Transform Healthcare Limited

Pines Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Not inspected

Summary of findings

Overall summary

We carried out an unannounced inspection (staff did not know we were coming) to enable us to observe routine activity. We carried out a focussed inspection of the core service of surgery only.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	The service had not been inspected before. We rated it as requires improvement because: • Staff did not always have training in key skills to keep patients safe. • Staff did not always assess risks to patients to keep them safe. • The service did not have a means of formally collecting feedback from patients which could help improve understanding and improvement of patient experience. • The service did not have a process for analysing feedback from staff. • The service did not always submit notifications to external bodies in line with regulation. • The service did not always have effective audit quality improvement processes. However: • The service had enough staff to care for patients and keep them safe. They managed medicines well. The service had processes in place to manage safety incidents and learned lessons from them. • Staff provided good care and treatment. Patients were provided with enough to eat and drink, and pain relief was administered 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 seven days a week. • 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.

Summary of findings

- Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care.

Summary of findings

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Summary of this inspection

Background to Pines Hospital

Pines Hospital is a private hospital in Manchester, England, owned and operated by Transform Healthcare Limited. The current provider has been delivering services from the hospital since October 2022 and provides outpatients and surgical services for both self-paying and NHS patients.

The hospital has had a registered manager in post since March 2023 and is registered to carry out the following types of regulated activity:

• Treatment of disease, disorder, or injury

• Surgical procedures

• Diagnostic and screening procedures

The hospital operates across three floors, offering patients surgery treatments. The service does not treat or offer surgery to people under the age of 18. The hospital has 22 beds, 2 anaesthetic theatre suites and 5 consultation rooms.

For the period of January 2023 to December 2023, there were 2982 patients operated on by the service. We have not inspected Transform Healthcare Limited Pines Hospital previously, however we did inspect the same site, when the hospital was operated by a previous provider.

The main service provided by this hospital was surgery.

We inspected and rated only the core service of surgery at this inspection.

How we carried out this inspection

Two inspectors and 1 specialist advisor carried out the inspection on the 19 December 2023 with support from an offsite inspection manager. We spoke with 5 patients, 12 staff and reviewed 10 patient records.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Surgery

Summary of this inspection

- The service must ensure that staff are provided with training in autism, learning disabilities and mental health needs and that all staff are up to date with mandatory training (Regulation 18).
- The service must ensure the risks to the health and safety of service users receiving care or treatment is assessed (Regulation 12).

Action the service SHOULD take to improve:

Surgery

- The service should ensure that CQC are notified of changes to the appointment of the Controlled Drugs Accountable Officer. (The Controlled Drugs (Supervision of Management and Use) Regulations 2013)
- The service should consider systems for the collection of formal patient feedback.
- The service should consider systems for the analysis of staff feedback.
- The service should ensure that all records are legible, and the correct forms are provided for staff use.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected

Requires Improvement

Surgery

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

Is the service safe?

Requires Improvement

The service had not been inspected before. We rated it as requires improvement.

Mandatory training

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

Staff mostly kept up to date with mandatory training. We reviewed compliance rates for sepsis which demonstrated a compliance across the hospital of 80%, in line with the provider's target. However, intermediate life support training was below the provider's compliance target across the hospital at 78.5%. Theatre staff had the lowest compliance rate with 74% of staff having completed intermediate life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

At the time of our inspection the service did not provide staff with training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia. This was raised with the registered manager following our inspection.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. 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 in line with intercollegiate guidance. For example, clinical staff had level 2 safeguarding training in both adults and children, managers had completed level 3, and the safeguarding lead was trained to level 4.

Safeguarding children training was provided by the service and had a compliance rate of 81% meeting the provider's target. The service did not carry out surgery on anyone under the age of 18.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and who to inform if they had concerns. The service had a safeguarding information board with all the necessary information on for staff to follow.

However, not all staff had completed safeguarding training with an overall compliance rate across the service of 78% for adult safeguarding training, just below the providers minimum target of 80%.

Cleanliness, infection control and hygiene

The service mostly controlled 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.

We observed that all ward areas were clean and had suitable furnishings which were clean and well-maintained.

