Ramsay Health Care UK Operations Limited

Cobalt 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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. 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 five 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.
- The service planned care to meet the needs of local people, 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However, in Diagnostic imaging we found,

- The Ionising Radiation (Medical Exposure) Regulations IR(MER)R referrers document appendices were out of date.
- There was no record of the environmental monitoring planned for September 2023 having been conducted.
- Controlled area handover forms had not been completed.
- Equipment and had not been signed back into use or marked as tested and satisfactory for use since September 2023.
- There was no functional testing of the equipment before being used and no documented requirement for it.
- The service did not have local diagnostic reference levels (DRLs) in place.
- Competency forms to use the C-arm were signed off by a manager who did not have a radiographer background.
- Gaps in information in relation to staff competencies were missing in some of the staff files.
- There were no records of staff having completed radiation safety training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Diagnostic imaging	Insufficient evidence to rate	We were unable to obtain enough evidence to rate this service. The hospital does not have an on-site diagnostic imaging department. They do not employ radiologists and radiographers. The only diagnostic imaging procedures were carried out by consultants trained in other specialisms using a C-arm which was infrequently used. A C-arm machine is a fluoroscopy system. Fluoroscopy is a method providing real-time X-ray imaging, which is particularly useful for guiding various diagnostic and interventional procedures. C-arms are generally not used in diagnostics, they are made for surgery. At the time of this inspection no surgical procedures supported by use of the C-arm were carried out. The service is required to be registered with the Care Quality Commission for diagnostic and imaging services to enable staff to use the C-arm during surgical procedures. We found, • The Ionising Radiation (Medical Exposure) Regulations IR(MER)R referrers document appendices were out of date. • Equipment and had not been signed back into use or marked as tested and satisfactory for use since September 2023. • There was no functional testing of the equipment before being used and no documented requirement for it. • The service did not have local diagnostic reference levels (DRLs) in place. • Competency forms to use the C-arm were signed off by a manager who did not have a radiographer background. • Gaps in information in relation to staff competencies were missing in some of the staff files.

Summary of findings

- There were no records of staff having completed radiation safety training.

Medical care (Including older people's care)

Inspected but not rated

We inspected but did not rate this core service.

- The endoscopy service performed well for cleanliness. The design of the environment followed national guidance. The department had suitable facilities to meet the needs of patients.
- Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. Staff monitored the effectiveness of care and treatment. Staff supported patients to make informed decisions about their care and treatment.
- 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 service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

The service only provided endoscopy under the medical care core service and therefore is

Summary of findings

a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the surgery report.

Surgery

Good 

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. 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.
- 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 service planned care to meet the needs of local people, 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how

Summary of findings

to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We rated this service as good because it was safe, effective, caring, responsive, and well-led.

Outpatients

Good 

Our rating of this service stayed the same. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment and gave patients pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. 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 5 days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and helped them understand their conditions. They provided emotional support to patients, families, and carers.
- The service planned care to meet the needs of local people, 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.

Summary of findings

- Leaders ran services well using reliable information systems and supported staff to develop their skills. 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. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Outpatients was a smaller proportion of hospital activity. The main service was Surgery. Where arrangements were the same, we have reported findings in the Surgery section.
We rated this service as good because it was safe, effective, caring, responsive, and well led.

Summary of findings

Contents

Summary of this inspection

Background to Cobalt Hospital

We undertook this inspection as part of our age of rating inspection programme. The hospital was last inspected on 29 to 30 June 2016 and 8 July 2016.

Cobalt Hospital is part of Ramsay Health Care UK.

The hospital provides surgery, medical care, outpatients, and diagnostic imaging services. It has a purpose built 6 bedded day-case facility with no overnight beds. The hospital does not provide any services for children and young people aged between 0 and 18 years. The hospital does not admit emergency patients.

The hospital had a registered manager in post at the time of inspection.

We inspected this service using our comprehensive inspection methodology. We carried out the inspection on 10 to 11 January 2024.

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.

How we carried out this inspection

The inspection of Surgery was conducted by a CQC Inspector, and 2 CQC Specialist Advisors.During the inspection we spoke with 13 staff members, 5 patients and reviewed 5 sets of patient records.

The inspection of Medical Care was conducted by a CQC Inspector, and 2 CQC Specialist Advisors.

The inspection of Outpatients was conducted by a CQC Inspector, a CQC Medicines Inspector and a CQC Regulatory Coordinator.

During the inspection of Outpatients we spoke with, the Head of Clinical Services with responsibility for outpatients, the Clinical Quality Partner, the Registered Manager, 3 Nurses, 1 Health Care Assistant, a physiotherapist, 2 reception staff, the stores coordinator, the senior engineer, the administrator responsible for the management of patient records and 4 patients. We checked 10 sets of Outpatients records and 10 staff records.

The inspection of the Diagnostics and Imaging Department was carried out by a CQC Inspector, CQC Specialist Advisor, and a CQC Regulatory Coordinator.

We spoke with the site theatre lead who had responsibility for oversight of use of the C-arm and the Head of Clinical Services. We reviewed 7 patient records.

Summary of this inspection

Areas for improvement

Diagnostic imaging

SHOULDS

The service

- The service should have a system to ensure polices, procedure and guidance documents are regularly reviewed and kept up to date.
- The service should consider implementing functional testing of the C-arm prior to its use.
- The service should have a process to ensure staff files are kept up to date.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diagnostic imaging	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate	Insufficient evidence to rate
Medical care (Including older people's care)	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Insufficient evidence to rate

Diagnostic imaging

Safe	Insufficient evidence to rate
Effective	Insufficient evidence to rate
Caring	Insufficient evidence to rate
Responsive	Insufficient evidence to rate
Well-led	Insufficient evidence to rate

Is the service safe?

Insufficient evidence to rate

We were unable to obtain enough evidence to rate safe.

Mandatory training

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

We checked the Identification, responsibilities, and training of Ionising Radiation (Medical Exposure) Regulations IR(MER)R referrers document during the inspection. The appendices were dated August 2022 and were therefore out of date.

See Surgery report.

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 and they knew how to apply it.

See 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.

The department was visibly clean.

Equipment cleaning records were up-to-date and demonstrated the equipment was cleaned regularly.

There was specialised PPE which consisted of a lead apron with belts to support it. We saw evidence of the apron usage being subject to audit on 2 November 2023. No issues were identified.

See Surgery report.

Insufficient evidence to rate

Diagnostic imaging

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.

We saw evidence equipment had been serviced in accordance with manufacturers requirements.

There was a standard operating procedure (SOP) document for the use of the C-arm which was in date. The SOP included reference to the Medical Physics Expert (MPE) being appointed to cover the work being carried out in relation to the physics or radiation exposures to patients and other individuals.

There was evidence of 3 monthly quality assurance testing along with manufacturer service records.

We saw evidence of tests being recorded on 26 July and 8 November 2023. No issues were identified.

We saw a copy of the routine survey radiology - X-Ray (GE - OEC Elite Miniview) conducted by the Radiation Protection Adviser on 9 November 2023. The survey covered, Image Quality, Manual Dose, Automatic Dose, and Radiation Safety. No issues were identified.

We were told there was no functional testing of the equipment before it was used and no documented requirement for it.

We reviewed the Patient Dosimetry and Diagnostic Reference Level Report dated 4 February 2022. Data was provided to analyse the ongoing patient dose audit. Data was provided for one type of examination, with 8 patients included. This was not enough data to establish local diagnostic reference levels, however it enabled an interim indication of dose to be given. At least 10 patients were needed to be able to establish local DRLs, however due to the low workload of the unit, this was expected to take a significant amount of time.

The following actions were recommended, more data should be collected for the same examination to enable local DRLs to be established and data should also be collected for other common procedures that are performed with this unit.

There was no evidence to conclude the actions had been completed.

There was a generic dosimeter for staff to use when operating the C-arm.

