Transform Hospital Group Dolan Park Hospital

Quality Report

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Date of inspection visit: 14 to 15 January 2020
Date of publication: 07/04/2020

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

Ratings

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

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.

Summary of findings

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

Overall summary

Transform Hospital Group Dolan Park Hospital is operated by Transform Hospital Group Limited . The hospital has 30 en-suite bedrooms which can accommodate 31 patients. Facilities include four operating theatres, and outpatient facilities.

The service provides cosmetic and weight loss surgery for adults from 18 years old to over 74 years of age. We inspected cosmetic and weight loss surgical services.

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 14 - 15 January 2020, along with a further unannounced visit to the hospital on 28 January 2020.

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 cosmetic surgery. Where our findings on surgical services – for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the main surgical service level.

The location was known as Dolan Park Hospital locally. We will refer to this name in the body of the report.

Services we rate

We rated this hospital as **Requires improvement** overall.

- The hospitals governance processes did not always operate effectively. There were not consistently effective governance processes to ensure that actions identified from the internal audit programme were monitored and completed. There were risks highlighted during our inspection that had not been recognised by leaders or included on a risk register, such as the management of medicines on the ward. Staff were not aware of how safety data was used to further improve services.
- There was no specific senior nurse leadership role, such as a matron or clinical services manager. The ward manager post was vacant, being actively recruited to and temporarily covered. We found there was no formal workforce plan for the hospital. Staff satisfaction was mixed. There was no staff forum, staff union support or monitoring of staff's wellbeing through, for example staff surveys. The culture did not always support an open approach, for example, not all staff felt comfortable challenging consultants to comply with the arms bare below the elbow policy.
- The service did not have effective processes in place to safely prescribe, administer, record and store medicines. The design, maintenance and use of facilities, premises and equipment did not always keep people safe.
- The hospital did not always control infection risks well. While the service had enough staff; staffing within theatres did not always meet national guidelines.
- Participation in external audits and benchmarking was limited. Patients' outcomes were not always compared to those from similar services. They did not always use the findings of local audits to make improvements to achieve good outcomes for patients. Data or notifications were not consistently submitted to external organisations as required. For example, the hospital did not submit all required data to the Private Healthcare Information Network.

However;

- The hospital had enough staff to care for patients and keep them safe. Staff had training in key skills and understood how to protect patients from abuse. The

Summary of findings

service managed safety incidents well and learned lessons from them. The hospital introduced a morning huddle meeting to enable a better flow of information, communication and engagement with staff.

- Staff provided good care and treatment, patients and visitors had access to hot and cold drinks, and staff gave patients pain relief when they needed it. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to meet the needs of patients.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The hospital planned care to meet the needs of most people accessing the service, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

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 four requirement notices that affected the location. Details are at the end of the report.

Heidi Smoult

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires improvement 	We rated this service as requires improvement because it was inadequate for well-led, requires improvement for safe and effective; although it was good for caring and for being responsive to people's needs. 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.
Outpatients	Good 	We rated the outpatients service as good for safe, caring and responsive; although requires improvement for well-led. We do not currently rate effective for outpatients. The main service at Dolan Park Hospital was surgery. Where arrangements were the same, we have reported findings in the surgery section.

Summary of findings

Contents

Requires improvement

Transform Hospital Group Dolan Park Hospital

Services we looked at
Surgery and Outpatients

Summary of this inspection

Background to Transform Hospital Group Dolan Park Hospital

Transform Hospital Group Dolan Park Hospital is operated by the provider Transform Hospital Group Limited. Dolan Park Hospital was opened in December 2006. It is a private hospital in Bromsgrove, Worcestershire. The hospital serves patients from across the United Kingdom, predominantly the Birmingham area and the South of England. It also accepts patient referrals from outside of these areas. The location comprises a theatre suite containing four operating theatres and a four bedded recovery area. There are three wards over three floors, with a total of 30 en-suite bedrooms which can accommodate 31 patients.

Cosmetic and weight loss surgical procedures are undertaken at the location and pre and post- operative consultations, post- operative wound care, gastric band adjustments and dietitian consultations are undertaken from the clinic suite.

The location is usually open seven days per week, however, there are occasions where there is no clinical activity. Patients can use the organisation 24-hour emergency telephone numbers should they have questions or concerns of a clinical nature during this time. The hospital also has a sister hospital in Manchester that could accommodate an urgent readmission if needed.

The organisation has undergone significant change in recent years with an organisational restructure and integration plan into one single corporate entity.

The hospital has had a registered manager in post since September 2017.

The hospital also offers cosmetic procedures, such as dermal fillers and laser hair removal. We did not inspect these services.

Our inspection team

The team that inspected the service comprised a CQC lead inspector,two other CQC inspectors, and specialist advisors with expertise in surgery, theatres, outpatients and governance.

The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection.

Why we carried out this inspection

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 previously under a different provider. This was the hospital's first inspection since registration with CQC under a new provider.

How we carried out this inspection

During the inspection, we visited the three wards. We spoke with 28 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 18 patients and one relative. During our inspection, we reviewed 15 sets of patient records.

Summary of this inspection

Information about Transform Hospital Group Dolan Park Hospital

Dolan Park Hospital comprises a theatre suite containing four theatres and a four bedded recovery area. One of the theatres is equipped for weight loss procedures.

The hospital is registered to provide the following regulated activities:

- Surgical services
- Treatment of disease disorder or injury
- Diagnostic and screening procedures

The hospital carried out the following (top ten) procedures for the reporting period November 2018 to October 2019:

- Abdominoplasty (tummy tuck) and liposuction (procedure to remove excess fat) – 161 procedures.
- Breast augmentation – 640 procedures.
- Breast augmentation and mastopexy (breast lift) – 181 procedures.
- Breast reduction – 131 procedures.
- Gastric band – 486 procedures.
- Gastric bypass – 171 procedures.
- Liposuction – 72 procedures.
- Breast implant replacement – 169 procedures.
- Rhinoplasty (surgical improvement in the appearance of nose) 140 procedures.
- Septoplasty (surgical correction of deviated septum that divides two nostrils) – 141 procedures.

In the reporting period November 2018 to October 2019 there were 3,675 inpatient and day case episodes of care recorded at the hospital; of which 100% were private funded patients.

There were 10,973 outpatient total attendances in the reporting period.

The outpatient department provides private clinics for pre and post-operative surgeon consultations, post-operative wound care, gastric band adjustments, dietician consultations.

Surgeons, and anaesthetists, worked at the hospital under practising privileges. There were 130 who had held privileges for over six months at October 2019. Regular resident medical officers worked on a week on week off rota. The accountable officer for controlled drugs was the registered manager.

Track record on safety

In the reporting period from November 2018 to October 2019:

- Clinical incidents reported; 110 no harm, 27 low harm, 15 moderate harm, zero severe harm and zero death.
- Zero incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),
- Zero incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)
- Zero incidences of hospital acquired Clostridium difficile
- Zero incidences of hospital acquired E-Coli
- 102 complaints

Services provided at the hospital under service level agreement:

- Resident medical officer
- Waste disposal
- Nursing and allied healthcare professional's agency staff
- Responsible officer
- Medical gases
- Fire extinguishers
- Generator
- Health and safety services
- Maintenance
- Cess pit
- Records
- Equipment decontamination

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:

- The service did not have effective processes in place to safely prescribe, administer, record and store medicines.
- The service did not always control infection risks well.
- The maintenance of non-medical equipment at the hospital was inconsistent.
- While the service had enough staff, the staffing within theatres did not always meet national guidelines.
- Staff were not aware of how safety data was used to further improve services.

However:

- The service provided mandatory training in key skills to all staff and made sure everyone completed it.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.
- The hospital had enough medical staff with the right qualifications skills training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- The service managed patient safety incidents well.

Are services effective?

Requires improvement

We rated effective as **Requires improvement** because:

- Participation in external audits and benchmarking was limited. Patients' outcomes were not always compared with similar services.
- Staff did not always use the findings of local audits to make improvements to achieve good outcomes for patients.
- The service did not always make sure staff were competent for their roles. We saw staff in recovery did not have the appropriate competencies regarding airway management.
- Patient's food was not always stored correctly.

However:

Summary of this inspection

- The service provided care and treatment based on national guidance and best practice. Staff protected the rights of patients' subject to the Mental Health Act 1983.
- Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.
- Staff gave patients enough food and drink to meet their needs and improve their health.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.
- Key services were available seven days a week to support timely patient care.
- Staff gave patients practical support and advice to lead healthier lives.
- Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Are services caring?

Good

We rated caring as **Good** because:

- Staff treated patients with compassion and kindness, respected their privacy and dignity, an took account of their individual needs.
- Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.
- Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. They ensure that people's communication needs were understood and used best practice and learned from it.

Are services responsive?

Good

We rated responsive as **Good** because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- The service was inclusive and took a proactive account of patients' individual needs and preferences.
- People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were not applicable and arrangements to admit, treat and discharge patients were in line with national standards.

Summary of this inspection

- It was easy for people to give feedback and raise concerns about care received and the service encouraged it.

Are services well-led?

Inadequate

We rated well-led as **Inadequate** because:

- Many of the issues we found during our inspection, had been recognised by staff or found during local audits and effective improvement had not occurred.
- Staff satisfaction was mixed. There was no staff forum, staff union support or monitoring of staff's wellbeing through, for example staff surveys.
- The culture did not always support an open approach. For example, not all staff felt comfortable challenging consultants to comply with the arms bare below the elbow policy.
- There were risks highlighted during our inspection that had not been recognised by leaders or included on a risk register, such as the management of medicines on the wards.
- The hospitals governance processes did not always operate effectively. There were not consistently effective governance processes to ensure that actions identified from the internal audit programme were monitored and completed. We found that actions were not managed effectively as many issues and concerns highlighted during our inspection, had already been identified.
- There was no specific senior nurse leadership role, such as a matron or clinical services manager. The ward manager post was vacant, being actively recruited to and temporarily covered.
- We found there was no formal workforce plan for the hospital.
- Data or notifications were not consistently submitted to external organisations as required. For example, the hospital did not currently submit all required data to the Private Healthcare Information Network in line with the Royal College of Surgeons standards.
- Leaders did not formally monitor progress towards achieving the organisations vision.
- While the hospital was responsive to our findings, we could not be assured that the changes, practices and systems were embedded as they were recent.

However:

- Leaders were visible and approachable in the service for patients and staff. Leaders and staff engaged with patients, staff and the public to plan and manage services.
- The provider had a vision for what it wanted to achieve and a strategy. Leaders and staff understood the vision.

Summary of this inspection

- The majority of staff were clear about their roles and accountabilities.
- There was a governance structure in place, which had been recently reviewed. Processes for practising privileges were being adhered to.
- Some data was monitored and benchmarked against other sites across the Transform Hospital Group Limited.
- Staff could find the data they needed to support its activities. The information systems were secure.
- Most of the staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had a culture where patients and their families could raise concerns.
- The hospital manager had introduced a morning huddle to enable a better flow of information, communication and engagement with staff.
- Staff told us they were committed to continually learning and improving services. There was evidence of some improvements being made.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

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

Requires improvement

Surgery

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

Are surgery services safe?

Requires improvement

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

We rated safe as **requires improvement.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff. Areas covered included: equality and diversity, health and safety, fire safety, infection control, and basic life support training.

Training was mostly provided via e-learning courses, with some face-to-face sessions, such as manual handling and basic life support. Staff we spoke with said they had also completed specific training in sepsis. The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. Staff within the service understood their responsibility to complete mandatory training.

Managers monitored mandatory training to ensure staff were up-to-date with their training and said that the training programmes were well embedded within the service. Managers confirmed they alerted staff when they needed to update their training. Staff were given allocated time to complete their training, which was confirmed by staff spoken with.

There were 13 mandatory training modules to be completed annually. The mandatory training data provided by the hospital showed an overall compliance rate of 91% as set out below. This was above the provider's target of 80%.

- Support staff – 90%
- Ward staff – 89%
- Theatre staff – 94% (Evidence source: D14)

Senior staff confirmed that all staff had received either basic life support training or advanced life support training dependent on their role.

Some nursing staff were employed on a bank basis (as and when they were needed). Senior staff confirmed their mandatory training was included with substantive staff to ensure they kept up-to-date with their training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

The hospital had clear systems, processes and practices to safeguard adults, children and young people from avoidable harm, abuse and neglect that reflected legislation and local requirements. There was an up-to-date policy on safeguarding for adults and children, which was due for review in June 2021. This was available to all staff on the hospital's intranet.

Nursing staff received training specific for their role on how to recognise and report abuse, appropriate for a service that did not provide care or treatment to patients under the age of 18 years. Staff we spoke with confirmed they had received training and explained how they would recognise, report abuse and knew how to apply it. Safeguarding training was provided via e-learning courses, which staff knew how to access. Data seen showed that all staff had completed safeguarding adults training. Nurses and operating department practitioner (ODPs) working in the hospital were trained to level two in adult and children's safeguarding. This was in line with the intercollegiate standards in Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, published by the Royal College of Nursing in January 2019.

There were six safeguarding leads across the organisation trained to level three in children and adults' safeguarding, including the hospital manager at Dolan Park Hospital. The leads met quarterly to review any safeguarding incidents that had arisen across all locations. The team reviewed the management and outcomes of safeguarding incidents, identified themes, shared learning and recognised areas of good practice.

Staff were encouraged to safeguard people who use services and the contact details of safeguarding leads were displayed in clinical areas. Processes were in place to respond to any signs or allegations of abuse or discrimination.

Female genital mutilation (FGM), modern day slavery and child sexual exploitation were included in safeguarding training. There was no named lead for FGM for the service. The safeguarding leads within the organisation had access to information regarding FGM.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with had a good understanding of their responsibilities in relation to safeguarding vulnerable adults and children. They could tell us what steps they would take if they were concerns about potential abuse to their patients or visitors. Staff we spoke with said that should they have any concerns they would inform their manager or the on-call manager out of normal working hours.

There had been no safeguarding concerns reported to the Care Quality Commission (CQC) in the reporting period from November 2018 to October 2019.

The service had access to an up-to-date chaperone policy. Notices were displayed advising patients that a chaperone was available on request. The policy contained guidance regarding the role and responsibilities of a chaperone. However, staff spoken with said they had not received chaperone training.

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Not all ward areas were clean although they had suitable furnishings which were mostly clean and well-maintained. We observed there were not effective systems to prevent and protect people from a health-care associated infection and ensure standards of hygiene and cleanliness were maintained. This was not in line with current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 61: Infection Prevention and Control (April 2014).

While cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, we found areas across the wards to be dusty. During the inspection we visited the lower ground ward which was not in use on the first day of our inspection (14 January 2020). The hospital did not have systems in place to ensure the ward area was cleaned when not in use. We found most rooms to be dusty and some rooms being used for storage. For example, we found rejected linen left on the floor and clean linen left on trolleys within some rooms. We also found a store room which was not locked. The room had boxes stored on the floor which meant that staff could not clean the area thoroughly to prevent infection. This was brought to the attention of senior staff who immediately arranged for the ward area to be cleaned and items of linen to be removed. After our inspection, a process was put in place to ensure that areas were stepped-down when not in use. A checklist was also completed to ensure the areas were clean and ready for clinical use.

Environmental surfaces were cleaned using appropriate environmental cleaning and disinfection products as per cleaning policies and protocols.

Adenosine triphosphate bioluminescence machines (a rapid sanitation test) were available for use, to aid the monitoring of cleaning effectiveness.

The privacy curtains in clinical areas appeared clean and all were dated when to review and change.

Alcohol gel/antimicrobial rub was available for general hand hygiene.

Domestic supervisors and clinic and hospital managers had responsibility for ensuring cleaners maintained high standards and covered all cleaning tasks, which included formal auditing/monitoring of these standards. The criterion followed the National Standards of Cleanliness that requires a set of 41 standards to be checked across the Transform Hospital Group Limited. During the inspection we saw completed cleaning checks in place.

Flooring throughout the service was well maintained. Flooring in the procedure and recovery rooms was in line with national requirements (Department of Health Building Note 00-10 Part A: Flooring (2013). This meant the service had mitigated the risk of infection from blood or other bodily fluid spillages.

The director of infection prevention and control (DIPC) was responsible for infection control and prevention within the Transform Hospital Group Limited and oversaw infection control policies and their implementation. The DIPC reported to the board. The DIPC was supported by a team of staff which included the infection control/microbiology consultant who provided advice and support. The consultant microbiologist and the Transform Hospital Group Limited infection control nurse were committed to providing urgent response within 24 hours 365 days a year. The resident medical officer (RMO) and clinical staff could call for advice on infection and infection control matters as the need arose.