We observed staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Staff followed infection control principles including the use of personal protective equipment (PPE). We noted that face masks were used and stored in line with national guidance and that hand sanitising gel was present in appropriate areas.

The service had a process in place to identify patients requiring pre-operative screening for MRSA to prevent surgical site infection.

Managers monitored how well the service prevented infections. We reviewed the surgical site infection rates for the period of January 2023 to November 2023 and found that over the 11-month period the average infection rate was 1.28%, in line with their target of below 2%.

The service had a dedicated Infection Prevention and Control (IPC) lead in post. There were infection prevention and control meetings every 3 months, led by a consultant microbiologist the service contracted and the infection control nurse lead, to discuss any thematic trends or patterns.

The service submitted the 2023 audit data for hand hygiene observations which took place twice a year. These showed the ward in July had a low compliance with hand hygiene best practice at 47%. Managers had created an action plan in response to this result and the subsequent audit in September showed that improvements had been made and the score had significantly increased to 95%. Hand hygiene audit results for operating theatres was in the compliance range of 93-100%

However, we reviewed the last 3 months of cleaning checklists and found these were not always completed consistently across theatres and the wards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The design of the environment followed national guidance. The ward was made up of individual side rooms that were wheelchair accessible and all with ensuite bathrooms. The service had 2 operating theatres which followed national guidance and were in good state of repair. Call bells and emergency cord pulls were in appropriate areas so patients could reach them.

Staff carried out regular safety checks of specialist equipment. We noted that the designated resuscitation trolley was checked daily, contained appropriate equipment, and had a seal in place. This ensured that staff had access to the right equipment, in the event of a significant patient emergency.

Requires Improvement

Surgery

The service had suitable facilities to meet the needs of patients' families. The service had a dedicated discharge area, where families could spend time with patients prior to leaving the hospital. We noted that drinks machines were available for refreshments, for patient's family or friends.

The service had enough suitable equipment to help them to safely care for patients. All equipment we observed in the operating theatres, recovery and the wards were within their service date. Theatre recovery was equipped in line with the recommendations from the Association of Anaesthetists.

Bariatric surgery was carried out at the hospital by another provider and had the equipment appropriate for these patients.

The service had processes in place for reporting faults and issues with medical devices and implants. The service recorded all implants used in patient records.

Staff disposed of clinical waste and sharps safely. Colour coded bins and bags were used for different types of waste and sharps bins were correctly labelled and used.

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. We observed that the service used the National Early Warning Score (NEWS) system to identify and escalate patients who were becoming more unwell. The escalation procedure was described as; a staff member would raise with the ward or theatre manager, who would then review the patient with the resident medical officer (RMO).

Staff told us that a resident medical officer provided 24-hour cover for the service. This potentially reduced patients having to be transferred to another hospital setting. We saw evidence the resident medical officer had been contacted for clinical advice when a patient deteriorated.

Staff in operating theatres and recovery had the relevant life support training to their role and an anaesthetist was always present during daytime and on call overnight.

The service had a policy in place for the event of a major haemorrhage and held blood products on site, correctly in-line with guidance.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. The service also had a patient selection policy which staff used to screen patients to determine if they high risk and unsuitable for surgery.

The service completed World Health Organisation (WHO) checklists appropriately. We reviewed 10 patient records and found all contained completed WHO checklists. The audit results for the last 3 months showed compliance rates with WHO checklists of 98%-100%.

Staff knew about and dealt with any specific risk issues such as sepsis and tissue viability. The service had a lead nurse for tissue viability which staff could access advice from.

Requires Improvement

Surgery

Staff told us about what would happen if a patient had to return to surgery and if this had to happen overnight. There had been no emergency transfers to theatre overnight in the last 12 months.

The service had access to specialist mental health support if staff were concerned about a patient's mental health. Patient's mental health would be screened during pre-operative consultation and staff could refer patients to a psychologist to help ensure informed consent if needed.

Staff shared key information to keep patients safe when handing over their care to others. In the 10 medical records we reviewed we saw that all had had signed clear handovers between staff when patients came out of the operating theatre and into recovery.