The theatres had an external x-ray warning light which would be illuminated when the C-arm was in use.

Any faults to the C-arm would be reported to another local Ramsay hospital who would organise the repair.

There was evidence of fault logs being maintained.

The local Radiation Risk assessment (RPA)stated that area monitoring was not required if the cumulative C-arm monitoring doses did not exceed 12mSv in a calendar year. The mini c-arm had its own dose badge attached and the results of these have been 0mSv annually, therefore the RPA had recommended that the doses for Cobalt are far too low to require a full environmental monitoring.

Insufficient evidence to rate

Diagnostic imaging

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.

We saw evidence the consultants responsible for surgical procedures using the C-arm held the responsibility for the levels of medical exposure to radiation.

To ensure the radiological protection of the patient the Medical Physics Expert (MPE) who worked at a different hospital listed only the following areas of the body could be x-rayed using the C-arm, hands, wrists, forearms, ankles, and feet.

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.

See Surgery report.

Records

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

We checked 7 patient records and saw evidence use of the C-arm and 5 of the records had the images obtained were recorded in the patient notes.

All had the completed and signed radiological request form required scanned onto the record. Two didn't have images attached but that was because images weren't saved. That was not unheard of for some procedures as the C-arm is an intraoperative tool rather than a diagnostic imaging system.

See Surgery report.

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.

We saw evidence staff were provided with feedback from the Radiation Protection Committee which was done through e mail distribution of the minutes.

Any incidents would be reported through the services` internal reporting procedures.

See Surgery report.

Is the service effective?

Insufficient evidence to rate

Diagnostic imaging

Insufficient evidence to rate

We were unable to obtain enough evidence to rate effective.

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 protected the rights of patients subject to the Mental Health Act 1983.

The service did not have local diagnostic reference levels (DRLs) in place. These were an optimisation tool for medical imaging procedures using ionising radiation. They gave an indication of the expected radiation dose received by an average-sized patient undergoing a given imaging procedure.

See Surgery report.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

See 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.

There were 8 consultants recorded as being able to use the C-arm.

The 6 competency forms were signed off by the Clinical applications specialist following applications training.

The consultants did have documented proof of applications for training from the C-arm company, which was recent, so they were all covered to use it.

We saw evidence of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) training records for consultants trained in the use of the C-arm which complied with IRMER regulations.

If trained staff had not used the C-arm more than 12 times in a year it was Ramsay policy the staff member would receive additional training. We did see evidence of this.

We saw evidence of in-house through mentorship/peer reviews which assessed competence and were set at 5 uses of the C-arm or until the operator felt competent.

Being trained in use of the C-arm was part of the consultants practicing privlidges.

Insufficient evidence to rate

Diagnostic imaging

We found in 1 staff record we checked a signature regarding competency was not dated. In another staff record there was evidence of IRMER training, but it was not clear how the competency had been signed off.

There were no records of staff having completed radiation safety training.

Multidisciplinary working

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

We saw evidence surgeons were sent diagnostic images through an image exchange portal (IEP) if the images had been obtained at an NHS hospital prior to the patient attending for preassessment, a surgical procedure or a post-surgical procedure outpatient appointment.

Health promotion

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

See 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. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

See Surgery report.

Is the service caring?

Insufficient evidence to rate

We were unable to obtain enough evidence to rate caring.

Compassionate care

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

We were unable to evidence compassionate care as there were no patient appointments where the C-arm was used while the service was being inspected.

Emotional support

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

We were unable to evidence emotional support as there were no patient appointments where the C-arm was used while the service was being inspected.

Insufficient evidence to rate

Diagnostic imaging

Understanding and involvement of patients and those close to them

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

We were unable to evidence understanding and involvement of patients and those close to them as there were no patient appointments where the C-arm was used while the service was being inspected.

Is the service responsive?

Insufficient evidence to rate

We were unable to obtain enough evidence to rate responsive.

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 service users.

The C-arm was used, if required, as part of a surgical procedure and not as a standalone diagnostic procedure.

Meeting people's individual needs

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

See Surgery report.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

The service was available Monday to Friday and was demand driven in terms of start and finish times linked to surgery.

See Surgery report.

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.

See Surgery report.

Is the service well-led?

Insufficient evidence to rate

Diagnostic imaging

Insufficient evidence to rate

We were unable to obtain enough evidence to rate well-led.

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. They supported staff to develop their skills and take on more senior roles.

See Surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

See Surgery report.

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 and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

See Surgery report.

Governance

Leaders operated 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.

See Surgery report.

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.

We saw use of C-arm radiology equipment in the theatre department had been included as a risk, however, the last review was dated 30 May 2023, with no updates since then.

See Surgery report.

Insufficient evidence to rate

Diagnostic imaging

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. Data or notifications were consistently submitted to external organisations as required.

See Surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

See Surgery report.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

See Surgery report.

Inspected but not rated

Medical care (Including older people's care)

Safe	Inspected but not rated
Effective	Inspected but not rated
Caring	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Inspected but not rated

Is the service safe?

Inspected but not rated

We did not rate safe. We found:

Mandatory training

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

See surgery report for further information.

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.

See surgery report for further information.

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.

The endoscopy service performed well for cleanliness. We saw evidence that theatre cleans took place immediately after the completion of endoscopies.

See surgery report for further information.

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.

Inspected but not rated

Medical care (Including older people's care)

The design of the environment followed national guidance. The endoscopy area had a dirty utility area for the manual cleaning and disinfection of endoscopes.

The department had suitable facilities to meet the needs of patients. The theatre in which endoscopy procedures were completed had appropriate ventilation.

Staff had enough suitable equipment to help them to safely care for patients and themselves.

Staff had quick access to the resuscitation trolley which was checked daily and weekly.

The service had safety tested all electrical equipment.

See surgery report for further information.

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.

A surgical safety checklist was completed with patients undergoing endoscopies. This provided details of safety checks completed at the start of the endoscopy procedure and before any of the team left the endoscopy room.

See surgery report for further information.

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.

See surgery report for further information.

Records

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

See surgery report for further information.

Medicines

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

The service had standard operating procedures for medical gases such as Nitrous Oxide and Carbon Dioxide used in endoscopy.

Inspected but not rated

Medical care (Including older people's care)

Please see the surgery report for further information.

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.

Endoscopy reported no clinical incidents in the last 6 months.

Please see the surgery report for further information.

Is the service effective?

Inspected but not rated

We did not rate effective. We found:

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.

Please see surgery report for further information.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service made adjustments for patients' religious, cultural and other needs.

Please see surgery report for further information.

Pain relief

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

Staff carrying out endoscopy procedures checked levels of pain pre, during and after the treatment. The National Early Warning Score (NEWS) was used to monitor a patient's condition.

Please see surgery report for further information.

Patient outcomes

Inspected but not rated

Medical care (Including older people's care)

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service inputted to the national Private Healthcare Information Network (PHIN) to improve patient outcomes.

Please see surgery report for further information.

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.

Please see surgery report for further information.

Multidisciplinary working

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

Please see surgery report for further information.

Health promotion

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

Please see surgery report for further information.

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 obtained consent for the endoscopy procedure at the pre assessment stage, and this was checked on admission as part of the World Healthcare Organisation (WHO) checklist.

Please see surgery report for further information.

Is the service caring?

Inspected but not rated

We did not rate caring. We found:

Compassionate care

Inspected but not rated

Medical care (Including older people's care)

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

Please see surgery report for further information.

Emotional support

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

Please see surgery report for further information.

Understanding and involvement of patients and those close to them

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

Please see surgery report for further information.

Is the service responsive?

Inspected but not rated

We did not rate responsive. We found:

Service planning and delivery to meet the needs of the 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.

Please see surgery report for further information.

Meeting people's individual needs

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

Please see surgery report for further information.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's 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.

Please see surgery report for further information.

Is the service well-led?

Inspected but not rated

We did not rate well-led. We found:

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. They supported staff to develop their skills and take on more senior roles.

