Circle Health Group Limited

The Meriden Hospital

Inspection report

Walsgrave Hospital Site
Clifford Bridge Road
Coventry
CV2 2LQ
Tel: 02476647025
www.circlehealthgroup.co.uk/hospitals/the-meriden-hospital

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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 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. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- 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.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	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. They managed medicines well. The service managed safety incidents well and learned lessons from them. • 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.

Summary of findings

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Summary of this inspection

Background to The Meriden Hospital

The Meriden Hospital is an independent hospital located in Coventry and is operated by Circle Health Group Limited.

The service was situated over 2 floors including 1 ward, Charlecote ward which had 52 beds. At the time of the inspection, 48 patient beds were in use. All bedrooms were single occupancy and had their own bathrooms. Facilities at this hospital included 3 operating theatres, an outpatient department with a minor operating suite, a cardiac catheter laboratory which reopened in June 2022 and an endoscopy suite which had 4 bays. On the top floor there were meeting rooms and office spaces.

The service provided care and treatment for both NHS and private patients.

The service has a registered manager in post and provides the following regulated activity:

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

We completed an inspection of this service due to a number of concerns received in relation to patient safety and poor culture. During the inspection we inspected the surgery core service and completed a focused inspection of the safe and well led domains.

During the inspection we reviewed 5 patients records and spoke with 2 patients with their consent.

During the inspection we spoke with 18 staff including domestic staff, a ward clerk, health care assistants, staff nurses, junior sisters, ward managers, consultants, anaesthetists, pharmacists, theatre managers and leads, an operating department practitioner, the Medical advisory committee and resident medical officer.

After the inspection, the service provided 241 additional pieces of evidence to help us make the judgement for the safe and well led domains.

How we carried out this inspection

The team that inspected the service comprised of a CQC (Care Quality Commission) lead inspector and 2 specialist advisors who were a theatre nurse and a consultant. The inspection team was overseen by a Deputy Director of Operations.

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

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

Safe	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.

Staff completed 21 mandatory training modules as required for their different roles. The service had not identified what their service target was to meet for their training, however, all training compliance was above 92%, except for Care and Communication of the Deteriorating Patient which was at 88.1% compliance. Five staff who were not compliant had been booked to complete this training in January 2024.

Mandatory training included fire safety, moving and handling, adult advanced life support, basic life support adult immediate life support, conflict resolution, and information governance.

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

Staff completed the Oliver McGowan mandatory training which was at 98% compliance. Staff also completed dementia training which was 100% compliant.

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

Managers monitored staff training and emailed staff to inform them that training was to be completed. Training was delivered through e-learning and some training was face to face. Staff spoke highly of the training and the development the service could offer.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

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

The service ensured that staff had completed prevent training which aims to protect people at risk of radicalisation.

The service ensured that staff, depending on their roles, had completed Safeguarding level 2 and 3 for vulnerable adults.

Good

Surgery

The service had 4 staff members who were trained to level 4 safeguarding for vulnerable adults and children, and 2 staff members who had received safeguarding level 5 training.

The service had a safeguarding lead who was responsible for all safeguarding matters. When speaking with staff they were not sure who the safeguard lead was, however, staff stated they would raise their concerns with managers.

Data provided by the service stated that they had 4 safeguarding concerns raised since July 2023. These were acted upon accordingly, and in the best interest of the people the safeguarding concerned.

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

Staff had a good understanding of how to protect patients from discrimination and had undertaken equality and diversity training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

The service had a safeguarding children and young people policy in place which looked to ensure that no act or omission by the service puts an individual using services at risk, and that rigorous systems are in place to proactively safeguard and promote the welfare of children. This policy was in date and had a review date.

The service had a safeguarding vulnerable adults' policy in place which stated that there are rigorous systems in place to protect adults at risk from abuse, or the risk of abuse, and to support staff in fulfilling their obligations. This policy was in date and had a review date.

Staff we spoke with could give examples of, and had an understanding of, safeguarding and how to raise any concerns. The service also had a safeguarding lead who would raise concerns with other agencies if required.

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.