The Transform Hospital Group Limited infection prevention and control committee (ICC) met bi-monthly and oversaw the work programme for infection control. The ICC reviewed audits, surveillance, incidents relating to infection control, including needlestick incidents, conducted root cause analysis where required, and responded to newly published guidelines and recommendations. We saw the ICC meeting minutes for October 2019 (evidence source: D06) which covered areas, such as: incidents, training and review of policies, procedures, guidelines and protocols. We noted that minutes also included a review of actions and matters arising.

All staff were required to complete infection control training as part of their yearly mandatory training compliance. Infection control training sessions including hand hygiene were delivered to staff by the Transform Hospital Group Limited infection control nurse. Classroom based wound care training had taken place for hospital, theatre and clinic nurses. Staff informed us this was delivered by an (external) accredited training provider. Mandatory training compliance across the organisation for all staff grades and training subjects was monitored and data for March 2019 showed 96% compliance.

We saw the theatre and wards hand hygiene audit for December 2019, which showed a compliance figure of 90%. The identified action was to continue to monitor monthly compliance across the wards and theatres (Evidence source: DR15 and DR16 ward and theatre hand hygiene audit).

The Department of Health via Public Health England requires mandatory surveillance of the following types of infection: MRSA bacteraemia, Clostridium difficile diarrhoea, Glycopeptide resistant enterococcal (GRE) bacteraemia (germs that are found in the bowels (gut) of most human), Methicillin sensitive Staphylococcus aureus (MSSA) and E. Coli. The infection prevention and control annual report January to December 2018 stated there had been no reported cased of infection within the hospital. Additional information provided by the hospital for the period November 2018 to October 2019, showed there had been no reported cases.

Patients were not routinely screened for MRSA (antibiotic resistant bacteria) unless they had previously been colonised with or infected by MRSA. This was in line with national guidance (Department of Health Implementation of modified admission MRSA screening guidance for NHS (2014). The pre-operative risk assessment form included patient history for MRSA.

Pre-operative screening processes were in place to identify patients who may be at-risk of complications and to detect

infection risks. This information provided the basis of whether to proceed with surgery. Patients who meet the criteria for screening underwent MRSA screening pre-operatively.

Staff worked effectively to prevent, identify and treat surgical site infections. Surgical site infections were monitored on an ongoing rolling basis, by analysis of surgical surveillance report forms and laboratory reports. We saw the results from May to December 2018. The hospital undertook 1,932 operations of which 34 (1.3%) had a surgical site infection. During the same period the hospital completed 2,749 weight loss surgery of which 11 (0.4%) had an acquired surgical site infection. There had been one patient identified with MRSA surgical site infection during 2018. A review found that there was no cause for the MRSA and no surgical association with the patient.

All applicable patients were screened for certain bacterium, including Clostridium difficile and MRSA. Data seen showed that there no issues or concerns.

Staff followed infection control principles including the use of personal protective equipment. During the inspection, we observed staff washing their hands and wrists. We observed staff washing their hands between each patient contact, in accordance with national guidance (NICE infection prevention and control: QS61, quality statement 3, April 2014).

During our visit to the theatres, we observed a staff member who did not follow the aseptic non-touch technique (ANTT). All staff should follow the aseptic non-touch technique when inserting a cannula which could cause a healthcare acquired infection. ANTT aims to prevent micro-organisms on hands, surfaces or equipment from being introduced to a susceptible site, such as a surgical wound, catheter or central venous line. We also noted that the use of ANTT was not included in the infection, prevention and control environmental / hand hygiene action, theatre audit. This meant that we could not be assured there were processes in place to oversee the correct use of ANTT procedures.

We observed that all staff during the inspection, adhered to the arms bare below the elbows and wore appropriate attire in the clinical areas. However, we observed two surgeons visiting the wards were not compliant with being arms bare below the elbows. They wore jackets and long-sleeved shirts. However, we did observe one surgeon discarding their jacket and roll up their sleeves prior to visiting a patient. Staff we spoke with confirmed that the surgeons usually visited the ward before the theatre lists and did not always comply with being arms bare below the elbows. Staff said that they did not feel comfortable in challenging the surgeons regarding this. This meant that we could not be assured that medical staff always complied with the arms bare below the elbow guidance.

All reusable surgical instruments were decontaminated off site, by licensed external providers, to national standards. Alternative single use items were employed in clinical areas. This eliminated the risk of cross patient contamination from re-used medical equipment. The hospital used a decontamination form which was used when equipment might be transferred between sites, to ensure safe transport, and communication of decontamination status of transferred equipment.

Appropriate theatre attire was worn by staff when they carried out surgical procedures. Theatre wear (commonly referred to as “scrubs” were laundered off site, which ensured that the attire was washed at the appropriate temperature. Designated theatre shoes were available for staff, patients and visitors to wear in the procedure room. This was in line with best practice (Association for Perioperative Practice Theatre Attire (2011)).

The antibiotic audit (compliance with antimicrobial stewardship guidelines related to appropriate antibiotic) showed the hospital achieving 98% compliance. (Evidence source: Infection prevention and control annual report January to December 2018)

The air conditioning and ventilation system was serviced annually and was last serviced in August 2019.

Water flushing tests were completed daily to prevent Legionella with no issues or concerns identified.

Environment and equipment

The design, maintenance and use of facilities, premises kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found the maintenance of non- medical equipment was inconsistent.

Patients could reach call bells and staff responded quickly when called.

Requires improvement

Surgery

The design of the environment followed national guidance. The premises were well designed, maintained and had adequate facilities for those patients attending cosmetic or weight loss surgeries.

We found concerns with the maintenance of non-medical equipment. For example, we were unable to find the updated electrical testing sticker for the microwave in the kitchenette on the lower ground floor ward. This was brought to the attention of senior staff who immediately disabled the equipment. Extra checks were then undertaken by the provider resulting in 13 items being electrical safety tested.

We found the control solution used to test the blood glucose monitor for accuracy was out of date. This meant staff could not be assured the monitor was fit for patient use because they were unable to accurately test it. During the revisit on 28 January 2020, we saw that relevant equipment had been replaced and was up-to-date.

There was controlled access to the theatres, offices, store rooms, anaesthetic room and post-operative recovery room to prevent unauthorised entry.

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 is a law that requires employers to control substances that are hazardous to health. During the inspection, we found a room on the lower ground floor which was unlocked with cleaning items left unattended which could be a risk to employees or unauthorised personnel. The room did not have any information for staff, such as a risk assessment and/or control of exposure. This was brought to the attention of senior staff who immediately addressed our concerns. Senior staff informed us they were arranging for a lock for the room door to manage cleaning equipment in line with COSHH regulations. During our revisit on 28 January 2020, we observed that a lock had been fitted to the room door. We spoke with cleaning staff who confirmed that they had received feedback regarding the use of COSHH and felt they were safer at work.

Staff carried out daily safety checks of specialist equipment. We saw the anaesthetic machine was checked by an external company six-monthly with the next due date July 2020. The theatre had a log book for the checking of anaesthetic equipment prior to each operating session. During the inspection we found inconsistencies in its completion with gaps where this had not been completed. We brought this to the attention of senior staff who apologised for the confusion. We saw that the service was piloting a separate checking schedule. This meant that the equipment was being checked appropriately. However, not all staff seemed to be aware of the pilot process.

The service had enough suitable equipment to help them to safely care for patients. Equipment was standard in all theatres. All four theatres had a laminar flow air system. Additionally, laparoscopic (a surgical procedure in which a fibre-optic instrument is inserted through the abdominal wall to view the organs) camera equipment was available in theatre one. The replacement of equipment in theatres was identified on the corporate risk register. During the inspection, we saw that the theatre area had received new equipment over the last five months which meant the hospital was addressing the risk of equipment coming to the end of its life.

All Transform Hospital Group Dolan Park Hospital medical devices and equipment were maintained and serviced by an external company. The company managed all equipment service scheduling, routine maintenance and repairs via an online portal and database. The database indicated when equipment was in service, when a service was upcoming or overdue. An engineer site visit was automatically scheduled as equipment entered the upcoming service status. This ensured that all equipment remained within service dates and in safe working order. Service history and any repairs to equipment were recorded within each asset profile along with site/department location. We saw an extract of the management system which showed the status of each piece of equipment, the location and when it was due for service. This meant the service had processes and procedures to ensure that all pieces of equipment were safe for use and maintained accordingly. (Evidence source: D27)

We saw the environmental audit for October 2019 which as RAG (red, amber, green) rated. The service scored 95% (amber) overall. (Evidence source: A14 Environmental audit October 2019)

Resuscitation equipment, anaphylaxis and hypoglycaemia boxes were kept on the wards. We saw new resuscitation trolleys on the wards and theatre areas which had recently been introduced. Resuscitation equipment in all areas of the surgical service appeared clean. Senior staff informed us that all trolleys should be checked monthly with a daily

check of the tag. During the inspection we found inconsistencies in the completion of both the daily and monthly checks. However, during our follow up inspection on 28 January 2020 we found that all resuscitation equipment had the appropriate checks which had been completed. Staff we spoke with explained how this was now part of their daily routine.

Staff we spoke with said they could easily access bariatric equipment when required.

We saw a range of consumable items in the procedure room including swabs, needles, cannulas and syringes. We found all were in-date with no issues or concerns identified.

There were processes in place for providing feedback on product failure to the Medicines and Healthcare Products Regulatory Agency. Details of products used on each patient, such as the lot number (an identification number assigned to a quantity or lot from a single manufacturer) was recorded and stored appropriately.

The Transform Hospital Group Limited maintained service levels agreements with a variety of external companies to ensure and maintain the safe care and treatment of patients. These included for example, the services of waste disposal and equipment decontamination.

Staff disposed of clinical waste safely. We saw the infection control audit regarding environmental waste for January 2020, which scored 100%. We saw sharp bins were being used appropriately. Sharps containers must be assembled correctly, with the date and named person clearly detailed on the label. However, we found on both the wards and theatres some sharp bin labels were not dated and did not have the name of the person outlined. We also found three sharp bins left unattended on the lower ground floor wards, which meant there was a risk for unauthorised personnel gaining access and coming to harm. This was brought to the attention of senior staff who immediately addressed our concerns.

We were assured that fire safety equipment was fit for purpose. This included fire extinguishers, alarm systems, heat and smoke detectors and emergency lighting. We saw evacuation chairs at each stairwell to support the safe movement of patients in an emergency.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Training records provided showed that 29 out of 32 (91%) had completed on-line training in 2019 on the use of the National Early Warning Score (NEWS2) assessment. NEWS2 is a tool which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

Patients seen at the hospital were generally fit and healthy. Staff completed a risk assessment for each patient. Therefore, it was unlikely they would see a patient with suspected sepsis. Staff we spoke with explained the processes they would take should a patient show any signs or symptoms of sepsis. If they suspected a patient had sepsis, they would contact the RMO who would initiate treatment before arranging for a transfer to the local acute NHS trust.

Dolan Park Hospital admitted elective patients for cosmetic or weight loss surgery. Patients had a planned length of stay based on the procedure and patient needs. Where patients were admitted for gastric sleeve surgery, an increased level of acuity was acknowledged. Staff trained in high dependency care were rostered for these patients in the post-operative phase. These staff were rostered from the hospital's substantive staff or the bank/agency team.

All patients attending the hospital had to have a maximum body mass index (BMI) of 50 or less. All patients who had a BMI over 50 were referred to an external hospital. BMI is a measure that uses your height and weight to work out if your weight is healthy, it classifies adults under the following categories: underweight, normal, overweight, obese.

All patients completed a hospital anxiety and depression scale (HADS) screening for psychological assessment. HADS is a tool designed to help doctors to assess the severity of a patient's anxiety or depression as well as showing how they are feeling.

Patients underwent general anaesthesia, although, where required local anaesthesia could be administered. All patients admitted to theatre were assessed according to the American Society of Anaesthetists (ASA) guidelines and

were either grade 1 (normal healthy patient for example, non-smoker, minimal alcohol intake) or 2 (mild systemic disease without substantial functional limitations, such as well-controlled diabetes, increased blood pressure, social drinker, pregnancy, obesity with a BMI between 30 and 40). Very exceptionally a patient with ASA 3 (systemic illness with substantial functional limitation, such as poorly controlled diabetes, reduced cardiac function) would be admitted and pre-operative clinical investigation conducted to assure patient safety prior to the procedure. No ASA 4 patients were admitted and there were no spinal or epidural anaesthesia undertaken.

Staff knew about and dealt with any specific risk issues. Safety performance was monitored and reported via the incident reporting and complaints processes.

While it was noted that an anaesthetist was allocated to each theatre list, we did not see evidence that an anaesthetist was always immediately available to cover emergency situations, for example, following extubation in recovery. This was not compliant with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines (2013) Immediate Post Anaesthesia Recovery. We raised this with the hospital manager. Following the inspection, senior staff informed us that they were reviewing their process regarding extubation and an action agreed to develop a policy and competency document for staff within the recovery area. (Evidence source DR28) It was also noted that staff could access the resident RMO in an emergency when required. Staff monitored patients' wellbeing during their stay and if there were any concerns there was a protocol to follow that included calling the RMO who was always on site and, if necessary, they would arrange transfer via ambulance to the nearby NHS hospital.

One allocated theatre provided emergency response to patients who required a return to theatre (for example, for evacuation of haematoma (a procedure to treat bleeding)).

For the period October 2018 to September 2019 there had been 3,820 patients assessed for venous thromboembolism (VTE) (blood clot) of which there were zero cases of incidents of hospital-acquired VTE or pulmonary embolism. We saw the VTE audit for November 2019. Overall compliance was RAG (red, amber and green) rated and the service achieved 95% (amber). We saw the overall summary and action plan together with a completion date. Actions seen outlined that:

- Staff must ensure that the VTE document is fully completed on admission, and for the nursing staff to ensure that the RMO, anaesthetist or the surgeon signs the VTE document. (Evidence source: A02 VTE audit)
- We viewed documented evidence that risk assessments for VTE was carried out for all patients at several points throughout the patient's journey. We found no issues or concerns in the records seen.

Theatre staff followed the World Health Organisations (WHO) Surgical Safety Checklist and this was always completed. We saw three WHO checklist audits for August, September and December 2019. The audits were split into two areas which included a documentation and observational review. The reviews were based on 10 records which focused on a surgical list. Overall compliance was RAG rated and the service achieved 95%, 97% and 83% (amber) respectively. We saw the summary with identified action plans. We saw the following were highlighted at each audit, which meant that we could not be assured how lessons were shared to improve compliance:

- Before induction of anaesthesia at sign in – all areas of the checklist should be completed with all relevant staff present and according to policy (70% to 90%).
- Before the immediate start of surgical intervention (knife to skin) at surgical pause – all areas of the checklist are completed with all staff present and according to policy (60% to 90%).
- All areas requiring times, initials and signatures are recorded and legible (70% to 90%).

Shift changes and handovers included all necessary key information to keep patients safe.

We saw on the ward (top floor), a poster on the management of massive haemorrhage. During the inspection we observed the exchange of blood received from a nearby hospital, which was a clear process and good communication. Additional blood, when required, was sent from a nearby hospital which took an average 20 to 30 minutes to arrive.

Patients were advised on how to seek support if their condition deteriorated after discharge from the hospital. Patients were provided with a telephone number which they could access for 24-hour advice. Patients we spoke with confirmed they were aware of the 24-hour telephone advice line.

Nursing and support staffing

Requires improvement

Surgery

While the service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment, the staffing within theatres did not always meet national guidelines. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service had enough nursing staff and support staff to keep patients safe. The ward manager could adjust staffing levels daily according to the needs of patients.

Data we reviewed, and observations made during our inspection confirmed there was enough staff to provide the right care and treatment across the hospital. We saw there were a total of 21.2 whole time equivalent (WTE) nursing staff of which 13.7 WTE worked in the inpatient departments, 4.9 WTE in theatre and 2.6 WTE in the outpatient departments. There was a total of 30.5 WTE ODPs and health care assistants of which 7.7 WTE worked in the inpatient departments and 22.8 WTE in theatre.

The data also identified there had been no unfilled shifts for the three months from September to October 2019.

The managers calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. We saw the ward ensured the continuity and safe staffing levels was based on the Royal College of Nursing guidelines for pre and post-operative care. We attended a morning safety huddle where staff acuity was discussed to ensure there were enough staff on duty throughout the day.

We found that not all staffing in theatres was in line with the Association for Perioperative Practice (AfPP) safe staffing guidelines for theatre teams. We found that during the inspection and our observation of the theatre list that one scrub staff was allocated with an additional scrub nurse undertaking an assistant role, which meant that there were not two scrub practitioners allocated for each session. This was not in line with the AfPP guidance, which includes the recommendation as a "minimum and after risk assessment of patients' needs and the skills and competencies required of the perioperative team:

- Two scrub practitioners as a basic requirement for each session, unless patient dependence and/or clinical service demand more or less. Two practitioners are recommended for a list of major surgery unless there is only one case. Two practitioners are recommended for a list of minor surgery that demands a quick throughput or has several cases on it, such as for an elective day surgery list."