Please see surgery report for further information.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Please see surgery report for further information.

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, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Please see surgery report for further information.

Governance

Leaders operated 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.

Please see surgery report for further information.

Inspected but not rated

Medical care (Including older people's care)

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.

Please see surgery report for further information.

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. Data or notifications were consistently submitted to external organisations as required.

Please see surgery report for further information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Please see surgery report for further information.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Please see surgery report for further information.

Good

Surgery

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

Is the service safe?

Good

Our rating of safe stayed the same. We rated it 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 and overall staff compliance was at 98% for all modules.

The service had a mandatory training policy which was in date and version controlled.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

The Hospital held monthly staff forums; these often-included guest speakers who would talk about areas of additional training such as autism awareness, these were held face to face.

Managers monitored mandatory training and alerted staff when they needed to update their training. The Hospital Director received monthly compliance reports regarding staff training to monitor that compliance levels were on target.

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.

All staff received training specific for their role on how to recognise and report abuse. The compliance rate for safeguarding adults and safeguarding children up to level 2 for all staff was 100%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Although the service had not made any safeguarding referrals in the last year, staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

The service had an adult's safeguarding policy and a children's safeguarding policy. Both were in date and version controlled.

The Head of Clinical Services was trained to safeguarding level 4.If they were not at work, one of the other level 3 trained managers would cover and be available to provide advice for staff.

There was a safeguarding flowchart on staff notice boards, so all staff were aware of process of raising a safeguarding concern with appropriate point of contact external to Cobalt. The safeguarding would also be reported using the hospitals incident reporting system.

In the ten staff files we checked we saw evidence of up-to-date disclosure and barring service checks (DBS).

Cleanliness, infection control and hygiene

The service 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.

The service had an infection prevention control policy which was in date and version controlled.

The service also had Viral Pandemic Policy and Plan. The aim of this policy and plan was to provide a planned response to an influenza, or other viral pandemic with clearly described roles and responsibilities across Ramsay Health Care UK.

The service had a service level agreement with the housekeeping department. This outlined the cleaning tasks by day, week, and month.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The ward area and theatres we visited were clean and had suitable furnishings which were well-maintained. Seamless easy-clean floor covering was used throughout all clinical areas, waiting rooms and toilets. Store areas were tidy and free from clutter.

The service performed well for cleanliness. PLACE audit results showed 100% compliance for cleanliness in 2022, which were the latest results available for this audit. The '50 Steps Cleaning Audit' results showed 100% compliance rate within theatre in the latest audit outcome results for September 2023.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The hospital completed daily cleaning checklists for the ward and theatre. All public areas had cleaning schedules. We reviewed a sample of checklists which were up to date.

Staff used records to identify how well the service prevented infections.

Good

Surgery

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand-washing and sanitising facilities were available for staff and visitors.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Items seen were visibly clean and dust-free and we saw a daily cleaning check list, as well as reviewing previous daily cleaning checklists which showed these were routinely part of day to day practice.

Staff worked effectively to prevent, identify and treat surgical site infections.

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.

Patients could reach call bells and staff responded quickly when called. We saw this happen during our inspection, where the emergency call bell was activated next to a patient and the staff response was fast and in line with policy for the appropriate action taken.

The design of the environment followed national guidance.

Staff carried out daily safety checks of specialist equipment. The most recent environmental audits showed 100% compliance in September 2023.

The service had a fire incident management plan which was in date and version controlled.

We saw fire extinguishers fixed securely on wall mounts, all had labels indicating they had been tested. The fire extinguishers were stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005 which outlined to prevent fire extinguishers from being moved or damaged, they should be mounted on brackets or in wall cabinets with the carrying handle placed 3-1/2 to 5 feet above the floor.

There were fire evacuation signs to direct people how to leave the building in the event of a fire. Fire doors were unobstructed. The service conducted weekly fire alarm tests.

The latest fire evacuation of the hospital had been successfully carried out in June 2023 and this was due to an incident in the car park. This report shows the incident was well managed and in line with policy. There were no learning action points identified from this incident, and appropriate action had been taken.

There was an equipment maintenance schedule in place that was up to date and showed any faulty equipment and actions taken. This also included clear records of all equipment and the last and next service dates alongside the serial number for the equipment in each area. Staff showed us during the inspection where any faulty equipment was stored and talked through the process of this being collected.

The service had suitable facilities to meet the needs of patients' families.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Good

Surgery

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. There was a comprehensive pre-operative assessment process that was used for all patients. The hospital had an effective process for assessing patients prior to admission. Patients had a pre-operative assessment to ensure they met the inclusion criteria for surgery and to allow any key risks, that may lead to complications during the anaesthetic, surgery, or post-operative period, to be identified.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. If there were any risks identified these were discussed by the treating clinicians. Patients with complex co-morbidities would not routinely be admitted for treatment.

Staff completed risk assessments for each patient on commencement of their treatment, using a recognised tool, and reviewed this regularly, including after any incident. The service used a modified 'five steps to safer surgery' checklist based on guidelines from the WHO Surgical Safety Checklist. We observed the theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the WHO checklist. The latest '5 steps to safer surgery' audit showed 100% compliance.

Staff responded promptly to any sudden deterioration in a patient's health. The service had a deteriorating patient policy where patients would be referred to another nearby hospital for specialised care which the hospital did not provide. Staff participated in simulated emergency scenarios quarterly to ensure they maintained skills in responding to a patient collapse or cardiac arrest.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score (NEWS2) tool to assess for patients at risk of deterioration. Staff were fully trained in this as part of their mandatory training and compliance at the time of inspection for this was 97%.

Staff knew about and dealt with any specific risk issues. There was a meeting held each morning to review any risks including patient safety risks and planned how to address these. We saw these meetings had minutes taken and were available to staff to access who might not have attended.

Staff shared key information to keep patients safe when handing over their care to others. This ensured continuity of care when people moved between services or received care from different staff in this service. Clinicians wrote to the patient's general practitioner after gaining the patient's consent.

Following surgery, patients could access a 24-hour helpline for advice and help if needed.

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 and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe and these matched the planned numbers.

Good

Surgery

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 hospital calculated staffing levels for each day, and we observed the staff ratio for each day was displayed on the ward. Staff said there was always senior staff on shift and an on-call team in the unexpected event of readmission or returns to theatre. The service monitored staffing to ensure it provided safe and responsive care.

The manager could adjust staffing levels daily according to the needs of patients. All theatre lists were pre-planned so the number of staff required for each shift, on the ward and in theatres, could be pre-determined. Staffing levels reflected demand on the service and known treatment support needs.

The service had no vacancies and were fully staffed.

The service had an 8.5% sickness rates for clinical ward staff between January 2023 – January 2024.

The service had low rates of agency nurses with 1.7% of total theatre hours worked over the previous year.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. There were two consultants employed directly and 26 consultants working under practicing privileges.

Assessments of applications for practising privileges, from doctors and allied health professionals, were carried out by the Medical Advisory Committee, which reviewed and approved the scope of practice submitted by an applicant. The service monitored compliance with the practicing privileges policy, and we saw evidence of this.

The medical staff on duty matched the planned number.

The service had an 9.7% sickness rates for clinical theatre staff between January 2023 – January 2024.

Managers could access locums when they needed additional medical staff.

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

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Records

Good

Surgery

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

Patient notes were comprehensive and all staff could access them easily. The hospital used electronic patient records. Records could be accessed across the departments, allowing continuity of record keeping. Bank staff could access the records they required.

When patients transferred to a new team, there were no delays in staff accessing their records.

We viewed 5 patient care records, which contained the patient's consent form, written theatre record, including observations and discharge information. Records we reviewed were completed appropriately.

Records were stored securely. Staff completed training in information governance and data protection.

The hospital completed audits such as a records audit which showed 99.5% compliance in the previous audit carried out in August 2023.