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

All areas including clinical areas were visibly clean. All rooms and en-suites were cleaned between patients stays, and all equipment was visibly clean.

The service generally performed well for cleanliness.

The service completed an infection prevention control (IPC) General Principles and Practices and Cleanliness audit for the ward and theatres, this had been completed by the IPC lead. For the ward in September 2023, the audit score was 97%, 100% in October and November 2023, and in December 2023 was 97%. For the theatre between September and December 2023 the score was 100%.

Good

Surgery

The service completed quarterly hand hygiene audits, and for the months September to November 2023 they scored 100%.

The service also completed an action plan so any issues that arise could be addressed and actioned. This was monitored by the IPC lead.

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

The domestic staff used a detailed form which was completed daily and identified whether patients were being discharged and if the rooms required a full deep clean. They also used a patient cleaning room sheet which identified all the areas that needed to be cleaned within the bedrooms and en-suites.

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

The service had hand gel on the wards for staff, patients, and visitors to use.

During the inspection staff demonstrated a good understanding of managing infection risks and the use of PPE. This was situated on the corridor walls on the ward and included gloves, masks, and aprons.

The service had a Control of Substances Hazardous to Health (COSHH) cupboard. This was locked at all times and staff could access this with a key code.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service did not use “I am clean stickers” however all equipment was visibly clean, and the staff followed a cleaning schedule outlining which equipment needed cleaning and when it needed to be cleaned.

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

The service kept a list that identified the methods of cleaning and frequency of use for each piece of equipment, including if the items were reusable or single patient use. Which staff kept up to date and signed when cleaning jobs had been completed.

The service also kept a list of disinfectants, and this had directions on how to use them and where they could be used.

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.

During the inspection we witnessed patients using call bells and staff responded quickly to these calls.

The design of the environment followed national guidance.

The service had keypads to allow staff to access store cupboards. There were electronic keypads on the pharmacy room, which ensured medicines were stored securely.

During the inspection all fire doors were clear and firefighting equipment was in clear view. All equipment was in date and sealed.

There were ward clerks situated on the ward to be able to guide and support patients, and visitors.

During the inspection it was identified that the floor beading within theatre 1 required re welding and cleaning. This was non-compliant with Health Building Note 00/10-part A. However, post inspection the service provided photographic evidence that this had been repaired.

Staff carried out daily safety checks of specialist equipment.

The service carried out quarterly audits which were based on observations and inspection of patient environment, equipment, and staff delivery of care where infection prevention and control practices are expected. For the months between September and December 2023 the ward scored 99% and the theatre scored 100%.

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

All bedrooms on the ward were single occupancy, meaning patients could spend time with their families in their own rooms and also have private conversations with staff. They were spacious, and each room had a chair and small table to be able to eat meals, as well as a small table to be able to put their belongings on. All bedrooms had a television situated on the wall. All bedrooms had their own bathrooms with hand basin, toilet, and shower. Patients could access to equipment, for example: a shower chair, if this was required.

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

During the inspection a concern had been raised that the service only had access to a computed tomography (CT) scanner Monday to Friday between 8am and 8pm. This was discussed with the registered manager regarding how this risk was mitigated. The service mitigated this risk by transferring patients to the local NHS trust which was located on the same site. Since January 2023, there had only been 1 instance where a patient had to be transferred to the local NHS trust, and there was no reported patient harm encountered.

Staff disposed of clinical waste safely.

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.

The service used National Early Warning Score (NEWS2) system when monitoring patients' vital signs and deteriorating patients. Patients records clearly identified deteriorating patients and observations and actions if a patient was to deteriorate.

Good

Surgery

The service completed NEWS2 audits which were conducted based on recording of NEWS2 monitoring for patients taken from the medical notes. Between April and July 2023, they score 83% and between September and December 2023, there score increased to 95%.

The service had a policy and an agreement with the local NHS trust for transferring patients who were deteriorating.

The service monitored the number of patients that required transferring to an NHS trust. Since January 2023, 12 patients had required a transfer for additional medical support. This means that the service had a system in place to ensure that deteriorating patients received the care and treatment they required.