During our revisit on 28 January 2020, we checked the rotas for two typical weeks and found that approximately 50% of the lists were compliant with the AfPP recommendations. This was brought to the attention of senior staff who informed us other staff were available to mitigate the risk in the event of an emergency. This included the theatre lead, theatre manager, hospital manager and other project lead staff. Theatres were staffed according to the hospital's policy. There was also a floating scrub practitioner able to assist as required between two lists. This meant that while the hospital was not compliant with AfPP safe practice guidance, the theatres were operating at approximately 50-60% of potential capacity and often had one theatre list in progress at a time. This reduced the potential risks. However, having floating scrub practitioner could lead to communication issues, such as unable to attend team briefings for two lists. However, we did not witness this during the inspection.

The ward manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants matched the planned numbers. During the inspection, we saw there were appropriate staffing levels on the wards, which ensured the safety of patients and enabled staff to have the resources to interact with patients and visitors. All patients had a named nurse responsible for their care during their inpatient stay enabling the patient to form a relationship with their nurse.

The service had contracted day and night staff in addition to several bank registered nurses. In the event of an increased requirement at short notice, whether due to unexpected staff absence or increased patient dependency, the service offered overtime or flexible working hours to their permanent employees.

Managers limited their use of bank and agency staff and requested staff familiar with the service. From November 2018 to October 2019 the average use of bank/agency usage was 10% with a peak of 16% in July 2019. However, where necessary the service utilised the bank/agency contracts to fill identified gaps and to ensure there was a full complement of staff available.

The service used agency staff familiar with the hospital to provide continuity and a knowledge of the service's procedures. Managers made sure all bank staff had a full induction and understood the service.

The service had low and/or reducing vacancy rates. Data provided by the hospital showed there were no vacancies as at October 2019.

The service had low and/or reducing turnover rates. Between November 2018 and October 2019, the inpatient department turnover rate was: 18% for nursing staff, 16.6% for health care assistants and 15.15% for other staff. For the theatre department we saw the turnover rate had reduced from 42% (November 2017 to October 2018) to 27% (November 2018 to October 2019).

The service had low and/or reducing sickness rates. Between the same dates the average sickness rate for outpatient staff, theatre staff and inpatient staff averaged 1% with a peak identified in May 2019 of 7%. (Evidence source: PIR information provided by the hospital).

Medical staffing

The hospital had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service had enough medical staff to keep patients safe. The organisation offered independent practising privileges to consultants and anaesthetists to ensure that safe and effective anaesthetic and surgical services were provided to patients. There were currently 130 doctors working with practising privileges. None of the clinicians granted independent practising privileges at the hospital had had their practising privileges removed in the 12-month period November 2018 to October 2019. A practising privilege is the 'licence' agreed between individual medical professionals and a private healthcare provider.

The service had 39 doctors which held practising privileges for cosmetic surgery of which 31 were registered on the General Medical Council (GMC) specialist register.

The surgeons were independent practitioners and were selected according to a stringent criterion as per the organisation's practising privileges policy. There was an ongoing cycle of monitoring of those clinicians granted independent practising privileges, which included completion of annual appraisal, appropriate indemnity insurance and where applicable GMC revalidation and registration.

Employees were recruited in accordance with a standard recruitment and selection process and once employment commenced an induction and mandatory training programme.

The service always had a surgeon on-call during evenings and weekends. Patient care was consultant-led. Surgeons were available for advice and/or review admitted patients. They provided 24-hour on-call for patients post-operatively and were required to be within a 30-minute drive of the hospital when off site.

It was mandatory for all admitting surgeons to visit their patients at least once per day, or more frequently if the patient was receiving a higher level of care. If the named surgeon was unavailable at any time while they had patients admitted to the hospital, they arranged appropriate alternative named cover by another surgeon in the same speciality.

Each surgeon remained on-call for their own patients for the immediate post-operative period, unless they had made alternative arrangements with a colleague. Any alternative arrangements were communicated to the ward team. In addition, there was an RMO on site 24 hours a day seven days a week, who provided first line assessment for any patient that was already an inpatient and for any patient who may attend out of hours for review, following discharge.

One anaesthetist was on call every night and provided an urgent response in the event of any requirement for a patient to return to theatre. Major weight loss cases had an enhanced-on call anaesthetist cover from an intensive treatment unit consortium.

The hospital had a service level agreement with an agency to supply RMOs who worked rotating periods to cover the service 24 hours a day, seven days a week. The agency provided appropriate training for the RMOs. The hospital informed us that training modules completed by the RMO included for example: safeguarding children and adults (level 2), equality and diversity, manual handling, privacy and dignity and infection prevention.

There was always an RMO on the premises who carried out routine work during daytime hours and who was on-call out of hours. The hospital monitored the RMOs on-call for those working 24-hour shifts. There was an RMO 'call out' proforma which monitored the number, type and duration of any RMO contact during silent hours and weekends. This was completed each time the RMO was called and used to review and identify reasons for the call, time and duration of call out and by which member of staff. This enabled the hospital to identify any trends, to monitor and therefore address any issues to reduce any unnecessary call out.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, records were not always stored securely.

Records were not always stored securely. We observed that confidential records were kept in a lockable trolley by the nurses' station on the wards, that only staff had access to. However, we observed these cabinets were not locked which meant there was a risk that these records could be viewed by unauthorised personnel.

We saw computer terminals were locked when not in use. This reduced the risk of unauthorised people accessing patient information. Records identified, where applicable, details of any device used in the event of product safety concerns or regulatory enquiries.

We saw the medical records management and documentation policy was up-to-date and due for review in September 2022.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients' surgical and inpatient records were hand written then added to the computer record management (CRM) system. The CRM system was available across the organisation, which allowed patients records to be immediately available to staff in the referring clinics.

Should medical records be unavailable at the time of pre-operative consultation, the patient would be invited back to enable records to be located and obtained. In the event patients were seen in an emergency in the clinic (for example six months after surgery) the service had the option of retrieving patient notes from the data storage provider and this could be done on the same day. The hospital informed us that over the last three months there had been no records unavailable.

Medical records were not taken off site until sent to the secure storage facility for archiving.

We saw the November 2019 pre-assessment documentation audit. This was RAG (red, amber, green) rated and the service achieved 81% (amber). The audit highlighted that when the patient was being discharged, the ward nurses were not documenting the patients pain score/level. The report identified that the state of the patients wound should also be documented clearly in the care plan when discharging the patient for example, if the patient was going home with a dressing. We saw the corresponding action plan, which included for example:

- Staff to ensure that the pre-operative health questionnaire is fully completed and that it is present in the patient notes.
- The pre-admission health questionnaire to be checked and assessed by a registered nurse as the audit identified that this was not always completed.
- Staff need to ensure there is written evidence that the patient is fit for discharge, or that the consultant has documented that the discharge is to be nurse led. There should always be documented evidence of a completed discharge summary for each patient, and that the patient has been offered a copy of this and a copy sent to the GP within 24 hours.
- Ensure the discharge summary is fully completed for each patient discharge. (Evidence source: A05 Documentation at pre-operative assessment)

We looked at nine records and found no issues or concerns regarding the completion of the pre-operative health questionnaire. Most of the records seen were for patients that were admitted on the day of inspection and therefore, we were not able to evidence the completed discharge summary for patients.

Patients were asked for their consent to share information with their GP. All patients who consented had GP letters sent, detailing consultations and procedures performed. Patients who did not consent were given a copy of their discharge summary and advised to show it to their GP.

Patient records were comprehensive, and all staff could access them easily. We reviewed nine sets of patient

records and found they were generally legible, up-to-date and contained all relevant information regarding patients' care and treatment. Appropriate pre-operative assessment information was recorded. This included a full explanation of the procedure, likely outcome and the patient's medical and social history. This was in line with national guidance (Royal College of Surgeons Professional Standards for Cosmetic Surgery (April 2016)).

The service was compliant with the Department of Health and Social Care mandate (January 2019) that informed all providers of the legal requirement for NHS Digital to collect breast implant data for all women who had breast implantation in England. As patient consent to data being input into the registry was now no longer required, a patient information leaflet (from NHS Digital) that clearly outlined the services' obligation to input breast implant data into the registry was provided to all patients.

Medicines

The service did not have effective processes in place to safely prescribe, administer, record and store medicines.

The hospital had a pharmacist who provided services four days a week. The days worked were pre-determined by the needs of the business and included weekends and bank holidays when required. The pharmacist was also contactable by mobile phone for advice as required. (Evidence source: D20)

The pharmacist informed us they were in the process of updating the medicine management policy. This was being done by taking best practice across the Transform Hospital Group Limited while incorporating the National Institute for Care and Health Excellence guidelines.

It was noted that some medicines management responsibilities were delegated to key head of departments by the Transform Hospital Group Limited pharmacist, which were detailed in the medicines management policy under standard operating procedures.

At Dolan Park Hospital, medicines were supplied by the pharmacist from the pharmacy department to other areas of the hospital. Each clinical area had a range of medicines, which were kept as stock. The senior registered nurse, head of clinical services or clinical nurse would determine the list of stock items with the Transform Hospital Group Limited pharmacist. It was noted that all ward stock was received directly from the wholesaler while clinical stocks were received directly from the Transform Hospital Group Limited pharmacist. Stock requirements were established weekly and ordered from the Transform Hospital Group Limited preferred wholesalers. Stock medicines were stored in their original container and not labelled up for individual patient use. Following the inspection, senior management informed us that all medicine stock was coming direct form the wholesaler with the pharmacy service becoming obsolete. The medicines management policy was being updated to reflect this. The pharmacy store held minimal stock that was in the process of being run down by provision of remaining stocks to ward and theatre areas.

Staff did not always follow systems and processes when safely administering, recording and storing medicines. During the inspection, we found approximately 40 boxes of intravenous fluids left unattended next to a lift and an open service delivery door, leading outside. We observed this door was in constant use, which meant there was a potential risk that the medicines could be tampered with. This was brought to the attention of senior staff who immediately addressed our concern and removed the boxes to the theatre area.

During our visit to the pharmacy, we carried out a stock check and found medicines which were out of date. This was discussed with the pharmacist who immediately removed the medicines. Following the inspection, senior staff informed us they had commenced weekly stock checks for the pharmacy, wards and theatre areas.

We checked a range of medicines across the surgical service and found six medicine suspensions which did not have a date of opening in the medicine trolleys on the ground floor and top floor wards. Without a date of opening recorded, it was not possible to determine whether the medicine would still be effective and therefore, safe to administer to a patient. This was brought to the attention of senior staff who provided us with an action plan following the inspection. This highlighted the removal and disposal of all liquid medicines that had been opened and not dated. The hospital's medicines management team implemented "date of opening" stickers with daily checks to ensure compliance. However, as this had only been recently implemented, we could not be assured the processes were embedded into the service.

Staff did not always review patients' medicines regularly and we found that medicines were not always managed and documented correctly. The medicine management policy stated that following the Transform Hospital Group Limited's medicines reconciliation process, a patient's regular medicine will be prescribed on the patient's medicine administration record by the RMO, following verification of a second source where necessary. During the visit on 28 January 2020, we reviewed three patient records on the ground floor ward and found that two of the patients had brought in their own medicines. However, these were not recorded on the medicine administration record. There was no evidence that the RMO or the registered nurses had made appropriate checks in line with the hospital's policy. This issue had been identified in three separate audits showing 0% compliance with this aspect:

- prescribing audit dated August 2019.
- the missed medicines dose audit September 2019.
- the medicines reconciliation audit for December 2019.

This meant that we could not be assured that staff were following the provider's policy regarding the administration of medicines for those patients who were self-administering. Also, the actions identified following the audits had not improved compliance. We raised this during our inspection. Subsequently we have been provided with an action plan to address medicines management issues. Actions related to this issue included, communication from the hospital manager to all RMOs to reiterate the requirement for 100% compliance with the medicine's reconciliation process. The medicine management policy was also to be amended to standardise the process of patient's own medicines brought in on admission. The hospital informed us they had also implemented weekly spot checks to ensure compliance. (Evidence source: DR17, DR18).

Staff stored most medicines in line with the provider's policy. Medicines were stored securely in locked cupboards and we saw processes in place for the safe custody of keys.

Medicines requiring refrigeration were stored appropriately. The fridge temperature was checked and recorded daily to ensure medicines were stored within the correct temperature range and were safe for patient use. Staff understood the procedures to follow if the fridge temperature was out of range. We saw fridge temperatures were within the recommended range.

We saw blood which was kept in the fridge in theatre had the appropriate checks. We saw daily fridge and temperature checklist where blood was stored. The fridge had an alarm system which went off when the temperature moved out of the recommended range.

We saw the medicine management audit for August 2019 which was RAG rated. The overall score was 54% (red). We saw the corresponding action plan with a closing deadline of December 2019. Areas identified included:

- Implementing a log for recording when ward and theatre staff have read and understood the medicine management policy and standard operating procedures. During the inspection, senior staff informed us the medicine management policy was being updated.
- A separate action log to be developed for each individual area regarding cleanliness and tidiness of storage areas. (Evidence source: A12 Medicine Management audit). However, we did not see a separate action log regarding the cleanliness and tidiness of storage areas during the inspection. This meant that we could not be assured that there were processes or systems in place to implement the actions identified.

We saw the controlled drug (CD) audit for August 2019 which was RAG rated. The overall score was 93% (amber). We saw the corresponding action plan which identified the following actions:

- CD signature record to be implemented.
- All medicines management policies to be circulated/ read/understood and staff log to be signed.
- Communication about how to correctly amend CD errors in the CD record book to be sent to theatre staff by the theatre lead. (Evidence source: A13 Controlled Drug audit August)

During the inspection we highlighted concerns with the management of patients own CDs on the top floor ward. For example, we found out of date medicines, as well as medicines not accounted for on the CD register or accounted for as ward stock. This was brought to the attention of senior staff. Following the inspection, we received confirmation that all identified medicines had been destroyed. A medicines management communication had been sent to staff reinforcing processes for the management of patients own controlled drugs when brought into the hospital. The medicine management

policy was to be updated to standardise the process of patients own medicines brought in on admission across the organisation. The policy change was to be reported at the next governance and compliance committee meeting. The facilities department were also tasked with identifying additional locked storage for each ward.

The hospital provided us with data which highlighted 12 incidents reported relating to medicines during the reporting period October 2018 to November 2019. All the incidents had been graded low risk. The report outlined the incident and the actions taken, which included discussion at staff team meetings. We noted that incidents were incorporated as an agenda item in the meeting minutes seen. (Evidence source: D24)

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses 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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff reported serious incidents clearly and in line with the hospital's policy. An incident form was used to record all incidents or accidents that occurred within the service. Staff we spoke with said they were familiar with this. The form included patient details, the date, time and description of the incident or accident, who it was reported to, action taken by staff, risk grading, learning outcomes and changes to practice. We reviewed two incidents reports and saw that learning outcomes were identified and changes to practice identified, such as communicating the results of pre-operative questions to other sources for review other than the anaesthetist for example, surgeons, ward sister and pharmacist if applicable.

There had been no never events reported during the period September 2018 to October 2019. Never events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff knew what incidents to report and how to report them. The hospital had an incident review teams who met a minimum of 12 times a year at each hospital site. Incidents occurring within the hospital were reviewed at each meeting, as well as those that had been reported from clinics within the geographical areas of the hospital.

There had been 152 clinical incidents for the period October 2018 to September 2019. Of these 110 were classed as no harm, 27 as low harm and 15 as moderate harm. There were no incidents categorised as severe or death related. There had been 37 non-clinical incidents during the same reporting period. For the same period there had been 98 non-clinical incidents. (Evidence source: PIR data provided by the hospital).

Staff we spoke with understood the Duty of Candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulation 2014 was introduced in November 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 that person.

The hospital reported three incidents which were classed as moderate harm/serious incidents. We saw the root cause analysis relating to these incidents and noted that it was comprehensive and included the patient's timeline, statements from relevant sources and recommendations. We noted that the reports were presented to the clinical governance and compliance committee, which meant that there were processes and procedures in place to manage incidents appropriately. However, the reports made no reference that the Duty of Candour regulation had been applied (Evidence source: D26).

Staff we spoke with told us that openness and transparency were encouraged, and staff understood their responsibility to report incidents. Where appropriate, incidents were reported to external bodies.

We saw both the nursing and theatre staff meeting minutes for August and September 2019 and found incidents were on the agenda, together with feedback regarding individual incidents to ensure lessons were learned.

Requires improvement

Surgery

Safety Thermometer

The service monitored patient safety information such as unplanned emergencies, complication and infection rates, and re-admission rates. However, nursing staff spoken with said they were not aware of how the wards were achieving regarding harm free care.