Medicines

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

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

Policies were in place to reflect the systems and processes used to prescribe and administer medicines. These were in date and regularly reviewed. A process was in place to ensure there was an audit trail for the supply of medicines given to patients to take home.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Remote pharmacist support was available if patients needed to speak to them about their medicines, however there was no routine pharmacist on site, though this post was out to advert.

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

Paper medicines administration records were completed thoroughly, and records of medicines administration were in place.

Staff stored and managed all medicines and prescribing documents safely.

Medicines and controlled drugs were stored securely, and regular stock checks were documented in line with guidance. Emergency medicines were available and were in date. Regular fridge temperature checks took place and were in range.

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

Good

Surgery

Medicines reconciliation took place upon admission and the relevant checks were in place to ensure patients had the correct medicines. Medicines required post operatively were prescribed before a patient was moved to a recovery area. Processes were in place to ensure medication required to take home was documented before discharge.

Staff learned from safety alerts and incidents to improve practice.

Staff knew how to report incidents and any incidents that occurred were discussed at weekly huddles to share learning.

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 service had an incident reporting policy which was in date and version controlled.

Staff knew what incidents to report and how to report them. The service had policies and guidance in place for staff on how to identify, categorise by level of harm and report incidents.

Staff raised concerns and reported incidents and near misses in line with provider policy. All incidents, accidents and near misses were logged on an electronic incident reporting system.

The service had no never events.

Managers shared learning with their staff about never events that happened elsewhere. Learning was routinely shared from other Ramsay Hospitals. We saw an example of this from clinical governance meeting notes from October 2023 that we reviewed showing learning from incidents.

Staff reported serious incidents clearly and in line with policy.

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 met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. Staff discussed learning from incidents at the Clinical Governance Committee meetings. For example, we saw consistent shared learning with actions and timely follow up for these.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Good

Surgery

Is the service effective?

Good

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

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. Staff had access to policy and guideline documents on the hospital intranet.

All surgical patients underwent a pre-operative assessment process which followed a documented pathway, this ensured staff gathered all the relevant information and prepared patients for their surgery. This was in line with the Association of Anaesthetists and the British Association of Day Surgery guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice.

Changes to clinical practice, national guidance and policies were reviewed and developed centrally by the corporate provider and cascaded to the hospital and shared with staff. Policies based on best practice and clinical guidelines were developed nationally and cascaded to the hospital for implementation. We saw evidence through minutes for medical advisory committee (MAC), clinical governance and departmental ward and theatre team meetings that changes in practice and guidance updates were routinely discussed.

Re-admission and return to theatre rates were monitored and showed there had been no return to theatre-re- admissions between January 2023 – December 2023.

Staff told us policies and procedures reflected current guidelines and were easily accessible through the provider's intranet. We looked at a selection of the policies, procedures, and care pathways and these were up to date and based on current national guidelines.

Theatre staff completed the World Health Organisation 'five steps to safer surgery' for all surgical procedures to monitor compliance with this standard.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. 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. Patients always had access to water. Patients were given a choice of food and drink to meet their cultural and religious preferences. The manager told us that the hospital gave patients a choice on what they want to eat to meet patient needs including responding to food allergies, and that these were chosen in advance.

Good

Surgery

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed the nutrition and hydration audit carried out in October 2023, which showed 100% compliance.

Patients waiting to have surgery were not left nil by mouth for long periods. The hospital had a pre-operative fasting standard operating procedure which was in date following a review in May 2022, and was version controlled. We saw these procedures were being followed during the inspection.

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 asked patients about their pain when taking vital observations.

Patients received pain relief soon after requesting it. Patients we spoke with told us their pain had been managed well by staff. They confirmed that staff administered pain relieving medicines in a timely way, when they had reported that they were in pain.

Staff prescribed, administered and recorded pain relief accurately.

Leaflets were provided to patients about management of pain post-operatively. These leaflets shared information on pain scoring, as well as further links to additional NHS information for example.

The most recent pain management audit results from October 2023 showed 100% compliance.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The service had a programme of local and national audits in place to benchmark the service against other hospitals in the provider group, local policy compliance and service improvements.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

The service had a lower than expected risk of readmission for elective care than the England average, with no re-admissions recorded in the previous 12 months.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Good

Surgery

The hospital submitted data to the Private Healthcare Information Network (PHIN). This is an independent, government-mandated source of information about private healthcare which supports patients to make better-informed choices of care provider. PHIN data from April 2021 to March 2022 did not identify any concerns and showed the service performed in line with national averages.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits. We saw evidence of the this from team meeting information shared and from what staff told us.

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.

We checked 10 staff files which were held on a computer-based system. All the documentation complied with Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014 set out in Schedule 3.

We saw evidence the service conducted monthly registration audits to confirm staff registrations and qualifications for various professional bodies were in date.

Staff were experienced, qualified and had 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 saw evidence of this is in the staff files we reviewed. Newly recruited staff had six weeks to complete their mandatory training. We also spoke to new staff who shared this with us. Bank and agency staff also had inductions before starting work.

Managers supported staff to develop through yearly, constructive appraisals of their work. The hospital provided data that showed 88% of ward staff and theatre staff had completed their appraisal. The target in Ramsay Health Care UK for appraisal completion was 85%.

Consultants had an induction programme, this included key information about the Hospital, the Hospital vision, mission, and values.

Consultants working under practicing privileges were required to submit evidence of their clinical appraisal annually from their main employer which was usually an NHS trust. This was reviewed as part of the practicing privileges process and during inspection we observed the database that monitored and recorded all appraisal information.

The service monitored the number of procedures that were carried out per year by each consultant and the medical advisory committee (MAC) discussed performance issues and competency regularly.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Good

Surgery

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with had completed the appraisal process and had tailored individual development plans.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. There were routine team meetings that involved staff from the different specialties. The patient records we looked at showed there was routine input from nursing and medical staff.

We saw theatre staff work together to complete the safer surgery checklist and patient preparation prior to surgery. Staff displayed good communication skills and effective teamwork.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff had access to specialist support for patients, such as, the dementia lead and infection prevention and control lead. Staff communicated with local authority safeguarding teams, social workers, community services and GPs when they planned care for their patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Staff shared information about a patient's admission and treatment in a discharge letter which was sent to the patient's GP.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on ward areas. The service had leaflets for patients which provided information on health promotion.

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

We saw evidence in the patient notes we checked of patients being given diet and exercise advice as to how to best recover post operatively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

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. They used agreed personalised measures that limit patients' liberty.

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

Managers told us they did not receive many referrals for patients with dementia or cognitive decline. The Integrated Care pathway (ICP) stated everyone over the age of 75 years should undergo mental capacity assessment. There was evidence of this in the patient records that we reviewed.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

We saw evidence in the staff files we checked, and the services training records all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

There was an interpreter service available to support patients whose first language was not English during the consent process. Interpreters were pre-booked to provide either face to face or telephone support. Staff told us family members were not used for consent purposes.

Is the service caring?

Good

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

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. We saw several positive, caring interventions by staff, who always took their time to ensure patients' needs were understood and met appropriately. Staff were very proud of the care they gave. From our observations, all staff were very pleasant and polite to patients, other colleagues and to all visitors.

Good

Surgery

Patients said staff treated them well and with kindness. Feedback from patients was positive about all of the staff. Visitors were very complimentary about the service provided.

Staff followed policy to keep patient care and treatment confidential. We saw staff respect and always maintained patients' privacy and dignity. Staff were able to give us a good summary of the patients under their care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The latest feedback results for the service showed a 92% score on customer service, including kindness, care, and compassion between January – June 2023.

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 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 theatre staff communicating effectively with a patient and providing reassurance prior to surgery.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity.

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 theatre staff communicating effectively with patients and providing reassurance prior to surgery.