The service completed venous thromboembolism (VTE) audits which were conducted based on completed VTE risk assessments. For the months between April and July 2023 they score 99% and between August and November 2023 they scored 100%.

The service completed safety performance audits and the audits were conducted based on review of clinical risk assessments on patient notes. The safety care audit for April to July 2023, was scoring at 94%, and between September and December 2023 this had increased to 98%.

The service told us that patients are allocated the number of nights they will be staying depending on their procedure. Where it had not been safe to discharge the patient, the service discussed this with the patient and agreed additional night's stay on the ward.

The service had an escalation policy and flow chart, which highlighted a number of incidents that could take place. A protocol was in place which explained who should be contacted, internally or externally, in the event of these incidents occurring.

The service had a care of the deteriorating patient policy in place, for staff to identify and care for patients who are acutely ill or at risk of physical deterioration. Staff had a good understanding of this policy and how to respond to a deteriorating patient, this policy was in date and had a review date.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

We reviewed 5 patient records and found that the service completed risk assessments in relation to VTE, IPC, pressure ulcers and falls. The patient records reviewed also contained completed World Health Organisation (WHO) check lists.

The service also completed a pre- assessment for all patients, which covered consent, past medical history, and evidence of the pre -operative instructions given to the patient, for example any medications that needed to be stopped before the procedure could take place, and any concerns that are raised with the consultant.

The service ensured that they reviewed patients' medical history, medication and any risks that could potentially be highlighted before the procedure took place.

During the inspection a patient's journey was tracked, from pre operation to the operation taking place and then the aftercare on the ward. All processes were followed and there were no concerns relating to patient safety.

The service had a mental capacity, deprivation of liberty and restrictive practice policy. This stated that staff were to understand and effectively implement the statutory requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2007. This policy was in date and had a review date identified.

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

The service completed 9 am safety huddles where information relating to theatres, pre- assessments, the number of patients on the ward and how many day cases were due to take place. Staff from other departments, for example: physiotherapists, were included. Staffing levels, and if they had the required number to ensure surgeries could take place, were discussed.

The service completed a morning test to ensure that all bleeps were working, and staff could respond to an emergency.

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 and agency staff a full induction.

The service had enough staff to keep patients safe.

The service for theatres and the ward both had vacancies and required the support of both bank and agency staff. On the day of inspection, the service had enough staff to keep patients safe. Post inspection the service provided copies of the last 2 months of staff rota's, which identified there were enough staff.

The service completed competencies in relation to staff having the right qualifications and skills to be able to complete their role. These were also identified as job role specific.

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.

Managers and senior managers had a good understanding of their staff teams, vacancy rates, and have completed a recruitment process to attempt to fill the staff vacancies they had. Vacancies were reviewed on a regular basis.

The service had low vacancy rates.

The ward had 32 full time equivalent staff members, of which bank equates to 2 full time equivalent (FTE), and agency equates to 2 FTE.

The theatre department had 30 FTE staff members, of which bank equates to 2 FTE and agency equates to 5 FTE.

The service had increased turnover rates.

The service had a slight increase of nursing staff turnover since September 2023 which was 16%, and for December 2023 this was 18%. The registered manager could give reasons of why this had slightly increased.

The service had increased sickness rates.

The service did not identify a target in which they aimed to keep their sickness below, however, the service had an increase of sickness from October 2023 which was 3.2%, for December 2023 this was 5.3%

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

Managers and senior staff told us that they used bank and agency staff, and that agency staff were block booked, to ensure that familiar staff were working at the service where possible.

Managers made sure all bank and agency staff had a full induction and understood the service.

The service ensured that all staff including bank and agency staff received an induction and had a good understanding of the service. The service also tried to ensure the same staff were booked through the agency to ensure there was consistency. The service had a buddy system in place, so new staff had support from someone who had knowledge of the service.

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

The service did not employ their own doctors and/or consultants but had 168 consultants and doctors working under practicing privileges. All of the consultants and doctors worked substantively at the local NHS trust, which was based on the same site, or at an NHS trust in the surrounding areas.