However, staff did not always complete all risk assessments for patients. In the 10 medical records we reviewed we found 1 that did not have a completed venous thromboembolism (VTE) risk assessment. This was highlighted to the registered manager who told us this had been identified as an area for improvement during the last 12 months of records audits.

Data we reviewed showed that the VTE compliance had been initially identified as below target during audit in December 2022 at 62%, an action plan was implemented and a repeat audit in April showed a similar compliance rate at 63%. This was consistently low with the following September audit result at 54%, October at 55% and then an increase in November to 75%. There was an action plan in place to address the low compliance rate however the rates had continued to be below target.

The service did not have an audit compliance target written in policy, however used a digital system with a compliance target rate of 99%.

Nurse staffing

The service had enough 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, agency, and locum staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The service had low vacancy rates and reducing rates of bank and agency staff. For December 2023, the service had filled 11% of shifts on the ward with agency staff and 20% in the operating theatres. Managers made sure all bank and agency staff had a full induction and understood the service.

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. Medical staffing cover was provided by a resident medical officer supplied by an agency company. Managers told us this system worked well.

The medical staff matched the planned number. The service had 1 resident medical officer onsite 24 hours a day, every day they were open.

Managers made sure these staff had a full induction to the service before they started work.

The service provided us with information which detailed that an on-call rota for anaesthetists was in place each day, to provide cover for any readmission or emergency.

Records

Staff kept detailed records of patients' care and treatment. Records were mostly clear, up-to-date and all stored securely and easily available to all staff providing care.

We reviewed 10 patient records during our inspection, records were paper based files. The service was starting to move paper files to a digital system which had not been implemented in the clinical setting yet.

The Breast and Cosmetic Implant registry records the details of any individual who has breast implant surgery, so they can be traced in the event of a product recall or other safety concern relating to a specific type of implant. It also allows the identification of trends and complications relating to specific implants.

Staff told us that patient surgery details were routinely communicated to their GP; however, this was not done for cosmetic surgeries. Patients were also given a copy of their discharge summary and had the option to pass this to their GP following cosmetic surgeries if they wished.

When patients transferred to a new team, there were no delays in staff accessing their records as the records would be transferred with them.

Records were stored securely.

Patient notes were mostly clear and comprehensive. We found 2 patient records contained anaesthetic notes that were illegible and unclear, however these were isolated to 1 individual practitioner.

The provider had introduced new paperwork whilst the old paperwork was still in place. This meant that care plans were not completed consistently, and it was not clear for staff what documentation should be completed. It was not clear in the records we reviewed how the provider ensured that staff understood all aspects of patients care and treatment needs.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the service had not notified the regulator that a controlled drugs accountable officer was appointed.

The service had a service level agreement in place for pharmacy support.

Staff followed systems and processes to prescribe and administer medicines safely.

Staff completed medicines records accurately and kept them up to date.

Staff stored and managed all medicines and prescribing documents safely.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Requires Improvement

Surgery

Staff completed medicines records accurately and kept them up to date. Staff stored and managed all medicines and prescribing documents safely. Medicine charts were completed correctly and were appropriately signed at prescription and administration and included patient's allergy status.

General medicines were locked away within a secure trolley and controlled drugs were locked within a cupboard in line with regulation standards.

The service had a controlled drugs accountable officer CDAO appointed, however had not notified us in line with regulation. This was raised with the registered manager following the inspection and was rectified immediately as a result.

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.

Staff knew what incidents to report and how to report them in line with provider policy.

Hospital management told us that the service had not had any never events within the previous 12 months.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed a sample of 5 incident records from the last 3 months for the service and found that these had been investigated thoroughly with a root cause analysis approach.

Managers shared learning with their staff about incidents that happened elsewhere. Managers told us of how learning from an incident at the provider's other location had been shared with staff across both sites.

Staff reported serious incidents clearly and in line with trust policy. The service had 1 serious incident reported in 2023 of a delay in duty of candour response given to a patient which was investigated and responded to appropriately. There was evidence that changes had been made as a result of learning from the incident. The provider implemented further staff training on dealing with complaints and duty of candour to prevent this from happening again.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents and could access finalised incident investigations and root cause analysis through the provider staff system. Incident feedback and learning was also shared in team meetings.

Is the service effective?