Understanding and involvement of patients and those close to them

Staff supported 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. Staff took the time to explain and interact with patients, offering explanations and being supportive when patients expressed concerns.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The hospital conducted patient surveys to obtain feedback on the service. These results were collated monthly and shared with the staff teams for learning and improvement. The results were displayed in the hospital waiting areas for patients and visitors to read. All patients received patient experience surveys sent to them by email 2 weeks post discharge to seek their views and experiences of the hospital.

Good

Surgery

All patients received a 'thank you for choosing Cobalt card', which had links to NHS choices for patients to leave feedback.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. We saw the latest friends and family report was shared with staff for December 2023 results which showed 100% good experience for all responses received across all parts of the hospital.

Is the service responsive?

Good

Our rating of responsive stayed the same. 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 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 needs of the local population. The hospital undertook a large proportion of their activity for surgical procedures on behalf of the NHS.

Patients could choose their appointment dates and surgery dates to suit their needs. Weekend and evening appointments were available to ensure flexibility to meet individual patient needs.

Facilities and premises were appropriate for the services being delivered. The ward and theatres were well equipped and complied with Department of Health guidelines. The layout of the wards meant that all areas were accessible for people using a wheelchair or walking aids.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, patients with a learning difficulty who were coming in for surgery were identified during the pre-assessment process. They would be supported by staff who would meet them during their pre-assessment and plan support they may need throughout their time in the hospital.

Managers monitored and took action to minimise missed appointments.

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

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs.

Good

Surgery

Wards were designed to meet the needs of patients living with dementia. The ward made reasonable adjustments for patients with complex needs. The hospital had information leaflets available in languages spoken by the patients and local community. Staff had access to print patient information in different languages where a patient's first language was not English. The hospital also had access to patient information in Braille to support visually impaired patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had access to translation service through a third-party provider. Staff could request face to face and telephone translators for patients whose first language was not English or for British sign language.

There was a prayer room available to be used by staff, patients, or visitors. There were clear signs in reception to share that this room was available.

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

Staff had access to communication aids to help patients become partners in their care and treatment. There was a hearing loop system in place in the hospital.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Patients could access the hospital either as privately funded patients or through NHS choose and book. All NHS procedures were prioritised by patient need following consultant review and agreement with the senior leadership team.

Managers and staff worked to make sure patients did not stay longer than they needed to.

All patient admissions were planned at a time to suit patients. The hospital had an inclusion and exclusion criteria in place to ensure that the hospital could safely provide care to their patients. The hospital did not have facilities to care for patients that required critical care beds following their procedure.

Managers worked to keep the number of cancelled operations to a minimum. Staff reported cancellations on the incident reporting system, and these were monitored by managers for themes.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Managers monitored patient transfers and followed national standards. There was a service level agreement with the local NHS trust in place for the transfer of patients requiring critical care transfer in the event of deterioration or an emergency.

Learning from complaints and concerns

Good

Surgery

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.

The hospital had a complaints policy which was in date and version controlled.

The complaints policy documented the service would respond to all complaints within 20 working days.

Between 1 January 2023 and 1 January 2024, 4 formal complaints were received by the hospital and handled in line with the policy.

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. We saw examples of this available in other languages and formats where needed.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice. We saw an example of this in relation to a project undertaken by staff which resulted in improving the information provided to patients at the point of discharge. This was based on identified feedback themes from the contact made with the out of hours telephone line.

Is the service well-led?

Good

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

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. They supported staff to develop their skills and take on more senior roles.

Staff told us that there was good departmental and hospital leadership. Leaders were very well respected, approachable, and supportive. All staff we spoke with were extremely positive about the leaders in the organisation describing them as visible, approachable, professional, friendly, and supportive. They told us that that all leaders had an open-door policy and they felt comfortable approaching any of the hospital leaders with concerns.

Good

Surgery

The senior leadership team, ward and theatre manager had the relevant skills and abilities to manage the surgical services effectively. They understood the risks to the services and had clear oversight on patient safety, governance and performance issues through daily involvement and quality monitoring.

A daily safety and business huddle took place at the start of each day. This was led by the hospital director and involved the senior leadership team and heads of department. There were regular safety huddles and team briefings in the ward and theatre areas so that staff received all relevant information.

Leaders held regular staff meetings and staff told us that they felt that their views were heard and valued.

Specialist lead roles were in place in the hospital such as the infection prevention lead and dementia lead, and they were passionate and knowledgeable in these positions. They were accessible to staff and were empowered to carry out their role by the senior leadership team. A staff member had been supported through their British Sign Language course and was the champion for the hearing impaired.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The hospital's vision was 'from Daycase to Inpatient Unit; expanding choice and access to public and private healthcare on Tyneside'. The hospital's clinical vision was 'To provide assurance for staff, the public and partners on the direction and key priorities for Cobalt Hospital focusing on the growth of safe and sustainable day case services whilst delivering excellence in patient experience and health outcomes'.

The hospital had a comprehensive clinical strategy for 2023 - 2026 with four priorities. These included 'patients', 'people', 'partnerships' and 'performance'.

The vision, priorities and enablers were clearly displayed on notice boards across the ward and theatre areas. All staff we spoke with had a good understanding of the vision and priorities. The service had good links with the local Integrated Care Pathway (ICP) and included these links in the vision and strategy for the future to align plans to the local health economy.

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, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff reported an open and honest culture and said they felt able to raise any concerns with their managers. Staff were extremely proud of the organisation as a place to work and spoke highly of the culture. All staff we spoke with confirmed that the needs and experience of their patients was at the centre of the service.

Good

Surgery

Staff told us they could raise concerns without the fear, and they were confident action would be taken as a result. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. The hospital leader demonstrated an openness to challenge, appropriate escalation and sharing of improvement.

Staff had access to a range of options to escalate any concerns. These included using Speaking up for Safety (SUFS), escalating concerns to a clinical quality partner or the corporate clinical team, raising concerns to the national freedom to speak up guardian and using the Ramsay Whistleblowing hot line.

The service was the first health care provider to deliver and work in partnership with the Cognitive Institute - Speak Up For Safety programme The aim was to heighten team working, accountability and communication to produce high quality care, patient centred, and in the best interests of the patient.

We saw a poster for staff to share information on how to escalate concerns.

Processes and procedures were in place to meet the duty of candour. Where errors had been made or where a patients' experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised.

Governance

Leaders operated 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.

There was a robust and effective governance structure, processes, and systems of accountability to support the delivery of good quality service and monitor and maintain high standards of care.

The service had effective data collection processes, which provided the management team with service level assurance. This included a variety of meetings and working groups that fed into committees for oversight. They hospital held three monthly (quarterly) clinical governance committee meetings. We reviewed 3 sets of meeting minutes and saw that they were well attended by the representatives from the senior leadership team, hospital managers and clinical leads. Agenda items included clinical governance, quality, risk, compliance, and audit. All levels of governance and management worked effectively together.

Heads of department shared information during team meetings. Managers told us that they communicated important information at team meetings with staff and by email or the staff notice boards, for when staff were unable to attend ward meetings or had been on leave.

The service provided all Heads of department with a "Team Brief" immediately following the senior leadership team (SLT) / heads of departments (HoDs) meeting. This enabled the HoDs to engage at the meeting without having to make copious notes and provided a consistent approach to information sharing at their department meetings.

The hospital produced an annual clinical quality account report, which included an overall review on all elements of quality performance.

Good

Surgery

There was a medical advisory committee (MAC) which met quarterly with responsibility for surgeon performance and surgery specific matters. The medical advisory committee (MAC) had oversight of audit results, complaints and incidents which were routine agenda items.

There was a robust programme for internal audit to monitor compliance with policies and processes. Audits were completed monthly, quarterly, and annually as per the providers audit schedule. Results were monitored by the local, regional, and national management team. Results were shared at relevant meetings including the hospital team and clinical governance meetings.

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.

Routine staff meetings took place to discuss day-to-day issues and to share information on complaints, incidents, and audit results.