All doctors working under practicing privileges had in date Disclosure and Barring Service and appraisals. Managers kept records of this and liaised with clinicians to arrange meetings to ensure that information remained up to date, and a discussion took place to discuss staff performance.

The service completed appraisals which were at 100% compliance. The service also had a policy in place in relation to medical appraisal & revalidation, which the managers monitored and completed.

The service always had a consultant on call during evenings and weekends.

Post inspection the review of rotas identified that there were sufficient consultant cover for evenings and weekends.

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.

Patient records were comprehensive and easily accessible and in paper form. Records included NEWS2, fall assessments, fluid balance charts, pressure ulcer risk assessments, VTE risk assessments, pain relief assessments and IPC risk assessments. However, we found that when patients came to the ward their patient records were not secured into a folder until the patient was discharged. This meant there was a risk that patient records could be lost or misplaced.

Records were stored securely.

Good

Surgery

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 pharmacy was situated within the ward area, and the pharmacy team worked closely with the doctors and nurses working on the ward.

The service had a medicines management policy in place which was in date and identified definitions to the management of medicines, including role and responsibility.

All medication was stored correctly in a locked room and in a lockable cupboard. All controlled drugs were stored appropriately, safely, and securely.

There was a robust system in place to highlight out of date stock and minimise waste of medicines.

All medication within fridges were stored correctly and were regularly checked. Temperatures were checked and recorded correctly.

The service provided a patient's helpline which was a direct line to the pharmacy, this was available between Monday and Friday 9am and 3pm.

The service had a service level agreement (SLA) for the delivery of medicines with the local NHS trust which was situated on the same site. Which staff stated that these worked well, and they had a good relationship with the local NHS trust.

The service had a process in place for patients accessing medicines out of hours.

The service were compliant with the Home Office controlled drug (CD) policy, which outlines the safe and storage of controlled drugs.

The service completed a quarterly medicines management audit, and for the months between August and November 2023 they scored 93%. The service implemented an action plan which had 5 actions identified and the person who was to ensure these actions were to be completed.

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

The service also had a comprehensive range of guidance leaflets above the usual packet instructions were provided to patients.

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

During the inspection we reviewed 5 patient's records, and these were well documented, allergies were documented well, and all medicine records were completed.

Oxygen was documented on the patients' drug charts.

Good

Surgery

Staff stored and managed all medicines and prescribing documents safely.

The service had systems and processes in place. The pharmacy team completed regular checks and completed stock rotation.

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

The pharmacy team had a good oversight of the administration of medicines, the pharmacy also had pharmacy liaison nurses and technicians.

Staff learned from safety alerts and incidents to improve practice.

The service had a policy for management of safety alerts. This was in date and identified the actions to take to disseminate information to the team. Where equipment needed to be removed from the service, the policy also identified whose role and responsibility it was to take this action.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them.

Staff had a good understanding of what was identified as an incident and how to report them. The staff reported incidents and near misses in line with the service's reporting incident policy.

The service did not have any never events within the last 6 months.

Managers shared learning about incidents with their staff and across the service.

Managers told us that they attended managers meetings and incidents were discussed in these meetings. Managers also held team meetings where this information was disseminated to the staff team.

Post inspection the service provided information which identified that managers were auditing incidents and identifying why the incidents have taken place. Between July 2023 and January 2024, there were 259 incidents reported. The most commonly reported incident was cancellation of an operation, of which there were 68. The audits stated that the level of harm to patients was either no harm or low harm.

During morning and afternoon debriefing with all managers, concerns and incidents were discussed, ensuring that everyone was aware of what had happened.

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.

Good

Surgery

Staff had a good understanding of duty of candour and stated that it was being open and honest with patients and giving a full explanation when things go wrong.

The service had a being open and duty of candour policy in place which had a review date identified. This also identified a process flow chart of each step to take, staff training and also whose responsibility it was to deliver this information to patients.

Staff received feedback from investigation of incidents.

Staff told us that learning from incidents were discussed in the team meetings and any learning from these were shared to prevent them from reoccurring.