Staff were not aware of how safety thermometer data was used to further improve services.

Are surgery services effective?

Requires improvement

We rated effective as **requires improvement.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients' subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and delivered high quality care according to best practice and national guidance. Policies and procedures seen were up-to-date and in line with current national guidance/legislation and best practice. Policies were stored on the hospital's intranet system, which all staff had access to.

Patients were seen for pre and post-operative consultations for elective cosmetic surgery procedures and weight loss procedures. The hospital saw on average 69% cosmetic surgery and 31% weight loss surgery. From patient records we reviewed, staff and patient's we spoke with, and observation of practice, we found cosmetic surgery was managed in line with professional and expert guidance (The Royal College of Surgeons Professional Standards for Cosmetic Surgery (April 2016)).

Patients care, and treatment was planned and delivered in line with current evidence-based guidance, guidance, standards, best practice and legislation. This includes supporting patients to make decisions and obtaining consent to care and treatment and the Mental Health Act (MHA) 1983. Services were reviewed against the National Institute for Health and Care Excellence (NICE) guidance.

Patient's suitability for proposed treatment was holistically assessed. The surgeon considered each patient's medical history, general health, mental health concerns and history of previous cosmetic surgery before any surgery was performed. The expected outcome was identified and discussed with each patient before treatment and was reviewed postoperatively.

On the day of surgery, women of childbearing potential were asked if there was any possibility they could be pregnant. Pregnancy tests were carried out with the patient's consent, where indicated. This was in line with NICE guideline (NG45): Routine preoperative tests for elective surgery (April 2016)). This was confirmed with staff spoken and we also noted this was a standard question on the pre-operative questionnaire, which staff discussed with patients during their appointment.

Patients were supported to be as fit as possible for surgery. For example, patients were advised to stop, or at least reduce smoking and alcohol intake before and following surgery.

There were policies in place to ensure patients and staff were not discriminated against. This included those with protected characteristics, in accordance with legislation (Equality Act 2010)

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patents' religious, cultural and other needs. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. However, we found concerns with the ward's storage of patient's food.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were given a light meal, such as a sandwich and hot or cold drink following their procedure. Patients could choose what they wanted from an extensive menu which catered for dietary and cultural needs.

Patients waiting to have surgery were not left nil by mouth for long periods. Prior to surgery patients were kept 'nil by mouth' and fasted in accordance with national safety guidance, to reduce the risks of aspiration during general anaesthesia. We attended a clinic and staff described how they provided clear instructions about fasting prior to

admission. Staff told us that information was given both verbally during the assessment and in writing. Most of the patients we spoke with, told us they had been taken down to theatre about the time they were expecting to go and did not have an extended wait, thus avoiding a lengthy fasting period.

We saw fasting was discussed in the minutes of the ward staff team meeting held on 30 August 2019, which outlined that patients could have a drink of water up to two hours prior to their surgery. (Evidence source: D08)

We saw that the patient's food and drink fridge temperature checks had been completed on the wards. During the inspection of 14 and 15 January 2020, we found two cartons of fruit juice with no dates of opening in the lower ground floor fridge identified for patient use. This was brought to the attention of senior staff who immediately removed the items. However, during our revisit on 28 January we found another two cartons of fruit juice with no dates of opening as well as two undated plates of food within the fridge on the lower ground floor ward. This meant that we could not be assured there were processes and procedures regarding the appropriate storage of patient's food.

Patients were routinely monitored for nausea and vomiting during and following their procedure.

We reviewed nine records and saw, where appropriate, staff had used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Specialist support from staff, such as dietitians, was available for patients who needed it. Patients who were undergoing weight loss surgery received information booklets providing advice regarding diet and support from dietitians.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff were trained to assess patients for pain relief as part of their normal practice. The hospital had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (published November 2015) to ensure that following surgery patients were given effective pain relief. The on-site resident medical officer (RMO) was available to provide support where patients pain was not satisfactorily managed. The RMO would liaise with the surgeon or anaesthetist should a pain relief issue occur.

Staff prescribed, administered and recorded pain relief accurately.

We saw the pain audit for December 2019. The audit did not provide an overall score but highlighted areas of good practice and areas which required action. Areas of good practice included:

- Patients were very happy with the attention given by the nursing staff during their stay.
- Allergy and identity checks were carried out in all cases.
- Requested medicine was being administered in a timely manner.

Areas for improvement included:

- Communication with the ward to reiterate that all regular and pro re nata (PRN) (as required) medicines should be offered.
- Patients were not always aware that they could request medicine if they felt they needed it.
- Pharmacist to provide a training session on how regular pain management can help during post-operative healing and the use of omission codes in the drug chart.
- A re-audit to be done in 12 months. (Evidence source: A15 Pain audit)

We observed staff asking patients if they were comfortable and pain free. Patients were given pain relief medicine to take home with them following their surgery, unless contraindicated. Patients were followed up with a telephone call within 48 hours post discharge, to check their well-being and whether they were in any pain.

Patients spoken with confirmed they had received pain relief when required and said nurses were very responsive.

Patient outcomes

Participation in external audits and benchmarking was limited. Patients' outcomes were not always compared with similar services. While staff monitored

the effectiveness of care and treatment, they did not participate in relevant national clinical audits. They did not always use the findings of local audits to make improvements to achieve good outcomes for patients.

The service did not participate in relevant national clinical audits which meant that outcomes for patients were not measured in line with national standards. The hospital did not submit performance data to the Private Healthcare Information Network (PHIN). PHIN publishes independent, trustworthy information to help patients make informed treatment choices. On behalf of the Competition and Markets Authority, PHIN publishes data for 11 performance measures at both hospital and consultant level. These volumes include the volume of procedures undertaken, infection rates, readmission rates and revision surgery rates. Senior management informed us that it recognised that the depth of submission required improvement. Senior staff said that a programme of work had commenced to implement enhanced information technology systems to enable improvement of submission to PHIN to the required level of compliance; including having a dedicated resource to fulfil this commitment.

Consultant surgeons we spoke with said they had performed very few revision surgeries. This is when patients want their procedure to be redone because they were unhappy with the outcome. The governance and compliance committee meeting reviewed revision surgery and the meeting minutes for November 2019 identified that revision data had been validated with no concerns noted. (Evidence source: D09). The hospital management information report for October 2019, showed that there were 561 revisions carried out in the year ending September 2019. This accounted for 12% of the number of total procedures (4,516) carried out in the same timeframe. Managers also monitored the number of revisions performed by each surgeon.

The hospital did not report to the Quality Patient Related Outcome Measures (Q-PROMs). The aim of the Q-PROMS is to ensure that surgeons collect patient related PROMs for all patients seen to audit the quality of the service they provide, and assess patient satisfaction following surgery. This helps surgeons to assess their work, and to identify any improvements required. Surgeons we spoke with confirmed that they would like to be able to report to Q-PROMS as this could be linked to their performance and be attributed to their appraisals and revalidation.

Patients' outcomes locally were routinely collected and monitored. The organisation had a comprehensive audit calendar in place to provide assurance that safety systems, processes and practices were monitored, action plans implemented, and lessons learned shared. We saw the audit programme for 2019/20. Areas audited included: monthly hand hygiene and infection control within theatres and the wards. However, most staff spoken with said they were not aware of how they were performing and felt they would like visual information, so they could easily see how well they were doing. We did not see any performance information on display when visiting the wards. (Evidence source: A01 audit schedule). We looked at minutes of various meetings including head of department, theatre staff and ward staff meetings. We noted a variance in audit information included. For example, while audit was a standing item on the agenda for the ward staff meeting; two out of three minutes we reviewed had no information in this section (Evidence source: D08).

We reviewed local audits including anaesthetic, venous thromboembolism, and various regarding areas of medicines management. We saw that the anaesthetic and VTE audits showed evidence of benchmarking to standard standards, action planning with action owners and improvements in results. However, actions highlighted to improve compliance with aspects of medicines management audits results were not effective, for example medicines reconciliation (see Medicines section for more details). (Evidence sources: DR10, DR14, DR17, DR18 and DR20)

We also saw gaps in post audit action planning regarding a National Early Warning Score documentation audit. This was dated July 2019, based on 10 records, and had an overall score of 93%. We noted that the recording of the patient's respiratory rate and temperature score had achieved 40% and 50% respective and had been rated red. While the audit had a summary and action plan, it did not identify which ward had participated in the audit or who was responsible for this action or the date for completion. This meant that we could not be assured that there were processes in place to manage the action identified. (Evidence source: DR26)

Surgeon outcomes were monitored and reported to the Dolan Park Hospital medical advisory committee (MAC) and the Transform Hospital Group Limited's governance and compliance committee. A high-level view was also reported

to the senior management governance board monthly. The responsible officer and head of operations met monthly to review surgeon outcomes and monitored and, where applicable, created actions when themes and trends were identified.

Information about patient's care and treatment, and their outcomes, were collected and monitored. Performance of services were discussed at departmental meetings, MAC, corporate level governance and compliance committee and senior management governance board.

Competent staff

Managers appraised staff's work performance and held supervision meetings with them to provide support and development. While the hospital had processes to ensure staff were competent in their role, we saw staff in recovery did not have the appropriate competencies regarding airway management.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. For example, all staff had received resuscitation training relevant to their role.

There were processes in place to ensure that the surgeons who worked at Dolan Park Hospital were competent and experienced to perform the treatments and procedures they provided. The majority also performed cosmetic and weight loss surgical procedures for NHS services. Most of the surgeons were registered with the specialist register held by the General Medical Council (GMC). The GMC lists the names and specialties of fully registered, medically qualified doctors who have completed specialist training or are otherwise eligible for entry on the specialist register, and thus allowed to take a fixed-term NHS consultant post in the UK. Surgeons were not required to hold a Royal College of Surgeons cosmetic surgery certification. This is a voluntary certification scheme developed in response to the 2013 Keogh Review, which highlighted an urgent need for robust regulation of cosmetic practice. The scheme provides recognition to surgeons who have the appropriate training, qualifications and experience to perform cosmetic surgery, and provides assurance to patients.

There was an up-to-date policy in place for the granting and reviewing of practising privileges. The documents required before practising privileges were granted included evidence of private medical insurance cover, appraisal records, Disclosure and Barring Service check and references. At the time of our inspection we found no issues or concerns.

The Transform Hospital Group Limited evidenced that all surgeons had undertaken their GMC revalidation and appraisal. Their appraisal was carried out with their substantive employer. We saw evidence that they participated in continued professional development activities.

We saw the revalidation data for registered nurses, operating department practitioners (ODPs) and dietitians for December 2019 was 100% compliant. (Evidence source: DR8)

The RMOs received 36 continuing professional development points yearly, which they could use towards their revalidation and appraisals.

All staff spoken with confirmed they had received an appraisal. Staff were supported to deliver effective care and treatment through the supervision and appraisal processes. We saw that 91% of ward nursing staff had received their appraisal. Theatre nurses, ODPs and health care assistants had completed their appraisals (76%). The hospital informed us that five appraisals expired December 2019, and these were scheduled to take place in January 2020, which would increase compliance to 93%. (Evidence source: DR7). The organisation had a clear and appropriate approach for supporting and managing staff when their performance was not meeting expected standards.

Following our inspection, the provider supplied objectives that had been set for roles including senior staff nurse, staff nurse and healthcare assistants. These set expectations for the roles enable development and performance management.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with confirmed that they had received an induction on commencement of their employment.

Managers did not identify the training needs of all staff. While in the theatre recovery areas, staff informed us they extubated (removal of breathing tubes) of patients. Anaesthetic staff spoken with confirmed they had confidence in the ability of the recovery theatre nursing staff to complete the procedure. However, the service was

not able to provide us with documented evidence that staff had received training or competencies in airway management. This was not compliant with the Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines (2013) Immediate Post Anaesthesia Recovery which states: "The removal of tracheal tubes from patients in the post anaesthetic care unit (PACU) is the responsibility of the anaesthetist, who may delegate the removal to an appropriate trained member of the PACU team who is prepared to accept this responsibility." We brought this to the attention of senior staff during our inspection. Subsequently, the hospital informed us they did not have a formal policy regarding extubation. However, we saw this had been discussed at an inaugural meeting (January 2020) of the managing the deteriorating patient group. An action had been agreed to develop this policy together with an accompanying competency document. We have also been provided with a copy of the Operating Theatre Department Recovery Suite Competency Assessment Tool dated 2016. However, we did not see this in use or referred to during the inspection.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

The teams worked well together, with care and treatment delivered to patients in a co-ordinated way. We observed nurses, doctors and other health care professionals working well together to provide good care. Staff told us they worked closely together to ensure patients received person-centred care and support. For example, we saw excellent teamwork and communication between the recovery staff and the theatre team.

We saw evidence of good multidisciplinary approach to patients attending the hospital. The pre-operative review was overseen by the surgeon, with screening by the nurse over the phone and in person when required. Also, we saw that dietitians could be involved by phone when required. Should there be any queries/concerns then an anaesthetic review would be arranged.

Treatment provided was consultant-led. All team members were aware of who had overall responsibility for each patient's care.

Relevant information was shared between the service and the patient's GP following their appointment. If patients consent, the surgeon wrote to the GP following the consultation. They informed them of the planned procedure and asked whether there were any contraindications. A discharge summary was sent to the patient's GP postoperatively. This included details of the surgery performed and any implants used, where appropriate.

The surgeon would involve mental health service when indicated. They had links with a psychologist, who they would refer patients to if they felt this was needed. They would also write to the patient's GP if they had any concerns about a patient's mental health.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, diagnostic imaging, such as x-rays, were not available on site. If required, the patient would need to be transferred or attend an NHS facility.

The hospital undertook elective surgery exclusively, and operations were pre-planned. The exception to this was if a patient required to return to theatre due to complications following a procedure.

Each surgeon remained on call for their own patients for the immediate post-operative period, unless they had made alternative arrangements with a colleague. Any alternative arrangements were communicated to the ward team. In addition, there was an RMO on site 24 hours a day seven days a week. They provided first line assessment for any patient that was already an in-patient and for any patient who may attend out of hours for review, following discharge.

There was an anaesthetist on call every night and provided an urgent response in the event of any requirement for a patient to return to theatre. Major weight loss cases had an enhanced-on call anaesthetist cover from an intensive care unit led consortium.

Following discharge, patients were able to access the RMO for advice and patients were provided with a helpline

number, which they could access 24 hours a day seven days a week. The RMO made a courtesy follow up call to each patient on the day following discharge from the hospital. This call was documented in patient records and any concerns reported to the surgeon.

The on-call theatre team provided out of hours on-call cover for any emergency patients who were re re-admitted from home, or in the event of a requirement for a patient who needs to be returned to theatre in the post-operative phase. We saw the make-up of the on-call team, such as anaesthetist, surgeon, recovery staff and OPDs met the requirements of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). NCEPOD reviews clinical practice and identifies possible corrective aspects in the practice of patient care.

Theatres operated seven days a week. Theatre sessions commence at 8am daily and aimed to close by 8pm each evening. Where unanticipated extended theatre opening times occurred, these were subject to incident report which was used to identify trends and themes.

The contracted Transform Hospital Group Limited pharmacist provided 20 hours a month service to Dolan Park Hospital. The pharmacist was based at Dolan Park Hospital an average of four to five days a week with the days worked determined primarily by the needs of the business and included weekends and bank holidays, should this be required. The pharmacist was available on their mobile phone seven days week should their expertise be required. (Evidence source: D20)

Weight management patients had access to specially trained clinic nurses for wound management and gastric band adjustments, as well a team of dietitians and bariatric surgeons. Patients could access weight management specialists 24 hours a day, seven days a week through the weight loss support service contact centre.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The smoking status and alcohol intake of patients was recorded at the initial consultation. Patients were advised to stop or at least reduce smoking before and after their surgery. They were also advised to avoid alcohol prior to and after surgery. Patients were provided with information on the potential risks and side-effects of smoking and having surgery. This was to reduce the risk of any complications and help promote healing.

We saw relevant information promoting health lifestyles and support on the wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and knew who to contact for advice. Medical staff spoken with said they had not completed procedures on any patients who may lack capacity. Two surgeons we spoke with explained that if they were not assured patients understood the procedure and implication of having surgery they would not proceed without the involvement from the patient's GP and a psychologist.

Staff received and kept up-to-date with training in the 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. There was an effective up-to-date consent policy for staff to follow.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. If a patient had a mental health condition, a GP or specialist mental health letter was obtained to provide an opinion and/or assessment on the patient's ability to make informed consent. We saw the pre-operative documentation explained the expected outcomes and ensured the patient understood these and any potential risks before agreeing to go ahead with the surgery.

Requires improvement

Surgery

Staff made sure patients consented to treatment based on all the information available. All patients received a patient information booklet which contained details of all risks and benefits of their chosen procedure. The booklet formed part of the informed consent process. Those patients who were 18 years or older and who met the organisation selection criteria both physically and mentally and had the capacity to provide consent for themselves, were admitted to Dolan Park Hospital.