Good

The service had not been inspected before. We rated it as good.

Requires Improvement

Surgery

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based 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. We reviewed medical advisory committee meeting minutes which showed that policies and procedures for review were discussed along with any changes to national guidance and any patient safety concerns relevant to the services activity.

The service had clear corporate policies, which were available on an electronic policy library. Staff knew how to access these policies and could also do so using a dedicated computer station within the hospital.

We reviewed a selection of policies and noted they were up to date and were accountable to the appropriate governance processes and committees. Policies were developed, in line with national legislation and relevant guidance such as the Mental Capacity Act 2005 and National Institute of Clinical Excellence (NICE).

We reviewed the service's patient selection policy, which was clear and detailed. It included inclusion and exclusion criteria based on both clinical and other circumstances. This meant that staff could screen patients effectively and ascertain quickly if they were suitable for surgery or not. The service would not operate on patients considered "high risk" in line with the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) recommendations.

The service submitted information and implant details to the national Breast and Cosmetic Implant Registry in line with regulation.

Staff routinely referred to the psychological and emotional needs of patients, prior to their surgery. Staff told us that they were focussed and aware of the psychological needs and motivations of elective cosmetic surgery. Staff had training on body dysmorphia, a condition that is a common motivation for people to have elective cosmetic surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural, and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We observed that patients were offered several choices to eat from a menu. Meal options including vegetarian, vegan, and gluten free choices. Religious needs were catered for patients, for example kosher compliant meals were available.

Specialist support from staff such as dietitians was available for patients who needed it. Patients could also access weight loss support through the customer service centre.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed patient records which evidenced that a patient's weight and height were recorded on admission, which corresponded to a body mass index score. This allowed the service to make relevant decisions. For example, a body mass index above a specific number, could exclude a patient from surgery.

Patients waiting to have surgery were not left nil by mouth for long periods. Records we reviewed showed that when patients were nil by mouth, intravenous fluids where prescribed when needed.

Requires Improvement

Surgery

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.

Patients received pain relief soon after requesting it.

The 10 patient records we reviewed demonstrated that staff prescribed, administered, and recorded pain relief accurately.

The service had had a recent incident logged following a new surgical procedure being carried out and it was identified that the gold standard pain relief had not been used in this case as it the provider did not have access to it. The patient was managed with other pain relief effectively, and it was logged as an incident so that it could be addressed prior to any of these surgical procedures being carried out in the future.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

The service submitted data to the breast implant registry. The registry is designed to capture all breast implant surgery carried out both privately and by the NHS.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We reviewed the audits carried out by the service. The audits covered areas such as patient care pathway, WHO checklists, theatre medicines audits and Venous thromboembolism audits. This demonstrated the service measured key areas that could affect patient safety.

We saw from team meeting minutes that audit results were a fixed agenda item and managers communicated audit results and action plans with staff.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

The service had a total of 22 readmissions for infection, haematoma, or other complications out of the 2982 surgeries performed for the year of 2023.

Managers told us that the service participated in national clinical audits such as the Private Healthcare Information Network (PHIN). Due to changes to the company name we were unable to see the reports at the time of our inspection.

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 and qualified. However, staff did not have all the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. We reviewed information from the service that evidenced signed competencies of employees, following the start of their employment.

Requires Improvement

Surgery

Managers supported nursing staff to develop through yearly, constructive appraisals of their work. We reviewed the staff appraisal rates which demonstrated a high compliance with an overall average for the hospital at 93%. Staff had the opportunity to discuss training needs with their line manager during these appraisals.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that they were given protected time to complete their mandatory training.

The service provided us with information which demonstrated that there were 177 clinicians within the service under practicing privileges. We reviewed documentation which showed the service had a process in place to ensure staff with practicing privileges had the relevant credentials, skills, and competencies.

Managers ensured that clinicians under practicing privileges had completed their General Medical Council (GMC) appraisal and had the necessary mandatory training.

We reviewed 3 practicing privileges personnel files and found all necessary documentation and recruitment checks were in place. Surgeons wishing to be accepted under practicing privileges to operate at the hospital had to evidence they had undertaken a minimum of 25 of those procedures in the last 2 years.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

The service had processes in place to identify poor staff performance promptly and support staff to improve through Human Resources.