There was evidence that changes had been made as a result of feedback.

The service reviewed incidents and made changes from what they had learned to prevent recurrence. Examples included that the anaesthetic machine in the catheter lab had not been checked 1 day, whilst not in use. The service now ensured that a member of the theatre team was allocated on each shift to check the anaesthetic machine. This was also discussed at the morning theatre huddle, and the theatre huddle template had been updated to support the allocation of this task.

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

Post inspection the service gave examples of where they had involved patients and families in relation to incidents. This included discussions of what had happened, and a meeting with managers and a consultant had been arranged to explain the services findings and to be able to explain these in a face-to-face meeting. There was also the opportunity that if patients or family members did not want to attend a meeting then communications could be continued via email or letters.

Managers debriefed and supported staff after any serious incident.

Staff told us that they feel supported by managers and had time to speak about the incident.

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.

The senior leadership team (SLT) consisted of an executive director, director of clinical governance, operation manager, clinical services manager for theatre, clinical services manager for the ward, and a quality and risk manager. The executive director was the CQC registered manager who was responsible for the day–to-day running of the service.

Good

Surgery

Staff we spoke to told us they felt positive about the managers, and they were supportive, approachable, and friendly.

The service had managers in place that were the safeguarding lead, IPC lead and the lead for health and safety and patient administration.

Staff told us that senior managers were present during the day to day running of the service. Managers also told us that staff can and have approached them when they are feeling concerned or needed to have a conversation.

Staff told us that they are supported with personal development within the service, and they stated this was a positive to work for the service.

The SLT held monthly meetings, and there was an identified agenda which included any safeguarding concerns, any SWARMs that have taken place, which means the service used swarm-based huddles to identify learning from patient safety incidents., staffing, changes to policy, quality and risk and training.

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 services aim and vision for the next 2 years was to provide high quality, safe and compassionate care patients need and expect. And to continue to embed and celebrate how they live the Principles and Values. The service vision was to be the hospital of choice in Coventry and Warwickshire, this vision was based on the following principles: People, Quality, Transformation, service and business development, and profitability.

The service had key principles which are underpinned by 8 values, which were split up into 4 principles and 4 values.

Leaders and staff understood the vision of the service and staff spoke passionately in relation to patients care.

The service had developed relationships with wider specialist providers to ensure that the service could work alongside to ensure a patient- centred approach of their care and treatment.

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.

The senior leadership team requested a culture review which took place in August 2023, triggered by a number of whistleblowers they had received. The service completed an action plan, which had identified 5 recommendations about how the service were going to address these concerns. The action plan also broke down into theatres and ward, of what was going to be done and if this had been completed.

The service completed a staff survey in April 2023, the service had not identified a target of the number of staff they aimed to complete the survey, however, the service had 69% of staff had completed. This was a slight reduction from the March 2022 staff survey.

Good

Surgery

The service implemented an action plan and had the following heading which identified their own actions, these included, the company, the managers, the team, wellbeing.

During the inspection we spoke with 18 staff of all different levels, and they stated that there were happy to be working at the service and they felt supported. However, there had been a lot of historical concerns relating to organisational cultural and staff told us that they felt this had improved over the preceding 3 months and continued to improve under the current management team. Post inspection we received information stating that there were still some concerns in relation to the culture.

Staff told us that they worked well together to meet the needs of patients that use the service, and the focus was on patients care.

During the inspection and whilst speaking to staff they told us that they liked the development of their roles and the training the service offer. Some staff also told us that they had received a promotion within the service.

Staff had a good understanding of the meaning of duty of candour and to be open and honest with patients and families relating to their care. Post inspection data received from the trust gave examples of where the service had involved patients and families with any concerns that they had 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.

The service had a governance assurance framework process which identified communication strategies between departments and managers. This also outlined how to communicate to the board. The service had clear lines of delegation, of who reports to who which enabled managers to have oversight of the service and individual departments.

We reviewed 3 sets of governance minutes from October, November, and December 2023. These minutes identified a chair, and staff who attended and there was a planned agenda which covered quality and risk, incidents, training, near misses, staffing, vacancies and the use of agency staff, and the risk register.

