for safety" (SUFS) programme in July 2018 as part of a Ramsay wide campaign. The aim of the programme was to encourage and empower staff to challenge anyone, including senior colleagues, who may be putting patients at risk with their behaviour. The programme included assertiveness training and this was being rolled out to all staff. Staff spoken with were very positive about the programme and we saw SUFS champions identified through the wearing of badges.

Governance

- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- There were structures and processes of accountability in place to support the delivery of good quality services. The service reported directly to the senior leadership team with clear lines of escalation in place.
- The manager attended meetings with the senior leadership team. Minutes showed that a standardised format was used for reporting on performance by modality, recruitment, service plans and finance. Minutes were descriptive and were circulated to the wider team for information. There was a list of

attendance and an action log to monitor progress against identified actions. Feedback from these meetings was provided to staff during daily huddles. The manager confirmed that team meetings were infrequent and there was work in progress to ensure these were a regular occurrence.

- Senior staff attended the radiation protection and medical exposure committee meetings. We saw the meeting minutes from October 2017 to November 2018. The minutes had a set agenda which included: a review of previous actions and a summary of ongoing and new actions, a governance report which reviewed incidents and lessons learnt and the review of policies. The service manager confirmed they received relevant information from their line manager. Radiographers spoken with confirmed senior managers provided them with information relevant to their role and the service during team huddles and staff meetings.
- See information under this sub-heading in the surgery report section.

Managing risks, issues and performance

- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.
- The service maintained a local risk register. Risks identified were recorded on a standardised template which scored risks as low, medium or high risk. Local risks were held on a department risk register and were escalated to the health and safety committee for consideration for addition onto the hospital wide risk register. We saw that the risk register was reviewed regularly and any actions taken to mitigate risks recorded.
- We spoke to senior staff about risks within their service and they confirmed the risk register was discussed as part of the service performance review meeting. Staff described their understanding of what constituted as a risk. A recent safety alert highlighted a potential risk to a 10-year-old x-ray machine if a part was not replaced. The hospital director told us that the head of department had raised this concern and it had been agreed that this would be placed on the local risk register. It was not on the risk register at the time of the inspection as the alert had only been issued the previous day.
- The service manager described the systems and processes which supported monitoring of performance and issues. They told us they had access to an online system to monitor, for example, training compliance and equipment maintenance. However, staff were not aware of the service's performance and we saw no information on display within the staff room to support their knowledge.
- Any performance issues or concerns were escalated through monthly departmental review meetings held between the heads of department, clinical lead, hospital director and finance director. However, not all of the performance audits seen had an identified action plan to improve performance.
- See information under this sub-heading in the surgery report section.

Managing information

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Staff could access patient electronic records appropriate to the needs of the procedure being completed. Computers were password protected and locked when not in use. We saw that computers were not accessible to patients.
- Staff confirmed they received information in a variety of methods which included; daily huddles, newsletters and e-mails. However, staff spoken with were not aware how well the service was doing and we saw no information on display within the staff room to support this.
- The radiation protection supervisor could contact the radiation protection advisor of support and information when required.
- See information under this sub-heading in the Surgery Report section.

Engagement

- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Good

Diagnostic imaging

- The service engaged well with staff and collaborated with partner organisations effectively. The service was proactive in forging working relationships with external providers and agencies. For example, the service had worked alongside the clinical commissioning group to set up a direct access pathway for musculoskeletal (MSK) MRI for Hertfordshire GPs.
- The staff engagement group worked with the senior management team and staff by holding regular forums to ensure staff were kept informed and had the opportunity to ask questions.
- The hospital gathered patients' views and experiences to shape and improve the services and culture. Due to patients attending the department for a short period of time, the service did not have any process in place to collect feedback from patients. Senior staff were aware of the shortfall and were looking at ways of capturing patient feedback.
- Staff surveys were completed annually, all staff reported that they enjoyed working at Pinehill Hospital and were proud of the work they completed. This was reflected in the response rate of the staff survey with 80% of staff across the hospital completing and stating they were happy to work at the hospital.
- Senior staff said that all staff members had been allocated an individual well-being objective as part of their appraisal. This was confirmed by staff spoken with. Examples included staff having access to a free online health support which offered advice on nutritional advice, health checks, fitness advice, personal coaching and medical factsheets. Staff confirmed their well-being was discussed during appraisals and were aware of the on-line service available.
- For detailed findings on engagement please see the Well-led section of the surgery report.

Learning, continuous improvement and innovation

- **The service was committed to improving services by learning from when things go well and when they go wrong, promoting training and innovation.**
- The inspection of October 2016 identified areas of concern. However, during this inspection we found concerns had been addressed and we found the following improvements:
  - Controls were in place to ensure all equipment was cleaned regularly
  - Medicine keys were stored appropriately in key cupboards
  - Policies and guidelines were in date
  - All staff within the imaging service had received an appraisal
  - Staff were aware of the hospital's vision and values
- However, the October 2016 inspection identified varied results regarding the friends and family test. During this inspection, we did not see any improvement in this as the imaging service did not have processes in place to routinely capture patient feedback.
- Staff felt they could approach other experienced staff for advice and support when required and said they had picked up valuable skills and awareness by working with colleagues who had such knowledge and expertise.
- The hospital had implemented the "speaking up for safety" programme to support the culture of safety and ensuring high professional standards are maintained throughout the hospital.
- There was a culture of improvement in the imaging service. For example, the service had implemented a one stop urology service where patients attending could receive their diagnostic procedure and be seen by the consultant on the same day which prevented numerous visits to the hospital.
- See information under this sub-heading in the surgery report section

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

We found areas for improvement including two breaches of legal requirements that the provider must put right. Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to meet the regulations:

We told the provider that it must take action to bring services into line with two legal requirements. This action related to one service.

Surgery service:

- The provider must ensure that post-operative risks to patients are identified, assessed, recorded and monitored. Regulation 12(1)(2)a.
- The provider must ensure that Venous Thromboembolism (VTE) risk assessments are fully completed and staff have been trained to do so. Regulation 12(1)(2)a.
- The provider must ensure that there are sufficient staff to cover the night shift to keep the patients safe when an additional area is opened. Regulation 18(1).

Action the provider SHOULD take to improve

We told the provider that it should take action either because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall.

Hospital wide:

- The provider should investigate and carry out further analysis to understand the reasons for high staff turnover.
- The provider should ensure that all staff have completed their mandatory training
- The provider should ensure all equipment is safety tested, in line with local and national requirements.
- The provider should ensure that all staff maintain good hand hygiene.
- The provider should ensure there are action plans in place when the service does not meet the hospital's standards for outcomes.
- The provider should ensure that all services have processes in place to routinely capture patient feedback
- The provider should ensure that performance data regarding turnaround times is captured and reported in order to demonstrate achievement of targets.
- The provider should ensure that there are systems in place so that service performance information is shared with all staff.

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
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment must be provided in a safe way for service users. Things which a registered person must do include assessing the risks to the health and safety of service users receiving the care or treatment. Regulation 12 (1)(2)(a)

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed. Regulation 18 (1)