Staff clearly recorded consent in the patients' records. Consent was obtained in line with national standards (Royal College of Surgeons Professional Standards for Cosmetic Surgery, April 2016). Most patients undergoing cosmetic surgery waited a minimum of two weeks between consultation and surgery. We reviewed eight patient records and found completed consent forms, which were signed and dated by the patient and the operating surgeon. The consent forms were comprehensive and included details of the planned surgery, potential risks and complications.

We saw the consent audit for November 2019, which was RAG (red, amber green) rated. The overall compliance was 88% (amber). We saw the corresponding action plan which highlighted the following:

Surgeons to be reminded to ensure that they complete the consent form using terminology the patient will understand.

Surgeons to document extra procedures and use of photographs on consent forms.

Surgeons must document clearly their name on the consent form and a signature alone was not enough. (Evidence source: A02 consent audit)

Are surgery services caring?

Good

We rated caring as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, an took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed a strong ethos across the service to provide person-centred care for patients. Staff were motivated and inspired to provide care that was kind and promoted patient's dignity. Staff introduced themselves to patients and made them aware of their role and responsibilities.

During our observation of a surgical procedure, we saw staff ensured that the patient experience was as pleasant as possible. Staff were compassionate and provided reassurance and support to patients throughout their procedure.

Patient's privacy and dignity needs were understood and respected. Where care and treatment required a patient to undress, staff ensured this was done in complete privacy through the provision of a private room, curtains and/or screening. Appropriate clothing, such as gowns, were provided where necessary. Patients could also request the presence of a chaperone.

Staff were encouraged to raise concerns about disrespectful, discriminatory or abuse behaviour or attitudes.

Staff we spoke with understood and respected patients' personal, cultural, social and religious needs, and took these into account in the way they delivered care and treatment.

Patient satisfaction was collected and reported bi-monthly at the local quality meeting and medical advisory committee (MAC). Patient feedback was by paper questionnaires, verbal or through a website which enabled patients to search, compare and book private doctors and health professionals in the United Kingdom. The website was available in the main reception and ward areas for patients and visitors to record their satisfaction with key areas, such as their overall experience, friendliness of staff, waiting time, cleanliness and how likely they were to recommend to their friends and family. This data was regularly reviewed, and actions taken when required.

Staff recognised and respected the patient's needs. Patient's views and experiences were gathered and acted on to shape and improve the services and culture. Patient feedback was sough in various ways including the Friends and Family Test, social media and the hospital website. Patients were encouraged to give feedback on the quality

of service they received. From May to October 2019, 98% of patients said they were likely/highly likely to recommend the service to their friends and family. This was based on an average response rate of 7% for the same period.

Patients we spoke with said that staff were "marvellous" and "did everything to make their stay comfortable." and they "couldn't fault them." We also saw thank you cards from patients displayed on the wards. One patient wrote; "Thank you for looking after me so well" and another said; "can't fault the staff they have been amazing."

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff spoken with explained the impact that a person's care and treatment could have on their well-being. Staff were supportive to patients who were anxious about their surgery. They took the time to reassure them. One patient said that "staff understood how I was feeling."

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We found where patients were anxious about the procedure they were admitted for, staff gave extra care and responded compassionately to put the patient at ease. We observed patients on the wards, in the anaesthetic room and in recovery being reassured by staff that were empathetic when patients were nervous or anxious. A patient told us that they had been very nervous about having an anaesthetic and the nurses on the ward who responded to this by informing staff in the theatres. The patient told us "staff were first class" and the anaesthetist had been to the ward to "ensure they were settled."

Patients admitted to Dolan Park Hospital were under the care of their chosen surgeon and they had a dedicated patient care coordinator who provided information, guidance and emotional support for the entire duration of the patient's journey.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. They ensure that people's communication needs were understood and used best practice and learned from it.

Staff made sure patients and those close to them understood their care and treatment. Staff communicated with patients in a way that they understood their care, treatment and advice given. The surgeon ensured that patients were fully consulted and had realistic expectations before they agreed to perform any surgery.

Patients told us they felt involved in their care and had received the information they needed to understand their treatment. Patients said they felt that they had been given time to think about the procedure which included all the "pros" and "cons" involved.

Staff underwent training in equality and diversity to ensure facilitate were planned and accessible by patients of different cultural and ethnic backgrounds. People with language other than English had 24-hour access to telephone interpreters. The needs and preferences of patients were considered and acted on when delivering and coordinating services.

There were appropriate and sensitive discussions about the cost of treatment. Patients were advised of the cost of their planned treatment at the booking stage.

Are surgery services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. The hospital offered appointments evenings and weekends to ensure patients could attend at their convenience. Clinics operated a seven per week appointment service.

Requires improvement

Surgery

Facilities and premises were appropriate for the services being delivered. The hospital had accessible rooms for patients with a disability that affected their mobility. We observed the waiting room area was spacious with adequate seating for patients and visitors. The theatres, recovery area and wards, were well laid out to support the needs of patients.

The wards were spacious, and patient centred. Inpatient rooms were well-appointed, with en-suite wet rooms and air conditioning. There was free Wi-Fi and a television in each room. The rooms had shower area with hand rails which provided enough space for patients with mobility issues. The wards and theatre were well signposted from the main entrance.

A drinks machine was available to patients and their companions when visiting for an appointment. There was a range of information leaflets on display in the waiting area.

All consultations and postoperative checks were carried out by the operating surgeon. This ensured patients received continuity of care.

Where service developments or changes were considered, input from clinicians was sought to fully understand impact on quality.

Services were planned to facilitate access by people of different cultural and ethnic backgrounds. Staff we spoke with confirmed they had received training in equality and diversity.

Upon discharge patients were provided with the ward contact number for 24-hour advice. In addition, Dolan Park Hospital's resident medical officer (RMO) carried a mobile telephone which was linked to the patient helpline number which enabled patients to receive advice in a timely manner. Weight loss patients had a designated on-call and out of hours telephone line.

Meeting people's individual needs

The service was inclusive and took a proactive account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The needs and preferences of patients were considered and acted on when delivering and coordinating services.

People with languages other than English had 24-hour access to telephone interpreters. However, information leaflets were not available in languages other than English or in a suitable format for sight impaired patients.

Staff worked together to understand and meet patients' needs. For example, staff assessed pain, nutrition and hydration needs. Patients with special dietary requirements could have their needs met. Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff understood and applied the policy on meeting the information and communication needs of patients. Reasonable adjustments had been made so that people with a disability could access and use the service on an equal basis to others. The service was accessible to wheelchair users. There was a lift to the wards and suitable toilet facilities.

Each patient received a comprehensive patient information booklet and could access detailed organisation website provided patients with information regarding any potential treatment or procedure. All patients received a detailed discussion with a surgeon regarding their chosen procedure. The booklet and consultation were designed to provide information about the procedure including risks and benefits and formed part of the informed consent process.

As part of the consultation, patients could ask for a second opinion from an alternative surgeon. As part of the patient's pre-operative assessment, letters from GP's and other health professionals were obtained if required to understand the patient's individual health needs.

Arrangements were in place for ensuring psychiatric support was available where necessary. Surgeons referred patients to a psychologist or their GP if they had concerns about their mental health and wellbeing.

The patient's discharge and referral plans took account of their individual needs and circumstances.

Access and flow

People could access the service when they needed it and received the right care promptly.

Patients could access services when needed and received treatment within agreed timeframes. The service provided an elective self-pay surgery and informed us they did not

have a waiting list for surgery. Waiting times from referral to treatment were not applicable and arrangements to admit, treat and discharge patients were in line with national standards. During the inspection, patients spoken with confirmed they had received an efficient service and had waited a very short time for their procedure. Dates for surgery were agreed with patients during their pre-operative consultation. This was based on the surgeons' scheduled theatre lists and the day/time most convenient to the patient. The theatre list from August 2018 to January 2020 showed that a total of 438 operating lists were completed. Of this number, 410 lists were completed prior to the scheduled closing time of 8pm, 17 lists were completed before 9pm, nine lists were completed before 10pm and two before 11pm. (Evidence source: B14-1)

Patients had timely access to consultations, treatment and after care. Most patients undergoing surgery waiting a minimum of two weeks between consultation and procedure. This "cooling off" period was in line with national recommendations (Royal College of Surgeons Professional Standards for Cosmetic Surgery (April 2016)).

Managers ensured that patients who did not attend appointments were contacted.

Managers monitored and acted to minimise missed appointments. Appointments with patient advisors, clinic nurses or surgeons were available for patients to be seen either pre or post-operatively on any day. The hospital offered unlimited number of appointments to patients. Appointments with surgeons were subject to the surgeon's availability. Pre-operative patients were offered an appointment with a surgeon of their choice. Where the patient wished to have a sooner appointment, or the surgery type did not fall into the range that the surgeon performed they were advised of alternative surgeons.

Patients could access care and treatment at a time that suited them. Evening and weekend appointments were available, which facilitated flexibility and promoted patient choice. The service offered evening and weekend appointments to ensure patients could attend at their convenience. Clinics operated a seven-days a week appointment service. Appointments with patient advisors, clinic nurses or surgeons were available for patients to be seen either pre or post-operatively on any day.

The hospital offered unlimited number of appointments to patients. Appointments with surgeons were subject to the surgeon's availability. Pre-operative patients were offered an appointment with a surgeon of their choice. Where the patient wished to have a sooner appointment, or the surgery type did not fall into the range that the surgeon performed patients were advised of alternative surgeons.

Managers and staff worked to make sure patients did not stay longer than they needed to. Patients have a planned length of stay based on the procedure and patient needs. Staff spoken with said that most patients were discharged within 48 hours. Managers monitored the number of nights patients stayed and reported this data to the Medical Advisory Committee. For example, in September 2019, 41% of cosmetic surgery were day cases, 49% stayed overnight and 10% stayed for two nights.

Where a patient required an urgent return or readmission for clinical reasons the service facilitated an admission at the next available date. Managers monitored the number of patients who required return to theatre and reported this data to the Medical Advisory Committee. For example, in the year ending September 2019, 95 cases returned to theatre. This accounted for 2% of the total procedures carried out (4,516) in the same timescale.

The on-call theatre team provided out of hours on-call cover for any emergency patients who were re-admitted from home, or in the event of a requirement for a patient who needed to be returned to theatre in the post-operative phase.

Where a surgeon had requested revision surgery to improve on the original outcome this was classed as elective readmission and booked in accordance to the patient and surgeon availability.

Managers worked to keep the number of cancelled appointments/treatments/operations to a minimum. Senior staff said that due to the elective nature of the surgery carried out, delays and cancellations were minimal. The service cancelled 34 procedures in the last 12 months for a non-clinical reason. All patients were offered another appointment within 28 days of the cancelled procedure.

Services generally ran on time. Patients were informed of any delays. The patients we spoke with said they had received timely access to treatment.

Staff did not move patients between wards at night.

Managers and staff worked to make sure that they started discharge planning as early as possible. Patients had a

planned length of stay based on the procedure and patient needs. Upon discharge all patients were provided with the ward contact number for 24-hour advice. In addition, the RMO carried a mobile telephone which linked to the patient helpline number enabling patients to receive advice in a timely manner.

Following discharge, patients were able to access the RMO for advice, patients were provided with a 24-hour, seven-day helpline number. The RMO makes a courtesy follow up call to each patient on the day following discharge from the hospital. This call was documented in patient notes and any concerns fed-back to the surgeon. Weight loss patients had a designated on-call and out of hours telephone line.

Staff supported patients when they were referred or transferred between services. The hospital had a service level agreement with a local hospital and an ambulance service, which would provide cover when transferring patients out in an emergency.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received and the service encouraged it. The service treated concerns and complaints seriously, investigated them promptly and thoroughly, and included patients and families in the process. The service shared lessons learned with all staff in the service and more widely.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Complaint could be made to any member of the services' staff either verbally or in writing. Where complaints were raised informally, staff would try to resolve the complaint immediately. The clinical manager had the authority to financially compensate a patient (to a specified amount) where it was clear the hospital had fallen short of patient expectations. Verbal complaints were addressed by the nurse in charge or escalated to the nurse in charge/hospital manager to enable resolution wherever possible.

The hospital had an identified complaint process. Should staff be unable to resolve a complaint to the patients' satisfaction at stage one, this was escalated to stage 2. Stage 2 review was provided by the complaint's manager. The Transform Hospital Group Limited subscribed to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS). Where a complaint was not resolved to the patients' satisfaction at Stage 2, the patient was provided with information to escalate their concerns to the ISCAS.

The hospital received 102 complaints from November 2018 to October 2019 of which two were referred to ISCAS. The organisation's key performance indicator for acknowledging a complaint within three working days was 98% and there were no complaints over three months before a final response. ISCAS rules state that complaints must be resolved within three months and response within 20 days.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were discussed at quality and heads of department meetings. These meetings were attended by the hospital manager and clinical and non-clinical hospital management, front line and clinic staff members.

Complaint data and trends were reviewed and analysed monthly within the senior leadership board meetings. All complaints were reviewed at the medical advisory committee meetings, whose membership included surgeons and anaesthetist representation. Complaints were also reviewed at clinical governance and compliance committee meetings, which were attended by the hospital manager for Dolan Park Hospital.

Patients and relatives knew how to complain or raise concerns. Patients we spoke with were aware of how they could raise concerns or make a formal complaint. All patients were provided with a terms and conditions document at the start of their journey which clearly explained how to make a formal complaint. The complaints process was also accessible on the hospital's website.

Are surgery services well-led?

Inadequate

We rated well-led as **inadequate.**

Leadership

There was no specific senior nurse leadership role, such as a matron or clinical services manager. The

ward manager post was vacant, being actively recruited to and temporarily covered. We found there was no formal workforce plan for the hospital. However, leaders were visible and approachable in the service for patients and staff.

The hospital had a management structure with the defining lines of responsibility. The registered manager who was also the hospital manager, held the accountability for the service at the location. The hospital manager had progressed from theatre manager at the hospital to this role. The hospital manager was supported by various staff including an interim theatre manager, clinic business manager, housekeeping/catering manager, facilities supervisor, head receptionist, medical records supervisor. There were also two leads for theatres.

There was no specific senior nurse leadership role at the hospital, such as a matron or clinical services manager. Although the hospital manager was also a registered nurse. The most senior nurse role for the ward was the ward manager. This post was currently unfilled and was being covered by the lead nurse for the ward. The lead nurse's role usually covered clinical projects rather than management of the ward. This was a temporary part-time cover and the lead nurse's role also included being the infection control lead for Transform Hospital Group Limited. The service was actively seeking to recruit to the ward manager vacancy. However, we found there was no formal overall workforce plan for the hospital.

The hospital manager was supported by staff at national/provider level. This included a national clinic nurse manager and a Transform Hospital Group Limited infection control lead. The Transform Hospital Group Limited's infection control lead had been supported to develop into this senior role, including completing the relevant studies.

Organisation restructure within the Transform Hospital Group Limited in December 2018, resulted in the development of three business units (cosmetic surgery, weight loss surgery and medical aesthetics). Each business unit had a reporting structure and senior management team leadership. The hospital manager reported to the head of operations and weight loss services. The hospital manager was also supported by the Transform Hospital Group Limited's head of governance and compliance.

The theatre manager oversaw the surgical team. The theatre manager was an interim position as they also oversaw the Transform Hospital Group Limited's other hospital location. The theatre manager had been in post for approximately five months and spent an average of three to four days a week at Dolan Park Hospital. They confirmed that they were currently reviewing the services' performance, the challenges they faced, and the actions needed to address those. We saw the theatre team worked well together and the senior management team supported the service with the day to day management.

Theatre staff we spoke with about the new leadership said they felt confident and empowered with their ability to move the service forward. They expressed the hope that the current team would bring more continuity of approach. Most of the staff we spoke with were very positive about the theatre management team and felt they were credible and willing to face the challenges.

The service also employed people with expertise in finance and accounting, and information technology to support the effective running of the service.

When we raised concerns identified during the inspection, such as medicine management, the management team took immediate action to address this.

Staff we spoke with were generally positive about the senior management team. They told us they were visible, and they felt well supported, valued and respected. However, while staff agreed that leaders were visible and accessible, we were also told there were issues with low staff morale.

Vision and strategy

The provider had a vision for what it wanted to achieve and a strategy. Leaders and staff understood the vision. However, they did not formally monitor progress towards achieving the vision.

The organisations vision, mission and purpose were to enhance the wellbeing and quality of life. The vision was to ensure they were experts in delivering solutions that empowered people to make their lives better, while their mission was to make Transform Hospital Group Limited the elective healthcare provider of choice, by delivering outstanding care, continuous innovation and exceptional experience.