The key risks relating to the surgical services were incorporated into the hospital wide risk register. The risk register showed that key risks were identified, and control measures were put in place to mitigate risks. Risks had a review date and an accountable staff member responsible for managing that risk.

Key risks and risk register entries were reviewed at monthly departmental meetings as well as clinical governance, medical advisory committee (MAC) and senior management team meetings.

There was a clear and effective process for identifying, recording, and managing risk. Risks had been identified and recorded on the register. The hospital used a red, amber, green risk rating system, to indicate the high, medium, and low risk. Each risk had a rating on entry to the register and a rating once mitigations were in place. All risks had a review date, a named owner, and an action plan.

Departmental risks were discussed at heads of department meetings held weekly and escalated as required to monthly senior leadership meetings.

Managers monitored performance against internal key performance indicators. The hospital was able to monitor their performance against key performance indicators and compare the results with other hospitals in the provider group.

The MAC discussed hospital risks during the meetings every three months. We reviewed the MAC meeting minutes which demonstrated these discussions had taken place.

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. Data or notifications were consistently submitted to external organisations as required.

The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Good

Surgery

Staff across the hospital accessed information from the hospital intranet which included policies and national guidance. Staff knew how to access information through the intranet in each of the areas we visited.

Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders, and the public. The hospital had access to local information and other Ramsay Health Care UK information to benchmark services.

The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital. Staff had access to the intranet to gain information relating to policies, procedures, professional guidance, and training.

The hospital submitted data to The Private Healthcare Information Network (PHIN) as required by the Competition and Markets Authority.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The hospital had undertaken the Better Health at work Award. The aim was to promote a healthy workplace which in turn aimed to add considerable benefits for employers, employees and patients. This was supported by a comprehensive, hospital wellbeing strategy.

The service carried out an annual staff survey to gain feedback from staff about their experiences. The hospital-wide colleague survey (2023) had an 88% favourable score for positive working environment for people's well-being, which was 15% higher than the UK Ramsay Health Care UK average result. The results showed that 93% of staff said that the amount of stress in their job is manageable. The staff survey showed the lowest score was 'receiving meaningful recognition when I do a good job' (54%). The hospital had developed an action plan for any low scores in response to the staff survey.

Staff told us they received support and good communication from their line managers. Staff routinely participated in team meetings and took part in daily huddles across the areas we inspected. The service also engaged with staff through newsletters, briefings and through other general information and correspondence that was displayed on notice boards and in staff rooms.

The service participated in the hospital's patient survey. Patients and their relatives could provide additional feedback through links on the hospital's public website. The public website also provided information and news about the hospital and the provider for service users.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

We saw evidence of the hospital's commitment to community engagement; we saw examples of stakeholder engagement showing recent activities and their impact. This showed commitment to continual learning and improving services.

Good

Surgery

The hospital was committed to continuous improvement and had put in place a dementia strategy with a dementia champion for the hospital.This was set up for the hospital to provide a more suitable environments and a better patient experience.

We saw work had been carried out by a staff member to improve information provided to patients at the point of discharge based on a review carried out to improve the out of hours helpline volumes and reasons for calls received. A further audit was being carried out to show the impact of this.

Good

Outpatients

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

Is the service safe?

Good

Our rating of safe stayed the same. Following this inspection, we rated safe as good.

Mandatory training

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

The service had a mandatory training policy which was in date and version controlled.

The corporate target for mandatory training was 98% for all modules. We saw evidence the Outpatients department mandatory training compliance was 98%

Staff had until the 31 March each year to complete the training modules before the recording system was reset and commenced again in April each year.

Staff who did not complete their mandatory training without good reason could be subject to discipline procedures.

Staff received and kept up to date with their mandatory training. Staff receive alerts when training was due and received adequate notice, approximately 3 months prior notice. Training renewal dates are determined by start date.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Cobalt held monthly staff forums; this often includes guest speakers who talked about areas of additional training such as autism awareness, these were held face to face.

Managers monitored mandatory training and alerted staff when they needed to update their training through had a computer-based system.

The Hospital Director received monthly compliance reports regarding staff training who held heads of department to account for ensuring compliance levels of training were on target.

In addition to maintaining computer-based records, we saw in the 10 staff files that we checked, a record of which mandatory training the member of staff had completed accompanied by the training certificates.

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.

All staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Although the service had not made any safeguarding referrals staff, we spoke with knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Although the service did not treat children staff followed safe procedures for children visiting the department.

In addition, we saw evidence staff had completed safeguarding children and young people training.

The service had an adult's safeguarding policy and a children's safeguarding policy. Both were in date, version controlled and followed intercollegiate guidance.

The service had managers trained to safeguarding level 4. The Director of Clinical Services was the safeguarding lead. If they were not at work, one of the other level 4 trained managers would cover and be available to provide advice for staff.

All other staff were trained to safeguarding level 3.

The Director of Clinical Services told us they would quality assure all safeguarding reports submitted by staff.

There was a safeguarding flowchart on staff notice boards, so all staff were aware of process of raising a safeguarding concern with appropriate point of contact external to Cobalt. The safeguarding would also be reported using the hospitals incident reporting system.

In the 10 staff files we checked we saw evidence of up-to-date disclosure and barring service checks (DBS).

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.

The service had an infection prevention control policy which was in date and version controlled.

The service also had Viral Pandemic Policy and Plan. The aim of this policy and plan was to provide a planned response to an influenza, or other viral pandemic with clearly described roles and responsibilities across Ramsay Health Care UK.

The service had nature a service level agreement with the Cobalt Hospital housekeeping department and Cobalt Hospital ward and outpatient (OPD) departments. It outlined the cleaning tasks by day, week, and month.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained.

Public waiting areas were visibly clean and tidy.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The 50 Steps Cleaning (FR1-5) inspection Report dated 7 November 2023 showed a 96.6% compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE).

On inspection staff were observed to be bare below the elbow, used correct handwashing techniques, and used (PPE) where appropriate when in contact with patients.

We saw hand hygiene and ward cleaning records. Each department had their own cleaning schedule. We saw hand hygiene audits were performed hourly during the Covid pandemic. We reviewed the cleaning schedules the week before he inspection and all were in order with no issues identified.

We saw the Hand Hygiene Observation (5 moments) Inspection Report dated 29 July 2023 showed 100% compliance.

Staff cleaned equipment after patient contact.

On inspection staff were observed cleaning equipment then labelling it to show when it was last cleaned.

The service conducted Methicillin-resistant Staphylococcus aureus (MRSA) screening for any implants. No positive results had been recorded.

Any NHS patient appointments were postponed for 3 months if they have been in hospital, screened and tested positive for MRSA.

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.

Staff conducted daily safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families. There was a reception desk and a patient waiting area.

There were 4 consulting rooms and 1 physiotherapy room.

Good

Outpatients

During the inspection we checked 2 consulting rooms and the physiotherapy room. All were found to be visibly clean and tidy. They contained suitable equipment for staff to use when treating patients.

Staff disposed of clinical waste safely. Clinical and non-clinical waste bins were labelled with date they commenced being used.

On inspection we saw resuscitation equipment readily available. Each piece of resuscitation equipment had unbroken seals applied which were dated to show the equipment was clean and ready to use.

There was evidence the resuscitation equipment was checked daily.

The service had enough suitable equipment to help them to safely care for patients.

Consumable items were stored in 6 different rooms. During inspection we checked 42 items in 3 different locations. All were in date.

Each storage area was visibly clean and well ordered. Consumable items were stored in clear labelled plastic trays or on shelves.

There were also large quantities of PPE available for staff.

Staff would inform the stores coordinator if the stock of consumable items were getting low. In addition, the stores coordinator conducted stock checks every second Monday.

Each consumable item had a bar code on the shelf next to where it was stored. If additional stock was required, the stores coordinator would scan the bar code which would auto generate an order through a corporate ordering system. The stores coordinator would receive a message if the item ordered was unavailable or there was going to be a delay in delivery. They could then go to another supplier to fulfil the order.