The service also monitored any actions that needed to be completed, who was responsible for completing the task and when this had been completed.

The service held the following monthly meetings, senior management team, head of departments, clinical governance, and staff engagement. The service also held Medical Advisory Committee (MAC), IPC, and Health and Safety meetings every 3 months. Within the MAC meetings the hospital, finances, clinical governance meetings, practicing privileges and the risk register was discussed., This also included an action plan, which identified what action had been identified, who was to complete the action, and if and when this had been completed.

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.

Good

Surgery

The service had a risk register in place which had identified 7 risks, the person responsible for the risk, the score the risk had been assigned before mitigation and then the score assigned after.

Mangers told us that the risk register was reviewed and updated if needed on a monthly basis during governance meetings.

The service used SWARM, a system to ensure that the risk had been mitigated and reduced the risk to prevent this from happening again.

The service had a local safety standard for invasive procedures (LocSSIPs) and national safety standard for invasive procedures (NatSSIPS) policy in place, this was in date and had a review date.

The service used an incident electronic reporting system. Incidents were assigned to managers to investigate and review, identify any learning to prevent this from happening again, and implement change.

The service had business continuity plans in place, covering adverse weather conditions, of if any of the main supplies such as gas, water, or electricity fail.

The service had SLA for servicing equipment. Which was adhered to and monitored by managers.

Managers reviewed staffing on a daily basis, to ensure that the service had the correct staff in the correct roles. this also covered the use of agency staff and was discussed in clinical governance meetings.

The service had a 9am safety huddle where they discussed risks, or anything that may become an issue or impact on performance. The service also had a nurse call/bleep test every morning to ensure this was working in an event of an emergency. This meant that if there was an emergency, staff could respond to the patient in a timely manner.

Information Management

The service collected reliable data. 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 service had an information policy in place which explained how they dealt with information and how this was stored, this policy was in date.

The service had a data protection policy in place which explained how to preserve and protect personal data. This policy was in date and had a review date identified.

Staff could access policies and procedures on the systems, and if there were any changes this was discussed in managers meetings and then disseminated to the staff.

The service completed regular audits for both the ward and theatre. These were monitored by managers and any audits that were not meeting the required score an action plan was implemented and the teams worked to complete the actions identified.

Data was discussed in the clinical governance meetings under quality and risk.

Good

Surgery

There were systems to ensure that when serious incidents and notifiable events took place, the service had notified CQC as required by law.

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.

Staff had the opportunity to complete a staff survey, and in 2023 68% of the staff team had completed this. The survey had 9 points for the staff to state how engaged they were, from most engaged to disengaged and likely to leave the service.

The service had implemented an action plan to identify the areas that needed to be completed and how they were going to implement this.

The service had completed a Snowdon charity event which raised money for a local hospice. The service also held other celebration days throughout 2023 which engaged with staff these included red nose day, Valentine's Day, Nurses, and outpatient's department day.

The service had a yearly calendar which identified special days in the Hindu, Sikh, Christian and Islamic faiths, as well as LGBT+ History Month, black history month and autism awareness month.

The service also held wellbeing meetings and these identified ways to include staff and promote wellbeing.

The service had raised money and in January 2024 this was donated to the local food bank within the local area.

Staff told us that the current management team were supportive and approachable.

The service worked closely with the local NHS trusts and 91% of the services doctors/consultants worked at this NHS trust.

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.

The service had a positive approach to learning and improvement which was led by the senior leadership team. The service completed audits to enable them to improve areas that were below the required score, and actions were completed which were identified on the service's action plans.

Staff told us that they received feedback and learning from incidents once these had been discussed in the clinical governance meetings. This ensured there was learning to reduce the risk of reoccurrence and keep people safe from avoidable harm.

Staff told us that they felt that the service provided a good development path, where they could progress to higher positions within the service.

Good

Surgery

The service held staff forums where staff were able to ask, “can we have”, and this was ideas that are brought to the management team, then the SLT decide if these requests could be implement.