We saw the Transform Hospital Group Limited values were:

- Accountability - Never hide from responsibilities. Always accept personal accountability for actions and results. Never make excuses or place blame, so when there is a job to do, do it.
- Integrity - Be ethical in all actions, promote honesty and integrity in everything we do. Keep promises and commitments made to patients and colleagues.
- Patient Care - Demonstrate dignity and respect when delivering high quality patient care. Understand patients' needs and be passionate about delivering an outstanding service and carrying out duties with candour.
- Innovation - Advocates positive change by never accepting there isn't a better way of doing things. Push the boundaries to keep improving and overcoming challenges.
- One Team – Be more effective when working together. Never let a colleague fail, share ideas and knowledge, respect each other's opinions and recognise the efforts of our colleagues. Foster open and effective communication which is timely, and solution orientated.

The providers' vision and values were developed through engagement with staff across the organisation. The engagement established what staff believed to be important to them in terms of behaviours which were fundamental to their role.

We saw the annual plan for the provider (May 2019 to January 2020). This included the vision and values alongside the priorities for the organisation. However, progress towards achieving priorities and monitoring progress towards achieving the organisations values was not seen.

Staff spoken with confirmed that they were aware of the providers' vision and values and knew how to access the information on the intranet.

Following the inspection, the hospital informed us that the vision for Dolan Park Hospital was to be a centre of excellence for weight loss surgery and to be fully compliant with the standards of the British Obesity and Metabolic Surgery Society.

Culture

Staff satisfaction was mixed. The culture did not always support an open approach. For example, not all staff felt comfortable challenging consultants to comply with the arms bare below the elbow policy. However, staff were focused on the needs of patients receiving care and patients and their families could raise concerns. Most staff felt respected, supported and valued. The service provided some opportunities for career development.

The Transform Hospital Group Limited had an equal opportunity and dignity at work policy which was due for review in August 2021. Most staff we spoke with said that they felt valued as individuals and were treated fairly and treated with respect. Senior staff said they were committed to creating a work environment free of harassment and bullying and where everyone was treated with dignity and respect.

The hospital manager had introduced a morning 'huddle' meeting with representation of the hospital teams. This was initiated in August 2019 with the intent to increase staff access to leaders within the hospital and to enable a better flow of information, communication and engagement with staff.

There were arrangements in place to promote the safety staff. There was an up-to-date lone worker policy. Staff spoken with confirmed they did not work alone and could call the services of security personnel as and when required.

Staff we met with, were welcoming, friendly and passionate. 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 for their patients. We observed staff working collaboratively and sharing responsibility in the delivery of good quality care.

Staff were aware of their role in the patient's experience and were committed to providing the best possible care for their patients. Most staff told us there was an open culture, which was centred on the needs and experience of people who used the service.

We saw that leaders, such as the hospital manager, were accessible and operated an 'open door' policy. Staff told us they felt confident to raise concerns. However, the culture did not always support an open approach. Not all staff felt comfortable challenging senior staff's behaviour. For example, some staff did not want to ask consultants to comply with the arms bare below the elbow policy.

Many staff had worked at the hospital for several years. However, some staff were concerned for their jobs as they felt there was financial uncertainty.

Governance

While there was a governance structure in place for the organisation, which had been recently reviewed, the processes did not always operate effectively. There were not consistently effective governance processes to ensure that actions identified from the internal audit programme were monitored and completed. Most staff were clear about their roles and accountabilities. Processes for practising privileges were being adhered to.

There had been a review of governance since the merger, this was outlined in the annual plan. The annual governance improvement objective plan (May 2019 to January 2020) was an interim strategy. It identified recommendations for the clinical governance and compliance committee to complete, so that the outcomes would form the governance strategy and strengthen the overall governance framework. Areas identified included: a review and reflect on the hospital's status; identify areas for improvement while refining the structures and processes. However, during the inspection we found that while processes had been reviewed these did not always operate effectively.

It was acknowledged that some progress had been made in implementing and delivering the governance requirements. For example, refined process for managing and maintaining clinician practising privileges. We checked three files in detail chosen at random during our inspection and saw there were clear processes for practising privileges and the policy was being followed.

Quality of care was measured through patient satisfaction, infection rates, revision rates, complaints, surgeon appraisals and adverse incident management. These processes were used as learning tools to address any shortfalls as an when they occurred. There was a regular reporting process through the organisation's committee structure.

The organisation's committee structure was headed by a governance board chaired by the Transform Hospital Group Limited chief executive officer. Dolan Park Hospitals' main committee was the medical advisory committee (MAC), which reported to the Transform Hospital Group Limited's clinical governance and compliance committee. There were incident review meetings and an infection prevention and control committee, which reported to the MAC. The Transform Hospital Group Limited's clinical governance and compliance committee reported up to the governance board.

The MAC was chaired by the hospital manager and met six times a year. The purpose of the MAC was to collate, analyse and report on governance outcomes in relation to the hospital and local clinic network. The purpose of the clinical governance and compliance committee was to assure the senior management board that the Transform Hospital Group Limited regularly scrutinised and reviewed the systems in place to monitor and improve the quality and safety of patient care. The MAC membership included representatives from staff groups, such as surgeons, anaesthetists and pharmacy.

The hospital manager also chaired a monthly head of department/quality meeting attended by senior Dolan Park Hospital staff. We noted that these meetings had not always been taking place and had recently been reinstated. Departmental updates were reported and issues arising within the hospital discussed and when indicated. Areas discussed included: infection control updates, incident reports and feedback including lessons learned, health and safety concerns, risk management and ward and theatre updates. However, we did not see evidence of actions to ensure that matters had been or were being addressed.

The Transform Hospital Group Limited infection prevention and control committee (ICC) met bi-monthly, which was attended by the director of infection prevention and control, microbiologist and representative from each department within the hospital. The infection control committee was led by the consultant microbiologist with responsibility to oversee all policies and practice associated with infection control. We saw minutes from the ICC which included: the review of audits, incidents relating to infection control including needlestick injuries, completed root cause analysis and an overview of newly published guidelines and recommendations. Any actions arising were brought forward to the meeting for review and update.

There was a corporate practising privileges policy. Practicing privileges is a term used when doctors have been granted the right to practice at an independent

hospital. The policy included the granting of practising privileges, and roles and responsibilities. The MAC had oversight of practising privileges arrangements for clinicians. We saw evidence in MAC meeting minutes of discussion about renewing or granting of practising privileges. The majority of clinicians also worked at NHS trusts.

To maintain practising privileges, medical staff had to provide evidence of an annual appraisal, indemnity cover, and an up-to-date disclosure and barring service check along with evidence of completed training. None of the clinicians had their practising privileges removed for the period November 2018 to October 2019. The hospital had recently introduced a bi-annual review of clinicians independent practising privileges enabling the hospital to consider the suitability of each clinician and the clinician to review their scope of practice within the hospital.

We saw the theatre and ward staff team meeting minutes for August and November 2019. We observed the minutes contained updates of areas of concerns identified and feedback from staff groups working within the theatres as well as managers. For example, a health and safety concern had been addressed, which included the fitting of a new lock to the Control of Substances Hazardous to Health cupboard.

During the inspection, we found that while the hospital had a structured audit programme with relevant actions recommended from the results, there did not appear to be effective governance process to ensure these were monitored and completed. For example, we reviewed the medicine management audits and found a recurring theme, such as the poor recording of patient's own medicines in the audits of August, September and December 2019 (Evidence source: DR17, DR18). We also reviewed three MAC minutes and saw that medicine management was always included on the agenda. However, the minutes only identified one action out of the three meetings in relation to medicine management. During our inspection, we found evidence that despite actions identified at multiple audits, patients' own medicines were not always being recorded (see Medicines section for more details).

Managing risks, issues and performance

There were risks highlighted during our inspection that had not been recognised by leaders or included on the hospital's risk register, such as the management of medicines across the wards. We found that actions were not managed effectively, as many issues and concerns highlighted during our inspection, had already been identified by staff. We saw that some data was used to monitor performance and benchmarked against other sites within the Transform Hospital Group Limited. While the hospital was responsive to our findings, we could not be assured that the changes, practices and systems were embedded as they were recent.

We reviewed the organisations risk management policy, which was in date and due for review June 2021. This described the maintenance of the hospital's risk register.

There was a hospital-wide risk register. It contained 11 current risks; the majority were related to environment or equipment risks. One was categorised relating to patient safety.

Senior staff we spoke with said they felt that risks relating to the service was accurately reflected on the risk register. However, we found concerns during the inspection, which were not reflected on the risk register. For example, the management of medicines.

Known risks and mitigation in the surgical service were discussed at senior management team meetings, such as the governance and compliance committee and the MAC.

Risks were not displayed on the wards to ensure staff were made aware of the main risks within the service and hospital. Following our inspection, the provider informed us that risk registers were managed by the governance team; who proactively reach out to theatres and ward teams, on a monthly basis to discuss any risks to be added to the register.

Following the inspection, senior staff informed us that they measured their performance and outcomes routinely against another hospital in the Transform Hospital Group Limited. We saw evidence of this in the annual infection prevention and control report 2018 (evidence source: B15-1) and the patient safety and quality report May 2018 to April 2019 (evidence source D25). Senior management informed us that Dolan Park Hospital was the only private hospital group that conducted purely cosmetic and weight loss surgery services.

There was a culture for staff to access the incident reporting process. Any team member was able to provide an outline report that was escalated to the incident review team (IRT) for oversight and management of investigations and dissemination of lessons learned. The IRT reported to the MAC and the clinical governance and compliance committee. Some staff had received training regarding root cause analysis investigation. Risk management was seen as the next area for staff to receive training and development.

During our visit to the theatres we were notified that some surgeons brought in their own specialised breast implants. This was in line with a service level agreement (SLA) with the surgeons. We reviewed NHS England's National Safety Standards for Invasive Procedures (NatSSIPs) which outlined guidance regarding prosthesis "before the procedure." NHSE guidance 4.10.1 (ii) (iii) states "When a prosthesis is non-standard or is not included in an agreed permanent prosthesis stock, i.e. a "non-stock" prosthesis, the operator must ensure that the prosthesis requirements are communicated effectively to the procedural team in sufficient time for the prosthesis to be ordered and received" and "A named team member should be responsible for ordering and checking correct implant delivery before the procedure. This information should be available to the rest of the team." We discussed this with the senior management team who informed us that following the inspection, the SLA had been amended (28/01/2020) to reflect that this practice of surgeon's supplying their own implants had ceased. This meant that the hospital had taken the necessary steps to reduce the potential risks related to this practice.

One of the main ways that leaders monitored the hospital services performance, was through receiving information reports to the MAC. We saw the information report for August and September 2019 included data sets including:

- Number and type of procedure undertaken
- Percentage of overnight stays per type of surgery
- Theatre efficiency/utilisation
- Revisions and return to theatre
- Cancellations on day of surgery

There was no analysis provided alongside the data sets to guide the committee members. The data sets were for discussion during the MAC and at the clinical governance and compliance committee. The data/ performance was benchmarked against the hospitals previous months and over the previous 12-month period.

Safety performance was monitored via the organisation's incident reporting system, complaints process and internal and external risk assessments. The hospital had a local audit calendar. Results were used to highlight any areas where standards were not being met. We found that actions were not managed effectively as many areas, issues and concerns highlighted during our inspection had already been identified in the audits results. While the hospital was responsive to our findings, we could not be assured that the changes, practices and systems were embedded as they were recent.

Managing information

Data or notifications were not consistently submitted to external organisations as required. For example, the hospital did not currently submit all required data to the Private Healthcare Information Network in line with the Royal College of Surgeons standards. Staff could find the data they needed to support its activities. The information systems were secure.

The hospital did not currently submit all required data to the Private Healthcare Information Network (PHIN). They also did not collect Quality Patient Related Outcome Measures (QPROMs) data for all patients, to audit the quality of the service provided. This was not in line with the Royal College of Surgeons standards. We raised this with managers during our inspection. There was a plan to submit all required information. They had recruited to a role who would administer this. The provider told us that they had engaged with PHIN to advise the reasons contributing to non-submission and of the plans in place to redress submission of the data backlog.

Information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Nursing and medical patient records were combined within the same record. This meant health care professionals could follow the patient pathway clearly.

The Information technology (IT) framework was documented on the hospital's risk register due to the multiple systems and a reliance on manual and/or paper processes. A range of IT systems were used to monitor the quality of care. IT systems currently in use, could result in duplication of effort, due to manual processes and multiple systems. This had resulted in a reliance on manual systems

to monitor and report on incidents, complaints, satisfaction, outcomes, appraisals and mandatory training. However, staff across the hospital described IT systems as fit for purpose.

The organisation had a Caldicott guardian/data controller whose role was to ensure the confidentiality, safety and security of patient and service user data and information. They also ensured any incident which involved breaches of confidentiality, breach of patient and service user data was investigated in conjunction with the Transform Hospital Group Limited head of governance and compliance. (Evidence source: P02)

The service had a website where people could access useful information about visiting the hospital and the types of surgical procedures available.

Staff could access the hospitals intranet system and told us there were enough computers for their needs. Staff showed us how they accessed policies and documents on the intranet. Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems when they had finished.

The hospital had partnered with an online review platform, which enabled patients to search for and compare private clinics. The platform featured reviews written by patients, helping patients to make informed choices.

Engagement

There was no staff forum, staff union support or monitoring of staff's wellbeing through, for example staff surveys. Leaders and staff engaged with patients, staff, and the public to plan and manage services.

The provider held a bi-monthly staff recognition and reward programme. The aim was to enable more staff satisfaction and create a culture where engagement and development opportunities were transparent. Any employee could nominate any colleague and the nomination was linked to one (or more) of the providers' values.

Senior staff informed us that key to staff engagement was the hospital's baseline training and induction programmes that ensured staff knew how to perform in their roles and understand the service's expectations.

Bi-monthly staff newsletter included a regular update briefing that informed staff about the organisational status while reinforcing the organisational goals and celebrating achievements.

From conversations we had with staff and observations made during our inspection, we saw staff being fully engaged in the service provided. Staff said they worked closely together and often shared information for the benefit of patients.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings were held in the clinic, on the wards and in the theatre each month. Heads of department meetings were held monthly, chaired by the hospital manager. The provider also informed us that there was a suggestion box available in the staff dining room. The hospital manager reviewed these and actioned where possible. However, there was no staff forum or staff side union support or monitoring of staff's wellbeing through, for example staff surveys.

Patient feedback was routinely sought during their attendance at the hospital. The results from Dolan Park Hospital inpatient satisfaction questionnaires completed from May to October 2019, showed that 98% of patients would recommend the hospital to their friends and family.

Patients considering or deciding to undergo cosmetic or weight loss surgery were provided with the right information and considerations to help them make the best decision about their choice of procedure and surgeon. We saw patients received comprehensive information about the surgery they were considering. This included how the procedure was performed, costs, and the risks and complications associated with the surgery.

Information about complaints procedure was available in the reception, waiting areas and the wards.

Learning, continuous improvement and innovation

Many of the issues we found during our inspection, had been recognised by staff or found during local audits and effective improvement had not occurred. However, staff told us they were committed to continually learning and improving services. There was evidence of some improvements being made.

Requires improvement

Surgery

Senior staff confirmed the service was committed to improving services by learning from when things went well or wrong. Leaders demonstrated that they were responsive to concerns raised during the inspection, taking necessary actions. However, many of the issues we raised had been recognised by staff and effective improvements had not occurred.

There had been some recent improvement projects prior to our inspection including; standardising resuscitation equipment trolleys, new medicines prescription chart and pilots regarding checking equipment/environment processes in theatres.

Good

Outpatients

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

Are outpatients services safe?

Good

We rated safe as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. The mandatory training completion data was not available specifically for the outpatient department. Dolan Park Hospital overall mandatory training compliance was 91%, this was above the provider's target of 80%.

The mandatory training was comprehensive and met the needs of patients and staff. Modules completed were role specific and included the Mental Capacity Act, Deprivation of Liberty safeguards, information governance, health and safety, equality and diversity, fire safety and infection prevention and control (IPC) and modules. Training data was not reported to show compliance with targets for individual subjects.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was delivered using a mixture of face-to-face training and e-learning. Mandatory training was monitored using a computer-based system. The system sent reminders to staff and their line managers when training was due, with certificates of completion issued when training was completed.

The national outpatient lead nurse had oversight over mandatory training of outpatient staff. Mandatory training completion was reviewed during one-to-one meetings with staff and during their appraisals. Staff told us they also checked online themselves to see if any training was due.

During our inspection, we reviewed five staff files and they contained details of mandatory training completion and staff were up-to- date with their training requirements.