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 service had a Medical Advisory Committee (MAC), we reviewed the meeting minutes from the most recent committee meeting held in April 2023, this was before changes were made to the governance framework resulting in more targeted MACs being set up such as cosmetic surgery, bariatric surgery, and anaesthesia. The service was still in the process of establishing these committees at the time of our inspection.

Managers gave examples of ad hoc multidisciplinary team meetings that had taken place for individual patient cases to discuss complications or complaints.

Staff referred patients for mental health assessments when they showed signs of mental ill health during pre-operative consultations when appropriate to do so.

Seven-day services

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

The service was available 24 hours a day, seven days a week. Staff could call for support from the on-call resident medical officer at any time if this was required. Staff told us that services were available to patients, at a time of their choosing.

Health promotion

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

Requires Improvement

Surgery

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle such as dietary advice and smoking cessation prior to surgery.

For patients enquiring about bariatric surgery who were above the BMI (Body Mass Index) limit for surgery at Pines, they would be sent a pack developed by the hospital with weight loss advice in.

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 we spoke with understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff gained consent from patients for their care and treatment recorded consent in patients' records in line with legislation and guidance. We reviewed 10 patients records and found all had completed consent documents in.

Staff made sure patients consented to treatment based on all the information available and the 14-day cooling off period was adhered to in all cases.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

The service advised however, that it was unlikely that they would provide surgery to a patient who may fall within the scope of the Mental Capacity Act 2005. This was due to both the cosmetic nature of the surgery provided and a defined exclusion policy of providing surgery for any patients with complex mental health or capacity needs.

The service did not provide any surgical procedures for anyone under the age of 18, therefore issues relating to child consent were not applicable.

Nursing staff mostly kept up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLs). Information sent to us by the provider demonstrated that MCA training overall compliance rate was 90.5%, just below the provider target and DoLs compliance just met the target at 80% completion.

Managers monitored compliance with the provider's consent policy through twice yearly audits of patients' records. However, for both audits undertaken in 2023 compliance rates were below the target of 99% at 90-95%.

Is the service caring?

Good

The service had not been inspected before. We rated it as good.

Requires Improvement

Surgery

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and 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.

Patients said staff treated them well and with kindness. Patients said that staff were professional and put them at ease.

Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. The service provided gender affirmation surgery to patients transitioning and managers had arranged training for staff on the use of pronouns and caring for transgender patients. We also observed a section in the staff newsletter written by the gender affirmation consultant on international pronouns day which explained why pronouns matter, how to use them and how to be supportive and respectful of people's identity.

Emotional support

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

Staff supported patients with their privacy and dignity. We observed that staff treated and spoke to patients with dignity and respect.

We observed that patient's privacy was respected and upheld, by having their own private rooms, within the ward.

Patients we spoke with told us they felt their privacy and dignity had been respected throughout their treatment at the service.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing. Staff were aware and focussed on the reasons behind a patient's wish to have cosmetic surgery. If the staff felt that it would be appropriate for a particular patient, they could be referred to the hospital's psychology liaison for input and support.

Understanding and involvement of patients and those close to them

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

Patients told us that staff made sure they understood their care and treatment and gave them the time and opportunities to ask questions.

Patients could give feedback on the service and their treatment through a national reviewing website. We reviewed information relating to patient feedback. The information evidenced a trend of positive comments about the caring nature of the staff and an overall score of 4.5 out of 5. However, we did note that feedback was mixed relating to aftercare and accessibility of the service post-operatively, with some service users also raising specific concerns about their individual treatments.

Managers reviewed and monitored negative reviews on the website and tracked these for themes and trends. These would be included in the weekly report shared with the senior management team.

Requires Improvement

Surgery

Otherwise, the service did not formally collect patient feedback so could not provide us with any other data.

Is the service responsive?

Good

The service had not been inspected before. We rated it 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 the communities it served.

The service was flexible, so they met the needs of the population it served. Patients had a choice of when to attend for appointments and surgery.