All staff we spoke with told us there was never a shortage of equipment.

We saw evidence the service had an asset register which recorded which equipment the service had and when it was required to be serviced.

The service had a contract with an external company for the servicing and repair of equipment. The contract included a service level agreement with an agreed time scale for the company to attend and repair the equipment or replace it.

The service had a fire incident management plan which was in date and version controlled.

We saw fire extinguishers fixed securely on wall mounts, all had labels indicating they had been tested. The fire extinguishers were stored in accordance with the Fire Extinguisher regulations which form part of the Regulatory Reform (Fire Safety) Order 2005 which outlined to prevent fire extinguishers from being moved or damaged, they should be mounted on brackets or in wall cabinets with the carrying handle placed 3-1/2 to 5 feet above the floor.

There were fire evacuation signs to direct people how to leave the building in the event of a fire. Fire doors were unobstructed. The service conducted weekly fire alarm tests.

All staff, patients and visitors had to sign in when entering the hospital. In the event of an evacuation the sign in sheets would be checked against who was at the evacuation points.

We inspected the storeroom where the hospital medical gases were stored. The storeroom held 18 oxygen bottles which was piped directly into the hospital. There were 4 reserve bottles and 6 nitrous oxide bottles. The oxygen had an alarm system to warn when the bottles were running low and there was a manual check performed each day of the cylinder gauges. There were 6 small portable oxygen bottles that store staff took into the building when requested by the clinical staff, which are then mounted on the wall in brackets.

There was a lockable cage outside the storeroom where the empty medical gas canisters were stored and removed and where full cylinders were delivered. BOC was the supplier and delivered when requested by the hospital.

There was adequate signage and CCTV was present all around the area of the hospital.

We re-entered the building through the staff entrance and noted the 'staff sign in/out' sheet on the notice board.

The service used an external company for their alarms and water lines testing. The hospital had 2 cold water tanks, 1 full and 1 empty. Once a year staff from the external company would flush both tanks, other yearly checks include the mixing valves on taps and both fire and burglar alarms.

Internally the senior engineer performed twice weekly tap run offs and housekeeping also did this every day.

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.

We saw evidence in the 10 staff files we checked and from speaking to staff they had received training in how to respond promptly to any sudden deterioration in a patient's health.

The service had a Recognition and Management of the Deteriorating Patient policy which was in date and version controlled.

The service conducted a daily crash bleep test to simulate a patient requiring urgent medical attention. A test was conducted during inspection and all the required staff responded to the bleep.

All referrals for outpatient appointments were reviewed by the Director of Clinical Services to identify any risks before the patient attend the hospital.

There was evidence in the 10 patient records we checked staff completed risk assessments for each patient on admission or arrival using a recognised tool.

The service used a surgical safety checklist to identify any patient risks. The checklist was kept with the patient medical record.

We saw an audit of the surgical safety checklist outpatients had been conducted between1 October 2023 to 30 November 2023; this showed 100% compliance against 10 areas reviewed.

We saw a copy of the Medical Records: Pre-Operative Inspection Report dated 24 August 2023 which showed a 98.3% compliance.

We saw a copy of the National Safety Standards for Invasive Procedures (NatSSIPs) Instruments Inspection Report dated 15 September 2023 which showed 100% compliance.

Staff we spoke with, knew about, and dealt with any specific risk issues.

We saw a copy of the 5 Steps Safer Surgery Inspection report dated 24 August 2023 which showed 100% compliance.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others.

During inspection, the daily safety meeting was observed. The meeting was attended by heads of each department who discussed ongoing issues and risks in their department including patient or staffing issues.

The discussions included all necessary key information to keep patients safe.

When patients were discharged, they were provided with information as to what to do if they felt unwell. This included who to contact to seek advice from at the hospital.

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 and agency 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 the number of outpatients appointments.

The registered manager (RM) oversaw working shift capacity and held a capacity meeting each Tuesday, this covered the upcoming 4 weeks schedule, and all shifts were planned 6 weeks in advance for contracted staff.

The service employed an outpatient team lead, 2 staff nurses, 1 Health Care assistant who also did pre assessment. The staff shifts were flexible to cover the outpatient clinics which ran from 8am to 8pm Monday to Friday with occasional clinics on a Saturday.

The service also employed 2 pre assessment staff nurses on a part time basis, 1 worked 12 hours the other 18 hours.

The outpatient's nurse lead told us they could adjust staffing levels according to the clinic demand.

On average there were 2 staff nurses and 1 HCA working on each shift.

Good

Outpatients

The service had no vacancies and was fully staffed.

Between 18 January 2023 and 17 January 2024 481 hours or 7.6% of hours were lost through staff sickness.

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 employed 1 consultant anaesthetist and 1 gastroenterologist endoscopy consultant. Both worked 40 hours per week.

There were 35 consultants who worked privately at the hospital providing clinics in the outpatient department from 8.00am until 8.00pm Monday to Friday.

All other consultants were independent practitioners and had personal responsibility for the care they delivered. Whilst they were not Ramsay employees, they were required to operate according to Ramsay policies and procedures when practising at Ramsay hospitals. Many were employed by the NHS and worked across several other independent providers.

The service had enough medical staff to keep patients safe.

Records

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

Patient notes were comprehensive, and all staff could access them easily.

During inspection we reviewed 10 sets of outpatients ` medical records. All were comprehensive and contained all relevant information.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely for 3 months at the hospital before being taken away for central storage.

Medicines

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

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

The service had policies which reflected the systems and processes used to prescribe and administer medicines. These were in date and regularly reviewed.

When a patient required medicines to take home, a process was in place to ensure there was an audit trail for the supply of these medicines.

Good

Outpatients

Managers told us outpatient audits included antibiotic usage. No issues had been identified from the audits.

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

Where staff monitored medicines to ensure they were fit for purpose, these records were accurate and up to date.

Staff stored and managed all medicines and prescribing documents safely.

Medicines were stored securely, with access restricted to the appropriate staff. Controlled drugs were stored securely, and regular stock checks were documented.

Fridge temperatures were recorded and were within range. Emergency medicines were available and were in date.

Staff learned from safety alerts and incidents to improve practice.

The service had processes in place to review safety alerts and incidents and share learning.

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.

The service had an incident reporting policy which was in date and version controlled.

Staff knew what incidents to report and how to report them through the services computer-based system.

Staff raised concerns and reported incidents and near misses in line with the service's policy.

The service had not recorded any never events.

Managers shared learning about never events with their staff and across the service.

The service received corporate safety-first flash alerts shared throughout all Ramsay hospitals the updates were cascaded to all HODs for information or action.

Managers shared learning with their staff about never events that happened elsewhere.

Staff reported serious incidents clearly and in line with the service's policy.

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

Staff received feedback from investigation of incidents, both internal and external to the service from the head of department.

Good

Outpatients

We saw evidence of shared learning from incidents at other Ramsay Hospitals. The information was displayed on notice boards for staff to read.

Staff met to discuss the feedback and look at improvements to patient care. This was done at the 8am staff huddle and during staff forums.

We saw in the Clinical Governance Meeting 25 October there was a section on what was learned from incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

The service had incident reporting and Duty of Candour policies which were in date and version controlled.

Staff we spoke with understood the principles of duty of candour. Managers we spoke with gave us examples when the principles of duty of candour had been applied.

Is the service effective?

Good

Effective was not rated during the last inspection. Following this inspection, we rated effective as good.

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 protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice introduced in 2008 following substantial changes and updates in legislation, policy, case law, and professional practice.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

The Director of Clinical Services told us the service did ensure it identified and implemented relevant best practice and guidance, such as NICE guidance. The process for this was through the provider's corporate governance department. They provided quarterly bulletins with NICE guidance for all Ramsey hospitals.

The Director of Clinical Services reviewed the information and implemented the NICE guidance relevant to the identified department. The implementation was conducted by the department head and signed off by the Director of Clinical Governance when completed.

The Director of Clinical Services told us this process worked well.

Good

Outpatients

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered, and recorded pain relief accurately.

Staff told us as part of the patients' consultations post operative pain injections were administered if required.

We saw evidence in the 10 sets of patient notes we reviewed that patients' pain was discussed and recorded.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits.

Managers told us benchmarking is done at national and local level on a yearly basis. The service benchmarked on Patient Reported Outcome Measures (PROMS) for carpel tunnel and mammoplasty.

PROMs assessed the quality of care delivered to NHS patients from the patient perspective.

Outcomes for patients were positive, consistent, and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes.

Managers and staff conducted a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

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.

We checked 10 staff files which were held on a computer-based system. All the documentation complied with Regulation 19(3)(a) of the Health and Social Care Act (Regulated Activities) Regulations 2014 set out in Schedule 3.

We saw evidence the service conducted registration audits to confirm staff registrations and qualifications for various professional bodies were in date.

Good

Outpatients

All the consultants were independent practitioners and had personal responsibility for the care they deliver. Whilst they were not Ramsay employees, they were required to operate according to Ramsay policies and procedures when practising at Ramsay hospitals. Many Consultants were employed by the NHS and worked across several other independent providers.

Consultants' appraisals were completed by managers at the NHS hospitals where they worked. Copies of the appraisals were shared with Cobalt.

Every Consultant was listed on the General Medical Council (GMC) medical register and underwent a thorough vetting process before being granted "practising privileges" to practice at a Ramsay hospital. They were subject to regular corporate review.

Staff were experienced, qualified, and had 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 saw evidence of this is in the 10 staff files we reviewed. Newly recruited staff had 6 weeks to complete their mandatory training.

Managers supported staff to develop through constructive appraisals of their work. We saw evidence on inspection all staff had recently had a half yearly review which was recorded in their staff files.

At the time of the inspection the appraisal rate in the outpatient's department was 100%.

The service had a Clinical Supervision policy which was in date and version controlled. The purpose of the policy was to offer a choice of clinical supervision processes that would provide support to staff by encouraging self-assessment and reflective learning using reflective and analytical skills.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. We saw evidence of this through the service's nursing apprenticeship scheme.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

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

Good

Outpatients

Staff held regular and effective internal multidisciplinary meetings to discuss patients and improve their care.

Patients could see all the health professionals involved in their care at one-stop clinics.

Managers told us consultants attended multidisciplinary meetings a local NHS hospital to discuss patients requiring skin cancer procedures.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas.

The service had leaflets for patients which provided information on health promotion.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle.

We saw evidence in the patient notes we checked of patients being given diet and exercise advice as to how to best recover post operatively.

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. They used agreed personalised measures that limit patients' liberty.

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

Managers told us they did not receive many referrals for patients with dementia or cognitive decline. The ICB care pathway stated everyone over the age of 70 years should undergo mental capacity assessment. There was evidence of this in the patient records we checked.

Staff ensured patients understood the treatment they were in hospital for. Staff asked patients to repeat what they've been told throughout preassessment and admission.

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

We saw evidence in the staff files we checked, and the services training records all staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Good

Outpatients

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

Managers told us at the patient pre-assessment meeting any patients with cognitive difficulties would be identified and plans put in place to support the patient during their care.

Is the service caring?

Good

Our rating of caring stayed the same. Following this inspection, 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.

See Surgery report.

Emotional support

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

See Surgery report.

Understanding and involvement of patients and those close to them

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

See Surgery report.

Is the service responsive?

Good

Our rating of responsive stayed the same. Following this inspection, 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. Managers told us 92% of the patients were NHS and the other 8% were private.

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 occasion.

Good

Outpatients

The service used a choose and book system which general practitioners (GP`s) could access for appointments with outpatient consultants. This system allowed patients to choose which consultant they wished to see depending on the specialism, on which day and at what time.

Staff who managed the appointment system told us they were able to identify gaps and were able to offer patients earlier appointments on occasions.

Appointments were available Monday to Friday between 8.00am and 8.00pm and on Saturdays if required.

When patients arrived at the hospital reception, they give their name to the reception staff who asked they confirmed their name of GP, date of birth, address and if they knew which consultant they were there to see. The details were added to the computerised booking system which alerted the outpatients staff the patient had arrived.

Patients were kept updated as to how long they would have to wait.

The waiting area was split into 2 areas, one for theatre and the other for clinical.

Staff told us post operative outpatient appointments were made after the patient was discharged from surgery.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention.

Managers monitored and took action to minimise missed appointments. Managers told us consultants would ring patients who did not attend an appointment and arrange another time and date.

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

Data for 2024 showed that out of 5485 patient appointments 403 did not attend which is 6.84%.

There was a Ramsay Clinical Standard Operating Procedures (SOP) to manage the principles of cancellation and DNA actions in line with Ramsay Access Policy 2023, which reflected national guidance, but would also adopt the local commissioner agreement on the management of the two groups, NHS and private, to offer equitable access in the community.

The service supported the NHS by carrying out skin cancer procedures on patients considered to be on “long wait” NHS appointments.

Meeting people’s individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Good

Outpatients

The service had information leaflets available in languages spoken by the patients and local community.

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

Staff had access to communication aids to help patients become partners in their care and treatment.

There was signage clear enough to be understood by people who are unfamiliar with the environment.

The service had a Patient Journey policy which was in date and version controlled. The purpose of the policy was to provide staff with a clearly described process detailing the patient journey from referral to discharge.

The building was designed so that people with a disability could access and use services on an equal basis to others. There were wide corridors, automatic doors and disabled toilet facilities which facilitate wheelchair access.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Managers monitored appointment times and consultant availability to make sure patients could access services when needed and received treatment within agreed timeframes.

Managers worked to keep the number of cancelled appointments to a minimum. We were told approximately 5% of outpatients appoints were not attended by patients. The patient would be contacted to find out why they had not attended and to rebook them.

There were 805 cancelled Outpatient appointments between July and December 2023. There were 22 different cancellation reasons. The top 3 were, Patient cancellation 290, Patient other more pressing engagement/unavailable 115 and treatment no longer required 85.

Any cancelled appoints were recorded on the service's incident reporting system so the cause could be identified, and action taken to prevent a reoccurrence.

When patients had their outpatient appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

Staff responsible for records told us they checked the theatre and clinics for the day, printed off the patient records and left them in the consulting rooms for the consultants. Once the appointment was concluded the completed patient record would be returned to the records office to be scanned and uploaded ready for audit.

There were no access and flow issues as the service controlled the appointments based upon patients and consultant availability.

Good

Outpatients

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.

The service had a complaints policy which was in date and version controlled.

The service's complaints policy documented the service would respond to all complaints within 20 working days.

Between 1st January 2023 and 1 January 2024, 2 formal complaints were received by the hospital. They were not in relation to outpatients.

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.

Staff understood the policy on complaints and knew how to manage them.

Staff knew how to acknowledge complaints.

Is the service well-led?

Good

Our rating of well-led stayed the same. Following this inspection, we rated well-led as good.

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. They supported staff to develop their skills and take on more senior roles.

See Surgery report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

See Surgery report.

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 and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Good

Outpatients

See Surgery report.

Governance

Leaders operated 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.

See Surgery report.

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.

The service had a business continuity plan which was in date. The plan has last been tested in 2022.

The plan outlined roles and responsibilities and various contact numbers external to the hospital including the Local Authority.

The hospital had a risk register 7 risks highlighted. No related to Outpatients'.

See Surgery report.

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. Data or notifications were consistently submitted to external organisations as required.

See Surgery report.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Reception staff handed patients friends and family feedback cards which were requested to be completed prior to the patient leaving the hospital. Once handed in they were scanned and uploaded onto the computer system before being shredded.

See Surgery report.

Good

Outpatients

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

See Surgery report.