For our detailed findings on mandatory training, please see under this sub-heading in the surgery report.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse appropriate for a service who did not provide care or treatment to patients under the age of 18 years. Outpatient staff had received safeguarding adults training and safeguarding children training level one or two, dependent on role. This was in line with intercollegiate standards in 'Safeguarding Children and Young people: Roles and Competencies for Healthcare Staff, published by the Royal College of Nursing in January 2019.

There were six safeguarding leads across the organisation trained to level three, including the hospital manager at Dolan Park Hospital. The leads met quarterly to review any safeguarding incidents that had arisen across all locations. The team reviewed the management and outcomes of safeguarding incidents, identified themes, shared learning and recognised areas of good practice.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they had received safeguarding training and would feel confident in how to report an incident should it arise. Staff confirmed they would report to their manager and on call manager out of normal working hours. However, not every manager on the on-call rota had been trained to level three so senior advice would not always be available out of normal working hours.

An up-to-date policy on safeguarding for adults and children, due for review in June 2021 was available to staff on the hospital's intranet.

Female genital mutilation (FGM), modern day slavery and child sexual exploitation were included in safeguarding training and staff we spoke with were aware of their responsibilities if they identified a patient who had undergone FGM or was at risk of exploitation or slavery.

The provider had an up-to-date chaperone policy developed in July 2019. The policy contained clear guidance of the role and responsibilities of a chaperone. Staff we spoke with were aware of the chaperone policy and confirmed that chaperones were available if needed. However, chaperone training was not delivered to staff and competence not assessed.

For our detailed findings on safeguarding, please see under this sub-heading in the surgery report.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However, hand hygiene audits were not carried out with the same frequency as in other clinical areas.

Outpatient staff received infection prevention and protection (IPC) training as part of their mandatory training package. Staff we spoke with understood current infection prevention and control guidelines. The national outpatient lead attended bi-monthly infection prevention and control meetings and disseminated information to clinic staff at monthly meetings and by email.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. Each clinical room had a room specific monitoring and checking file in place. The file included documented checks monitoring the cleanliness of the room and equipment daily. We reviewed five monitoring files and four were completed consistently. One file had not been completed between May and December 2019. The service had identified the issue and the documented checks had been completed consistently from December 2019.

Staff followed infection control principles including the use of personal protective equipment (PPE). There were enough hand wash basins and hand sanitisers available in clinical rooms within the outpatient department. We observed a patient (after obtaining consent) being examined by a consultant. Staff sanitised their hands appropriately. However, hand sanitiser was not available outside the clinical rooms or in the reception area. During a further visit to the site, we saw hand sanitiser available and being used by patients in the reception area.

We saw staff adhering to arms bare below the elbow guidelines and being compliant with recommended hand hygiene practices. However, no signs were in place to inform people entering the outpatient department they were entering a clinical area and therefore an arm bare below the elbows area.

An annual IPC observational audit was included in the audit schedule. We reviewed the audit and action plan from October 2019, which showed 99% compliance with the metrics. The audit included a range of IPC metrics, for example hand hygiene, sharps disposal, environment and equipment. However, hand hygiene audits were not scheduled to take place in line with the frequency undertaken within other clinical areas at Dolan Park Hospital. Spill kits for managing accidental spills of bodily fluids or biohazard fluids were not available in the outpatient department but were always available from the facilities department. Staff we spoke with knew how to obtain spill kits if needed.

For our detailed findings on cleanliness infection control and hygiene, please see under this sub-heading in the surgery report.

Environment and equipment

Good

Outpatients

The maintenance and use of facilities, premises and equipment kept patients safe. However, the design of facilities did not always keep staff safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment followed national guidance. The outpatient service was easily accessible to patients and visitors as it was located on the ground floor of the hospital within the hospital's main reception and areas were accessible to wheelchair users.

The service had suitable facilities to meet the needs of patients' families. The outpatient department was seen to be tidy and suitable for the services offered. The reception area was spacious and there were numerous seating areas.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to PPE in every clinical room. Equipment for patients who required bariatric equipment including appropriate weighing scales and trolleys were readily available. Resuscitation equipment, anaphylaxis and hypoglycaemia boxes were kept on the adjacent ward. Each clinical room had an emergency alarm that when activated, alerted a core group of staff, including the registered medical officer (RMO) of the need to attend the department urgently. Ward staff would bring the resuscitation trolley, anaphylaxis and hypoglycaemia boxes with them. During our inspection, we saw evidence of monthly practice drills carried out to ensure the emergency call bell summoned appropriate assistance, with any issues identified and actions taken in response.

Staff managed general and clinical waste appropriately. Sharps disposal bins were correctly labelled and were not overfilled. We saw waste disposed of in the correct colour of waste bags with a closed lid when not in use. Waste was removed daily by the facilities staff.

Equipment checks in the outpatients department were up-to-date. The equipment we inspected had maintenance stickers showing they had been serviced in the last year. For example, electric treatment couches in the clinical rooms had been serviced and undergone electrical safety testing.

The outpatient department did not have a clean or dirty utility room and if required these were accessed in the adjacent ward. Outpatient staff could access the ward at all times through two separate entrances.

Staff were not always protected from the risk of threatening behaviour by patients and people accompanying them. Staff worked alone in the clinical rooms when they carried out a consultation and they did not have a way to immediately alert colleagues if they felt threatened. In one clinical room the furniture layout meant a patient could block the exit. Staff told us if they felt threatened, they could phone reception and use a code word, and this would bring assistance. However, there was no system to alert others if staff could not use the phone.

For our detailed findings on environment and equipment, please see under this sub-heading in the surgery report.

Assessing and responding to patient risk

There were systems and processes to assess, monitor and manage risks to patients.

Staff shared key information to keep patients safe when handing over their care to others. Patient records were comprehensive and included details of risk assessments conducted. Staff knew in advance which patients were booked to attend clinics that day. New patients filled in a health questionnaire. Patients requiring additional assistance or support were highlighted in the electronic patient file and on the daily list of attendance. For example, a comment would be added if a patient required assistance with mobility.

Staff responded promptly to any sudden deterioration in a patient's health. Staff we spoke with told us that acutely unwell patients would not visit the outpatient department. However, if a person's medical condition deteriorated while in the department, there was always an RMO on site. Staff we spoke with explained how they would respond promptly to any sudden deterioration in a person's health, including using the emergency 999 service to call an ambulance.

Staff could access the local sepsis policy for guidance. This was in line with national guidance.

The department carried out practice resuscitation drills. We saw evidence of two practice resuscitation drills since November 2019 and actions taken to improve compliance from the findings.

For our detailed findings on assessing and responding to patient risk, please see under this sub-heading in the surgery report.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave bank staff a full induction.

The service had enough nursing staff of relevant grades to keep patients safe. As at October 2019, the outpatient department was staffed with 2.6 full time equivalent qualified nursing staff. The were no vacancies as at October 2019 for qualified nursing staff in outpatients.

Managers ensured enough staff were available for the outpatient clinics to run safely. Two qualified staff were on duty each shift. In the event of unplanned absence, qualified staff from the other 19 clinic locations nationally would carry out the telephone appointments.

The service did not use agency staff. Managers limited their use of bank staff to those familiar with the service and provided a full induction. The two-bank staff used, one of which was a previous employee, both knew the service well and were employed to maintain safe staffing levels as required. Both bank staff had received a full induction, and we saw this evidenced in the staff files we reviewed.

There were no unfilled shifts from August to October 2019.

The service had a zero-turnover rate from November 2018 to October 2019.

The service had low sickness rates. The sickness rate from October 2018 to October 2019 was under 1%.

For our detailed findings on nurse staffing, please see under this sub-heading in the surgery report.

Medical Staffing

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

The service had enough medical staff to keep patients safe. The outpatient department had access to senior medical staff who provided clinic appointments across a range of specialities. An RMO was available to provide medical cover to the outpatient department should there be an emergency.

Consultants worked at the hospital using practising privileges. A practising privilege is the 'licence' agreed between individual medical professionals and a private healthcare provider. One consultant had recently started working within the hospital with his own secretarial support and renting space and services from the provider. Other consultants were employed by other local NHS trusts in substantive posts and had practising privileges at the service.

For our detailed findings on medical staffing, please see under this sub-heading in the surgery report.

Records

Staff kept detailed records of patients' care and treatment.

Records were stored securely. Paper medical records were stored in a keypad locked room and stored in line with general data protection regulation. Electronic records were stored on secure password protected computers. We observed staff logging out of the system when leaving their desk.

Patient records were in paper format and kept in the clinic that the patient attended for pre-procedure care. Copies of the patient record were scanned or emailed to Dolan Park Hospital from clinics before surgery was scheduled.

There was a safe system for the transportation and management of records. Records were kept on site and clinic staff collected and returned them to the record store before and after each clinic. Records were stored in a desk during clinic when staff were present. If staff left the room, the room was secure with keypad protected access. We did not see records left on desks or in community areas.

Good

Outpatients

Patient records were comprehensive, and staff could access them easily. Staff confirmed they were always available for patients' appointments. The patient records demonstrated good use of care pathways. The records included all patient information. We saw the records had details of tests carried out, medicines, medical history, assessments and reports. The allergy status, pain scores and a treatment plan were included.

When patients were transferred to a new team, there were no delays in staff accessing their records. Patients operation and inpatient records were hand written then added to the computer record management system (CRM) system once an episode of care was completed. The CRM system was available in all Transform Hospital Group Limited locations which allowed patients records to be immediately available to staff in the referring clinic.

We reviewed five patient records and found them to be up-to-date and easily available to staff providing care. However, the handwriting in patient records was not always legible and would not have enabled anyone to provide safe continuing care if required.

For our detailed findings on records, please see under this sub-heading in the surgery report.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

There was a pharmacist based on site who provided cover for the Transform Hospital Group Limited locations across the country. Doctors who prescribed medicines in outpatients did so on a hospital prescription. Patients could either be given medicines from a small stock kept in the outpatients' department or take their prescription to the community pharmacy in their local area to be dispensed.

Prescribers had been issued with their own prescription pad and were responsible for the safe storage and management. The clinic kept one spare prescription pad for use if any prescriber did not have their own pad with them, which was stored in a locked cupboard.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Stationery used for prescribing, was stored off site and replacement stationary was only issued once the used stationary had been returned. Replacement stationary was posted using a secure next day delivery service. During the inspection we checked the stock of medicines kept in clinic, they corresponded with the medicines recorded in stock register and were in date. However, the medicine register recorded the number of boxes present, not the number of tablets. This meant that medicines could be used from a box without being recorded to ensure safe medicine practice. Staff told a revised register which included the number of tablets in stock was in the process of being reprinted and was due to be introduced.

Medicines were stored securely in a locked cupboard in a locked room in the department. Medicines that required refrigeration were stored in a dedicated refrigerator, where the temperature was checked daily to ensure it was within the correct limits. Staff knew the actions to take if the refrigerator temperatures were not within an acceptable range.

Controlled drugs were not kept in the outpatient department. Registered nurses held the keys to the medicine cupboard, which was in line with legal requirements. Out of hours, the keys to the medicine cupboard were stored in a safe.

For our detailed findings on medicines, please see under this sub-heading in the surgery report.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

The outpatient department had no reported never events. 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.

In the 12 months before our inspection, there had not been any serious incidents reported in outpatients.

Staff knew what incidents to report and how to report them. Staff we spoke with were clear about what constituted an incident and would require reporting.

Staff reported incidents using a paper system. Details of each incident were then uploaded onto a spreadsheet. Staff told us they received feedback on incidents. They showed us a specific area on the opening page on the providers intranet were incident were available to be reviewed.

Staff we spoke with were familiar with the Duty of Candour regulations and were able to explain what this meant in practice. They identified the need to be honest about any mistakes made, offer an apology and provide support to the affected patient. The Duty of Candour is a regulatory duty that relates to openness, transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff received feedback from investigation of incidents within the hospital. For example, staff were aware of an incident that had occurred when equipment was dropped in theatre. Staff we spoke with told us that they received individual feedback if they had reported an incident. Staff told us, and we saw evidence of lesson learned posters in the department to share lessons with staff from incidents and complaints.

We saw that every member of staff had access to the latest information about incidents from the whole Transform Hospital Group Limited on the log in page of the intranet.

For our detailed findings on incidents, please see under this sub-heading in the surgery report.

Are outpatients services effective?

We do no rate effective, however, we found;

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies were developed in conjunction with national guidance and best practice evidenced from professional bodies, such as the National Institute for Health and Care Excellence. The guidelines we reviewed were easily accessible on the hospital's intranet and were up-to-date.

Medical history and pre-operative assessment proformas were in use in clinics. We were told that the service audited the medical history and pre-operative assessment proformas. We requested copies of these audits following our inspection. We were told audit due November 2019 had not been undertaken due to changes in the documentation. The audit was now scheduled for February 2020.

Patients were told how to seek help and advised what to do if their condition deteriorated. Staff told us patients were given a telephone number to access 24-hour advice. Patients we spoke with confirmed they were aware of the advice line. A patient told us they had used the emergency contact phone line and confirmed it was answered quickly and they received the help needed.

For our detailed findings on evidence-based care and treatment, please see under this sub-heading in the surgery report.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs.

Hot drinks and water were freely available to patients in the outpatients waiting area.

For our detailed findings on advice given to patients at pre-assessment, such as fasting prior to an operation, please see under this sub-heading in the surgery report.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Good

Outpatients

Consultants and clinical staff assessed patients in their clinics and prescribed pain medicines accordingly. Staff told us part of the pain risk assessment, staff asked patients how much pain they were in using a scoring system with zero being no pain and three being severe pain. We saw evidence of this in patients' records we reviewed.

Pain advice was included in the patient information booklets and the electronic version given to or sent to patients as preparation for surgery and for use post-operatively.

The hospital's registered medical officer (RMO) could be used to assess patients and prescribe pain relief when patients required urgent attention.

For our detailed findings on medical pain relief, please see under this sub-heading in the surgery report.

Patient outcomes

Staff did not always monitor the effectiveness of care and treatment.

Managers and staff carried out an audit programme in outpatients, which concentrated on procedure rather that patient outcomes. The audit programme included audits of pre and post-operative documentation completion, adherence to the process for gastric band adjustment, safety and medicines management.

The audit performance results were reviewed at hospital manager, head of departments and quality team meetings and then reported to the medical advisory committee and then to the national governance team.

Managers shared and made sure staff understood information from the audits. Managers and staff told us audit outcome results were discussed with teams at the team meetings. However, we did not see any evidence of this.

The service did not participate in national benchmarking clinical audits.

For our detailed findings on patient outcomes, please see under this sub-heading in the surgery report.

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 development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff competencies were specific to each role and evidenced in the staff files reviewed during our inspection.

Managers gave new staff a full induction tailored to their role, before they started work. New starters had a supernumerary period tailored to their individual needs followed by an induction programme. We saw a completed two-week induction plan and further evidence in staff files that practice was in line with the services induction policy.

Managers supported staff to develop through yearly constructive appraisals of their work. Appraisal rates for nurses who worked within the outpatient department were 80% at the time of our inspection.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff described appraisals as useful and gave them an opportunity to discuss their training and development needs. We saw evidence of this in the staff files reviewed during our inspection.

Staff had enough support to access learning and development. Staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills and knowledge through training relevant to their roles.

Managers made sure staff received any specialist training for their role. We saw evidence in staff files that staff had completed training required for their roles. For example, staff working in clinic had completed the outpatient competency framework, which included a range of subjects appropriate for outpatient staff.

Managers supported staff to develop through regular, constructive clinical supervision of their work. The service had an up-to-date supervision policy in place. Staff we spoke with told us they received regular supervision sessions with protected time and named supervisors to support this.

Good

Outpatients

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Monthly team meetings had recently been introduced to the outpatient department following a restructure of management. They were scheduled to occur when activity in the department was low, to ensure as many staff could attend as possible. Minutes from the meeting were sent to staff by email.

Managers supported staff to attend external courses and obtain extra qualifications. Staff were encouraged and given opportunities to learn by their manager. Staff had completed courses, such as a mentorship course and a healthcare assistant apprenticeship course, funded by Transform Hospital Group Limited.

For our detailed findings competent staff, please see under this sub-heading in the surgery report.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Patient's care and treatment was delivered though multidisciplinary working across a range of staff groups including medical and nursing staff, patient care assistants, dietitians and administrative staff.

Nursing staff confirmed they had good working relationships with consultants and could easily ask for help. They maintained good relationships with the dietitians. They had access to diagnostic test results, which were available on the electronic system and were accessible to staff in the outpatient department.

There was a bariatric (weight management) clinic where dietitians, consultants and nurses worked together to benefit the patient.

Patients could access a bariatric (weight loss) telephone support line to speak to an advisor. The advisor would then contact dietitians, consultants and nurses to deal with any patients' questions and concerns following weight loss surgery who worked together to benefit the patient.

For our detailed findings on multidisciplinary working, please see under this sub-heading in the surgery report.

Seven-day services

Key services were available seven days a week to support timely patient care.