Managers monitored and took action to minimise missed appointments. Staff told us that surgery cancellations were rare but did occur for example, due to surgeon sickness. If this happened, then patients were advised as soon as practical and offered the soonest available date after.

Facilities and premises were appropriate for the services being delivered. The hospital was wheelchair accessible and all equipment on the wards and theatre where appropriate for patients undergoing bariatric surgery.

Staff could access mental health support from a psychologist if patients needed this.

Meeting people's individual needs

The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Managers told us of a patient who had stayed at the hospital for a longer period who was offered choices of food not on the regular menu.

However, staff did not have training in mental health needs, learning disabilities, autism, and dementia.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment were in line with expected standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed time frames. Hospital management told us that patients were able to book a convenient time for their cosmetic surgery dependent on consultant availability and subject to a 14 day 'cooling off period'.

Requires Improvement

Surgery

Managers monitored patient transfers, there had only been 1 incident in the last 12 months of a patient requiring transfer to an NHS facility.

The service had dedicated patient flow coordinators, so that patients always had a direct point of contact pre- and post-surgery and during their stay within the hospital for continuity of care.

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 all staff. The service included patients in the investigation of their complaint.

Patients, relatives, and carers knew how to complain or raise concerns. The service had a patient facing complaints policy.

The service clearly displayed information about how to raise a concern in patient areas. We observed posters on giving feedback on care to CQC in ward areas.

Staff understood the policy on complaints and knew how to handle them. Staff had training in complaints management as part of customer service training, we reviewed the compliance rate for this training and found it had a rate above the service's target at 82%. We reviewed staff meeting minutes which demonstrated that complaints were a fixed agenda item for discussion.

Managers investigated complaints and identified themes. We reviewed the service's complaints policy which included a 3 stage complaints process with stages both internally and externally. The external stage had not yet been formalised at the time of our inspection but was in the process of being implemented.

Patients received feedback from managers after the investigation into their complaint. The service had 37 complaints in the year of 2023, 32 had been acknowledged within the 3-day timescale.

The service mostly provided a response to complaints within the 20-day target, with 6 out of the 37 responding to within 23 days.

Managers could give examples of how they used feedback from complaints to improve daily practice. We were told of the implementation of a new staff role to care for patients pre-operatively throughout their journey in the hospital which was something that had been raised in complaints.

However, review of their patient feedback on a national review website showed mixed comments about the services communication with patients, with multiple patients stating they were not responded to in a timely fashion when they directly contacted the service. We note that the website does state that 100% of negative reviews have been responded to on the platform.

Is the service well-led?

Requires Improvement

The service had not been inspected before. We rated it as requires improvement.

Requires Improvement

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

We observed that the senior management team had a clear structure. Each person within the structure had a clearly defined role and responsibilities. Staff told us they felt senior leaders were visible and approachable.

Hospital management told us that the service was rigorous in the recruitment and selection process, which included competency-based interviews, DBS (Disclosure and Barring Service) checks and references.

Vision and Strategy

The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

We reviewed information from the provider which included the service's mission statement, vision, and corporate values.

The service vision was one main statement of "trusted experts, delivering solutions that empower people to make their lives better". The service had their company values on their website of which quality was a top priority.

The service's vision and strategy were present on staff communications such as the monthly newsletter so that staff were aware of what the providers values were and how their work contributed to this.

The service had a business plan across the company which evidenced that quality and sustainability of service were a priority, and a strategy was in place to achieve this.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff told us they felt respected, supported, and valued and enjoyed working at the hospital.

Staff had completed training on the Equality Act. Information the service provided showed that 83% of staff had completed this training, in line with the provider's target.

The service had an equality, diversity, and inclusivity strategy for 2024, this included appointing ambassadors for protected characteristics and establishing MDTs for equality and diversity. The service was also looking to send staff on a women of colour management course to develop their careers.

The service had a freedom to speak up network in place with posters in clinical areas of who the freedom to speak up guardians were and how to contact them. Staff were all aware of who the guardians were.

Team meetings were held for the ward and theatre staffing every 3 months, we reviewed the minutes of the last 3 of these meetings for both areas and saw they had fixed agenda items on such as policy updates, complaints, health and safety and infection control.

The service had monthly staff newsletters to disseminate key messages relating to safety and governance. For October freedom to speak up day the service held events throughout the hospital for staff to get involved in such as a "best dressed in green competition" which was included in the newsletter to raise awareness. The newsletters also included celebrations of staff achievements and a wellbeing section.

However, the service did not collect staff feedback to address any potential issues or make improvements to staff experience or the service.

The service collected staff feedback through appraisals and team meetings, however there was no process for the analysis of feedback to identify themes and trends and make improvements to quality of care.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service held Governance and Compliance Committee meetings monthly to review data, incidents, risks, and complaints. Leaders described to us the governance structures of the hospital. The structures were clear and relevant to operations, providing a direct link between the ward and theatre departments to corporate board level.

At the base of the governance structure were MDTs for specialist areas such as cosmetic surgery and anaesthesia. These MDTs were the first and main opportunity for issues to be highlighted and escalated, through the governance channels to board level. The MDTs were also an opportunity for decisions made at board level, to be cascaded down to the relevant staff and committees.

The Governance and Compliance Committee had overall responsibility for approval of policies and procedures. We asked for evidence of how the process for approval of new surgical procedures at the hospital was done but only received information for 1 of the 2 procedures we asked for.

The service relied on their partner organisations to monitor and communicate infection rates and outcomes. However, this was not embedded with all partners. The service's governance processes to monitor patient outcomes were not fully effective.

Managers did not have effective oversight of all audit and quality improvement processes, such as the low VTE compliance being initially identified in December of 2022, and the subsequent audits not carried out regularly until September 2023 when they went to monthly. At the time of our inspection, we saw that the compliance rate for VTE over the last 12 months had been significantly below the 90% target at rates of 54%-75%.

The service did not have effective processes in place to ensure records were legible and staff were not provided with up-to-date paperwork for care plans and assessments.

The service relied on the other companies operating at the Pines to communicate their infection rates and post operative outcomes and did not have a standard process in place for the sharing of this information for all organisations. This meant that not all patients outcomes following surgery at the Pines hospital were monitored.

Requires Improvement

Surgery

Management of risk, issues, and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Leaders told us about the most prevalent risks to the service and how they effectively managed these. The service had a risk register to monitor service risks and the actions in place to mitigate these.

Risks were escalated by staff to the relevant manager. This could then be escalated further within the weekly management meetings. The weekly managers meeting reviewed the risks that were present on the services risk register.

Risks were managed by the Hospital Management team as part of the governance framework. Risk register entries were assigned a score and if this was above a certain number, the risk was escalated further to clinical governance and compliance. During inspection, we reviewed the service's risk register. We noted that the risk register had a description of the risk, a score based on the likelihood of the risk occurring and the impact, who was responsible for the risk and an action plan to mitigate.

The service had a major incidents policy which set out responsibilities and procedures for loss of key amenities or infrastructure.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Notifications were not always submitted to external organisations as required.

We observed electronic computer systems were password protected.

Staff completed General Data Protection Regulation (GDPR) mandatory training, the information from the service evidenced that 80% of clinical staff had completed this training in line with the provider's target. This meant staff could understand how to properly use and protect individual's data within the relevant law.

We observed that patients care files were appropriately secure and located, so that staff could easily access information or data when this was needed.

The service submitted cosmetic implant data to the National Breast and Cosmetic Implant Registry.

Notifications were mostly sent to relevant organisations using an electronic system in line with requirements however, the service had not notified us of an appointment of a Controlled Drugs Accountable Officer in line with regulation.

Engagement

Leaders and staff did not actively engage with patients, staff, equality groups, the public and local organisations to help improve services for patients.

The service did not formally collect patient feedback to implement improvements to the service.

The service did not formally collect staff feedback.

Requires Improvement

Surgery

Learning, continuous improvement and innovation

Leaders encouraged innovation in the service.

The service provided gender affirmation surgery and managers and the consultant were keen to expand the work and support they offered to these patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure the risks to the health and safety of service users receiving care or treatment is assessed, such as venous thromboembolism risk. (Regulation 12).

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that staff are provided with training in autism, learning disabilities and mental health needs and that all staff are up to date with mandatory training (Regulation 18).