The outpatient department was open from 9am to 7pm Monday to Friday, 9am to 1pm on Saturday and did offer Sunday appointments if a consultant was available.

The RMO was available 24 hours a day seven days a week for advice if required.

The location was usually open seven days per week, however, there were occasions when no clinical activity takes place. On these occasions' patients were able to use the organisations 24-hour emergency telephone numbers should they have a question or concern of a clinical nature.

Patients had access to weight management specialists 24 hours a day, seven days a week through the providers weight loss support service contact centre.

For our detailed findings on seven-day services, please see under this sub-heading in the surgery report.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

Staff assessed each patient's health when they first attended clinic and provided support for any individual needs to live a healthier lifestyle.

For our detailed findings on health promotion, please see under this sub-heading in the surgery report.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff could demonstrate an understanding of their responsibilities under the Mental Capacity Act (2005) and were able to talk about the Deprivation of Liberty Safeguards. However, they told us they had not had to put this into practice.

Staff clearly recorded consent in the patients' records. Patient consent was recorded correctly in the five records

we reviewed. The service had an up-to-date consent policy, which covered legislation. However, references to the appropriate legislative acts were not included in the policy.

Staff and patients, we spoke with confirmed they had received the required 14 day cooling off period as recommended in the Royal College of Surgeons publication 'Professional Standards for Cosmetic Practice', from agreeing to the procedure to having it carried out. This was designed to ensure that patients were able to fully reflect on their decision.

Staff made sure patients consented to treatment based on the information available. As part of our inspection, we observed surgeons explaining planned procedures to patients comprehensively and in an understandable way. Patients we spoke with told us they received written information that was clear and understandable. During our inspection we reviewed written information given to patients and it contained clear information about the procedure, risk, side effects and aftercare.

For our detailed findings on Consent, Mental Capacity Act and Deprivation of Liberty Safeguards, please see under this sub-heading in the surgery report.

Are outpatients services caring?

Good

We rated caring as **good.**

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Patients we spoke with were unanimously positive about the service they received in outpatients. They told us they had "excellent relationships with the team" and "staff were all wonderful".

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff took the time to ensure patients did not have any further questions or concerns during our observation of consultations.

Patients said staff treated them well and with kindness. Patients we spoke with confirmed staff had treated them with dignity, respect and kindness. During our inspection we saw staff introduce themselves at the start of a consultation. Patients also told us staff introduced themselves at the beginning of an appointment and explained their role.

Staff followed policy to keep patient care and treatment confidential. The reception desk was positioned away from the waiting area to ensure patients could speak to the receptionist without being overheard. Patients were seen in separate consulting rooms. This ensured patient's privacy and dignity was maintained. We saw staff pulled curtains around patients when they were undressing for their consultation to ensure privacy.

Staff ensured that when intimate personal care and support was being given, service users were offered a chaperone. The provider had an up-to-date chaperone policy developed in July 2019 which contained clear guidance of the role and responsibilities of a chaperone and included the need to offer same gender chaperones. Staff we spoke with were aware of the chaperone policy and confirmed that chaperones were available if needed. Patients we spoke with during our inspection told us they had not required a chaperone but confirmed it was offered at each appointment.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with during our inspection, told us staff listened to what anxieties they and their families had. They told us staff offered appropriate individualised support. For example, one patient explained how the consultant spent extra time with them due to their anxiety about the planned surgery.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff interactions with patients and relatives. We noted that information and explanations were given to them in a

kind and sensitive manner. Patients we spoke with during our inspection told us that staff were kind, caring, sensitive, not judgemental and that explanations of procedures were given in an understandable way.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We observed and were told by the patients that we spoke with, that patients were given time to ask questions about their care and treatment.

Staff talked with patients, families and carers in a way they could understand. Staff we observed introduced themselves and communicated well to ensure that patients and their relatives and carers fully understood about their care. Staff spoke with patients sensitively and appropriately dependent on their individual needs and wishes.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback could be given in a variety of ways; for example, a comments book was available along with an electronic tablet, to allow patients and visitors to leave feedback in main reception.

Staff supported patients to make informed decisions about their care. Patients that we spoke with following a consultation told us that they felt they had been fully informed of upcoming treatments, test results and their next appointment.

Are outpatients services responsive?

Good

We rated responsive as **good.**

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of people accessing the service.

Managers planned and organised services, so they met the changing needs of the people using the service. Patients were offered the next available appointment with their chosen consultant. Patients confirmed they had not waited long for their appointment and the timing had being negotiated with them.

The service minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one or two occasions if possible.

Managers monitored and took action to minimise missed appointments. The service had an automated system within the customer management system that sent text messages and emails to remind patients of their appointment details.

Managers ensured that patients who did not attend appointments were contacted. Clinic staff told us they would ring a patient if they did not attend an appointment to rearrange at the patient's convenience. A patient we spoke with confirmed this had happened when they had missed an appointment.

The department was able to open seven days a week, depending on surgeon availability. It was routinely open Monday to Friday from 9am to 7pm and Saturday from 9am to 1pm. Due to the location of the clinic, within the main entrance, reception staff were always on duty to provide support. This meant a surgeon could run a consulting clinic at other times on Saturday afternoon and Sunday if required.

Outpatient facilities and premises were appropriate for the services being delivered. The outpatient environment was suitable for patients and visitors. There was enough comfortable seating, toilet facilities, magazines and hot and cold drinks were available. Patients could find the department easily as it was located adjacent to the reception in the main entrance.

The outpatient department did not have a dedicated quiet area where patients could wait if they found the waiting area distressing. However, appointments were carried out in individual rooms and if required, a clinic room would be reallocated to become a waiting area to ensure patient needs would be met.

Good

Outpatients

For our detailed findings on service delivery to meet the needs of local people, please see under this sub-heading in the surgery report.

Meeting people's individual needs

The service took account of some patients' individual needs. Staff made reasonable adjustments to help patients access services. However, information leaflets were not available in languages other than English.

The service ensured that appointments allowed time to ask questions. Appointment time slots were dependant on the type of appointment and the individual care requirements of the patient. Patients told us they never felt rushed and appointments allowed time for them and their carers to ask questions. One patient we spoke with told us how the service arranged a second appointment to discuss their surgery with the consultant to ensure they had the information needed.

Clinic nurses would work late if a patient could not take a phone appointment due to their work commitments and appointment slots could be lengthened to suit individual patient needs. A patient told us they had received a telephone assessment at 7 o'clock due to their work commitments.

The environment was suitable for patients with a physical disability. Corridors were wide enough for wheelchair users.

Managers made sure staff, and patients, relatives and carers could get help from interpreters and signers when needed. Staff told us that telephone-based interpreting service was available 24 hours a day for people who did not have English as their first language and showed us where they would access the contact details. However, information leaflets were not available in languages other than English or in a suitable format for sight impaired patients.

The service was not designed to meet the needs of patients living with dementia. However, the service did not treat patients who were living with dementia. Staff conducted dementia awareness training as part of their mandatory training.

For our detailed findings on meeting people's individual needs, please see under this sub-heading in the surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly.

Patients had timely access to initial assessment, test results and treatment. The service did not have a waiting list. Patients self-refer into the service by submitting a form online or making a telephone call. Patients were offered an appointment with the surgeon of their choice at the first availability. If a patient wished to be seen sooner or the surgery type does not fall into the range that the surgeon performed, they were advised of alternative surgeons.

Patients could access care and treatment at a time to suit them. Appointments were made in negotiation with patients. Appointments were available in the evenings and weekends over 7 days a week. Patients were offered an unlimited number of appointments to see the clinical team both before and after surgery. Patients we spoke with said it was easy to make an appointment and were seen quickly.

Managers worked to keep the number of cancelled appointments to a minimum. Due to the elective nature of the surgery carried out, delays and cancellations were minimal.

If patients had their appointments cancelled, clinic staff made sure they were rearranged as soon as possible at the patient's convenience.

Same day appointments were available if the clinic was not fully booked.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with staff.

Patients, relatives and carers knew how to complain or raise concerns. The providers website had a link where there was information on how to make a complaint.

Good

Outpatients

The service provided patient information leaflets about how to raise a concern. However, these were only available in English and during our inspection we did not see this displayed in any of the outpatient areas.

Staff understood the policy on complaints and knew how to handle them. Staff said they tried to resolve complaints informally. However, if patients wanted to raise it further, they escalated complaints to their line manager.

From June to October 2019, the hospital received 49 complaints. Following our inspection were asked how many were related to outpatients. However, the information provided was not broken down to department level therefore we were unable to see how many complaints related to the outpatient service.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with understood how to deal with complaints and told us they would try to resolve any immediately they became aware of them. Staff told us about a recent complaint when telephone assessment appointment was missed by staff and what actions had been taken.

Are outpatients services well-led?

Requires improvement

We rated well-led as **requires improvement.**

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff.

The outpatient department had a dedicated outpatient manager who had worked at the hospital for 14 months and had ten years previous experience in healthcare management. There were clear lines of leadership and accountability. The outpatient manager reported to the hospital manager on a day-to-day basis and ultimately to the regional manager for the West, who reported to the operations director.

There was a national outpatient lead was a registered nurse who had worked for the provider for four years and in the current role for two years. They were supported by the hospital manager and reported to the head of operations.

The outpatient manager was based on site at the hospital and the national lead nurse visited as required. Staff we spoke with during our inspection were extremely positive about the leadership. They told us that the leaders were visible, approachable and always contactable by email or phone if not on site.

For our detailed findings on leadership, please see under this sub-heading in the surgery report.

Vision and strategy

The provider had a set of values underpinning what it wanted to achieve. Leaders and staff understood and knew how to apply them.

The provider had a clear set of values with quality as the main priority. The values were developed with staff involvement. Copies of the values were displayed in several locations within the outpatient department and staff we spoke with could tell us what the values were.

Staff felt engaged with the values and understood their role in achieving them. Staff that we spoke with during our inspection were aware of the values and could explain how they supported them. For example, staff we spoke with spoke with passion about ensuring quality of care and the value of good team work in providing that. However, the outpatients department did not have its own set of vision or values in place.

For our detailed findings on vision and strategy, please see under this sub-heading in the surgery report.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns.

Staff we spoke with told us they felt supported, respected and valued by colleagues and managers. Staff confirmed they could approach managers and were confident they would be listened to and any appropriate actions would

be taken. Staff gave examples of when they had been supported by the management for long term health conditions and how their return to work was managed well.

The culture centred on the needs and experience of people who use the outpatient service. Staff we spoke with spoke with passion about providing service that were delivered to address the needs of patients.

Staff felt positive and proud to work for the department and organisation. Staff told us they were proud to be part of the team and that they would recommend outpatients as a place to work.

Staff described the culture as one that encouraged openness and honesty within the organisation and for people who use services. We spoke with a patient who told us they were able to raise concerns about their care while they were being treated without fear of reprisals. The patient confirmed any issues would be dealt with immediately.

The provider has an equality and diversity policy due for review in 2021, which reflected current legislation for people with protected characteristics. We were told how working patterns and place of work had been adapted to support a member of staff using the policy.

There were cooperative, supportive and appreciative relationships among staff. Staff and teams worked collaboratively. Staff without exception told us they felt supported as individuals in their roles but also as part of the wider organisational team. For example, in the event of unexpected staff absence support was given from outpatient clinics nationally. We saw this working during our inspection when staff at other clinics carried out the telephone assessments booked for Dolan Park Hospital.

For our detailed findings on culture, please see under this sub-heading in the surgery report.

Governance

For our detailed findings on governance, please see this sub-heading in the surgery report.

The manager of the outpatient department attended the monthly hospital manager, head of departments and quality meeting. The meeting had standing agenda items including hospital updates, data on incidents, complaints, patient experience results, new or updated hospital policies and updates from specific wards and departments.

Staff were clear about their roles and accountabilities. Staff we spoke with could tell us who their line manager was and describe the wider management structure within the outpatient department and hospital.

Regular monthly team meetings had recently been introduced to the outpatient department following a restructure of management. They were scheduled to occur when activity in the department was low to ensure as many staff could attend as possible. Minutes from the meeting were sent to staff by email.

Managing risks, issues and performance

There were risks highlighted during our inspection that had not been recognised by leaders or included on a risk register.

There was a hospital risk register. There were no risks specific to the outpatients department on the risk register. Following our inspection, the provider told us that outpatient risks were recorded on one risk register that covered 20 clinic locations for the Transform Hospital Group Limited and were not recorded at individual site level.

The managers did not have full oversight of the risks within the service. Managers could not tell us what was included on the risk register.

Following our inspection, we saw an excerpt of the clinic location risk register. This had two risks recorded for Dolan Park Hospital and did not include risks we identified during our inspection. For example, the potential risk to staff when seeing a patient alone in a clinic was not included.

For our detailed findings on managing risks, issues and performance please see this subheading in the surgery report.

Managing information

The service did not collect data on the performance of the outpatient department.

The service did not have operational performance measures which were reported and regularly monitored.

Good

Outpatients

Staff we spoke with during our inspection told us they could request data from the information technology department, but this was not routinely available or reported on.

For our detailed findings on managing information please see the well led section in the surgery report.

Engagement

Leaders and staff engaged with patients and the public to plan and manage services.

Peoples views and experiences were gathered and used to improve the service in a variety of ways.

A comments book was available for use of patients, and families on the reception desk in main reception. We saw this contained positive comments about the staff, support received and information that had been provided.

The service had introduced an electronic system using an electronic tablet to allow patients and visitors to leave feedback in main reception and to comment on the service.

The provider carried out a national outpatient department satisfaction questionnaire over a two-week period annually. Patients who attended the departments were included. The questionnaire covered seven metrics and results for Dolan Park Hospital from February 2019, showed positives scores of 100% in five metrics and above 94% in the remaining two. However, there was a 21% response rate.

The weight loss service had partnered with a weight loss surgery hub, which provided an online community, advice and support for patients following weight loss surgery. This was provided free for a year after weight loss surgery. The hub was also open to the public and could be accessed for a monthly fee.

The provider had introduced a bi–monthly newsletter, Pulse which contained information about the provider nationally. A recognition of an employee of the month was included and this had been awarded to a member of the outpatient staff.

For our detailed findings on engagement, please see this subsection in the surgery report.

Learning, continuous improvement and innovation

Staff told us they were committed to continually learning and improving services.

All staff we spoke with told us they were committed to continually learning and improving services. They told us that managers encouraged their development and told us they believed they would be listened to if they had ideas that would improve the service.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that effective actions are completed to improve compliance with all audit results including, medicines management and World Health Organisations Surgical Safety Checklist. (Regulation 12 (1) (2) (a) (b) (f) (g))
- The provider must ensure that all relevant staff have completed competencies regarding extubation procedures. (Regulation 12 (1) (2) (a) (b) (c))
- The provider must ensure there are controls in place to ensure the safe administering of theatre lists. (Regulation 12 (1) (2) (a) (b))
- The provider must ensure that risk management strategies including the risk register, are maintained effectively to manage all risks to the provision of services. (Regulation 17 (1) (2) (a) (b))

Action the provider SHOULD take to improve

- The provider should ensure that there are effective processes in place to safely prescribe, administer, record and store medicines. (Regulation 12 (1) (2) (a) (b) (g))
- The provider should ensure that there are processes in place to manage the performance of the service effectively. (Regulation 17 (1) (2) (a) (b))
- The provider should ensure there are systems to ensure infection control risks are effectively prevented, monitored and managed. (Regulation 12 (1) (2) (a) (b) (h))
- The provider should ensure staff follow the aseptic non-touch technique processes and comply with arms bare below the elbow, to prevent healthcare acquired infection. (Regulation 12 (1) (2) (a) (b) (h))
- The provider should ensure there are processes in place regarding the storage of patient's drink and food. (Regulation 12 (1) (2) (a) (b))
- The provider should ensure that all staff have an annual appraisal. (Regulation 18 (1) (2) (a))
- The provider should consider they have systems in place to participate in relevant national clinical audits.
- The provider should ensure they have systems in place to ensure that equipment is maintained appropriately. (Regulation 12 (1) (2) (a) (b) (e))
- The service should ensure information is available in a variety of accessible formats including for example, sight impaired patients and for those when English is not their first language.
- The provider should ensure that action is taken to reduce risks for staff when conducting consultations alone in a clinic room. (Regulation 17 (1) (2) (a) (b))
- The provider should ensure patient information leaflets about how to raise a concern are available in outpatient areas.
- The provider should ensure monitoring and reporting the operational performance in outpatients is undertaken. (Regulation 17 (1) (2) (a) (b))
- The provider should ensure medical records are clear, accurate and legible. (Regulation 17 (1) (2) (a) (b) (c))
- The provider should consider delivering training on the roles and responsibilities of chaperones to staff who fulfil this role.
- The provider should consider developing a vision for each department.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance