The Karri Clinic Ltd

Kinvara Private 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?	Requires Improvement
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 improved. 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 enough to eat and drink. 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 flexibly.
- 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;

- Staff did not always receive an appraisal and complete one-to-one supervision, especially bank staff.
- The provider risk register version we saw did not include all their top risks, with agreed actions and updates from review where appropriate.

On our last inspection in September 2022, we served two section 29 warning notices against the provider and the registered manager for breaches of Regulation 17, under Section 29 of the Health and Social Care Act 2008, which specifically related to employment of fit and proper persons and governance.

These identified specific areas the provider must improve and set a date for compliance of March 2023.

We also informed NHS stakeholders of this action.

The provider initiated immediate steps to improve, included working with stakeholders, developing an action plan with clear timescales for improvement and a review of systems and policies.

On this inspection we found significant improvements in all areas where we had previously taken enforcement action including leadership and governance. As a result, all the breaches were removed, and we re-rated this service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	Our rating of this service improved. 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 enough to eat and drink. 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 flexibly. • 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.

Summary of findings

Outpatients is a small 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, and responsive, well led. Effective and Caring were inspected but not rated.

Surgery

Good 

Our rating of this service improved. 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.
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Summary of findings

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;

- Staff did not always receive an appraisal and complete one-to-one supervision, especially bank staff.
- The provider risk register version we saw did not include all their top risks, with agreed actions and updates from review where appropriate.

Outpatients is a small 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 Kinvara Private Hospital

Kinvara Private Hospital Limited is an independent hospital owned by The Karri Clinic Ltd.

It is registered to provide the following regulated activities:

• Treatment of disease, disorder or injury.

• Surgical procedures.

• Diagnostic and screening procedures.

The hospital has a manager registered with CQC.

The hospital provided a range of elective day-case and in-patient surgery treatments for NHS and other funded (insured and self-pay) adults, (the service did not admit children). The hospital provided a range of specialities including gynaecology, orthopaedic surgery, cosmetic surgery and general surgery.

The hospital's total number of operations performed was 1334.

The surgery service had 14 beds. These were arranged as ten single ensuite rooms and four double rooms with ensuite, across 2 floors. At the time of our inspection the service was due to open a new Chantry ward with six extra ensuite beds.

There were two operating theatres and two anaesthetic rooms. There was a separate recovery area.

There was a dedicated outpatient's department.

Our inspection was short-term announced. We had previously inspected this service on 20-21 September 2022.

Outpatients is a small proportion of hospital activity. The main service provided by this hospital was surgery. Where arrangements were the same, we have reported findings in the surgery section.

How we carried out this inspection

The service had inpatient activity during our inspection. The inspection team:

• inspected and rated all five key questions

• visited the wards, operating theatres and outpatients department

• looked at the quality of the environment

• spoke with 16 members of clinical and non-clinical staff, including the senior management team for the service

Summary of this inspection

• spoke with four patients using the outpatient service

• reviewed ten health care records.

After our inspection, the inspection team:

• looked at a range of policies, procedures and other documents relating to the running of the service

• spoke remotely with four patients who used the surgery service

• spoke with the Registered Manager.

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.

Outstanding practice

The service had implemented a sustainability model and audit approved in February 2023 which helped improve patient outcomes and performance. For example, the clinical lead explained this had helped reduce their yearly number of complaints. Learning and themes from complaints formed part of the sustainability audit at least yearly. The hospital was implementing two initiatives under this audit; improved recruitment and streamlined surgery scheduling. Both initiatives had improvement analysis with priority areas outlined for sustaining them. The audit was also an added column on the hospital's risk register which risk owners must action within a year of the identified risk.

Areas for improvement

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

Action the service MUST take to improve:

Service wide

- The provider must ensure staff complete and sign the controlled drugs (CDs) register book correctly, omitting any inconsistencies or gaps so they can fully track CDs.

Action the service SHOULD take to improve:

- The provider should ensure theatre staff always fully document their surgical safety checks, even if they are not part of the world health organisation (WHO) checklist, and that audit monitoring captures any omissions.
- The provider should ensure all staff receive an appraisal and complete one-to-one supervision, especially bank staff.
- The provider should ensure all versions of their risk register include the top risks, with agreed actions and updates from review where appropriate.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Good	Inspected but not rated	Inspected but not rated	Good	Good	Good
Surgery	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Outpatients

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

Is the service safe?

Good

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

Mandatory training

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

See also under 'Surgery'.

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 also under 'Surgery'.

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.

See also under 'Surgery'.

Clinic rooms were visibly clean and had suitable furnishings which were visibly clean and well-maintained.

Housekeeping staff were responsible for cleaning all environmental areas. Cleaning schedules were comprehensive and demonstrated all areas were cleaned regularly.

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.

See also under 'Surgery'

Good

Outpatients

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.

See also under 'Surgery'.

The provider clarified all clinical procedures carried out in the consulting rooms were documented in the patient's record and on the electronic clinic booking system. This system provided oversight for managers.

The consulting rooms were equipped to carry out clinical assessments and minor procedures. These included, for example, pre-operative assessments, joint injections with steroids and minor skin lesion removal under local anaesthetic.

Follow-up physiotherapy sessions and consultations following surgical procedures were being carried out.

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 also under 'Surgery'.

During the inspection, we were not able to observe clinics for outpatients, this is because outpatient clinics form a small portion of the service.

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 also under 'Surgery'.

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

Medicines

The provider did not administer medicines to outpatients, only inpatients. Outpatients were given a private prescription, fulfilled by external pharmacies. We saw a filed copy of the private prescription.

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

See also under 'Surgery'.

Is the service effective?

Good

Outpatients

Inspected but not rated

We did not rate this domain.

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.

See also under ‘Surgery’.

Managers presented audit results to staff at departmental meetings. Audit results were displayed in the department.

Nutrition and hydration

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

There was a selection of refreshments available in the department.

Pain relief

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

See also under 'Surgery'.

Patient outcomes

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

See also under ‘Surgery’.

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

The provider had evidence of outpatient audit activities.

Competent staff

The service made sure staff were competent for their roles. Managers provided support and development. However, they did not always complete appraisals and supervision for substantive and bank staff’s work performance, so they met target.

See also under 'Surgery'.

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

See also under 'Surgery'.

Seven-day services

Outpatient services were not available seven days a week.

See also under 'Surgery'.

Health promotion

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

See also under 'Surgery'.

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 also under 'Surgery'.

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

Patients were risk assessed against specified admission criteria in the outpatient departments prior to being accepted into the service.

Is the service caring?

Inspected but not rated

We did not rate caring.

Compassionate care

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

See also under 'Surgery'.

There was no outpatient activity in the department during our inspection. However, patients we spoke with remotely told us they were satisfied with the way outpatient staff treated them

Emotional support

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

See also under 'Surgery'.

Good

Outpatients

We did not observe any outpatient activity during inspection. However, patients we spoke with remotely told us that they felt well supported.

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 also under 'Surgery'.

We did not observe any outpatient activity during inspection. However, patients we spoke with remotely told us they felt well supported.

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.

See also under 'Surgery'.

Managers planned and organised services, so they met the needs of the local population.

During interview the clinical lead told us consultants with practising privileges suggested the provision of new procedures for the hospital.

These proposals were discussed, and decisions made whether these were appropriate and safe.

Facilities and premises were appropriate.

The hospital was accessible throughout, with the department on the ground floor and accessible for people who used a wheelchair.

The car park provided free parking spaces with a level entry into the building.

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 also under 'Surgery'.

Good

Outpatients

There was no outpatient activity in the department during our inspection.

However, patients we spoke with remotely told us they were satisfied with the way outpatient staff treated them.

Access and flow

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

See also under 'Surgery'.

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 also under 'Surgery'.

Is the service well-led?

Good

Our rating of well-led improved. 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.

See also under 'Surgery'

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 also under 'Surgery'

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 also under 'Surgery'

Good

Outpatients

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 also under 'Surgery'

Management of risk, issues and performance

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

See also under 'Surgery'

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 also under 'Surgery'

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 also under 'Surgery'

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 also under 'Surgery'

Good

Surgery

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

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

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

On our last inspection we told hospital leads they must implement effective systems and processes to ensure all staff are compliant with mandatory training, including but not limited to, safeguarding vulnerable adults and children, to a level appropriate for their role.

On this inspection we found significant improvement. The service's training policy was no longer overdue review.

We reviewed the service's mandatory training compliance data. All substantive staff had completed their mandatory training as of 30 November 2022. All managers completed their mandatory training on 20 December 2022. The former head of clinical services (HCS) updated the training needs analysis (TNA) and policy on 31 October 2022, to reflect topics relevant to the setting.

Of 59 total staff employed by the service, only four had not completed their manual handling training.

Service leads had created a mandatory training compliance database to ensure easier oversight of staff completion. Compliance was now set at 80% to reflect an achievable target. Staff were not offered shifts and consultant's practicing privileges were suspended until they met this target. Leads recognised there may be instances where this was not possible, for example due to staff sickness or maternity leave.

Leads had created a colour-coordinated training matrix which identified staff who had not completed courses or expired certification. The service's human resources (HR) department audited staff's compliance with online training and their files. The training plan was a 12-month rolling programme from staff's start date. On the week of our inspection four staff were attending first aid training after hours.

Managers we spoke with told us consultants attended mandatory training at their employing NHS trust, and this was monitored through the appraisal process, GMC revalidation and at review of practising privileges.

However, as of February 2023 14 of the hospital's 51 active consultants had not achieved the 80% mandatory training compliance. Non-compliant consultants had all been contacted to request they promptly complete their outstanding modules and were given access to the provider's online training.

Resident medical officers (RMOs) were employed through a national agency with whom they completed mandatory training.

Safeguarding

The provider was assured all staff understood how to protect patients from abuse. They ensured all staff had training on how to recognise and report abuse.

All the service's theatre and ward staff were level 2 safeguarding compliant for adults and children. The safeguarding lead had delivered a training presentation session addressing all types of abuse and warning signs on a teambuilding day in March 2023.

The service's safeguarding policies were now in-date and had been rewritten. They had a safeguarding children policy even though they did not treat child patients as children still accompanied adult patients and visitors onsite.

Staff accessed training specific for their role. For example, the RMO received safeguarding training via their agency. The hospital's named safeguarding vulnerable adults and PREVENT lead was trained to level 3 in accordance with intercollegiate guidance and maintained professional contact with the local authority safeguarding lead. They told us improving access to a level 4 lead was their next stage. They discuss any safeguarding issues with staff face to face before completing incident or disclosure forms to avoid needless errors. Staff were encouraged to escalate any concerns if they were unsure. Staff we asked knew who their safeguarding lead was and felt comfortable raising concerns.

The provider was a small hospital, so the safeguarding lead provided supervision informally in accordance with NHS practice.

The provider's target for all safeguarding training was 80%. At the time of our follow up inspection all staff groups met target compliance for safeguarding training. All substantive staff had completed their safeguarding vulnerable adults training to level two or three.

However, five substantive staff were overdue their safeguarding children and young people level two or three. This was 17.2% of the total which meant compliance still met the provider target at 82.8%. All bank staff except two had completed their safeguarding adults, children and PREVENT training.

This meant staff had the appropriate skills and knowledge to protect patients from abuse and to recognise and report abuse.

The service confirmed they had no adult safeguarding referrals in the year before our inspection.

Staff we spoke with described the different types of abuse, including female genital mutilation (FGM). We asked staff specific questions about how they would recognise, for example, domestic abuse. They clearly described the warning signs and told us if they considered someone may be in immediate danger they would report to police without delay. This was in accordance with local policy.

Good

Surgery

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept equipment and the premises visibly clean.

The provider had infection prevention and control (IPC) and COVID-19 policies.

Staff received mandatory IPC and hand hygiene training. Overall staff compliance was 88.1% which met the provider target. Seven of 59 eligible staff's infection control – one year training was overdue at either level 2, 3 or 4. Of these seven staff, five were bank. This meant the provider was assured all staff understood and consistently demonstrated robust IPC practices.

At the time of our inspection three new starters were undertaking this IPC online training.

We reviewed the service's two latest IPC hand hygiene theatres audit from May 2023. Both scored 65 out of 65 and no actions were needed.

We reviewed the theatre suite's latest full high-degree clinical deep clean carried out on 17 January 2023. They undertook monthly deep cleans of all areas as per their schedule. Their next deep clean was booked for 17 June 2023.

Both ward and operating theatre staff conducted hand hygiene audits monthly. The senior management team carried out spot cleaning inspections.

All substantive staff had completed IPC training levels 1 and 2 as of December 2022. Bank staff were offered IPC online training in addition to their mandatory modules.

Housekeeping staff were responsible for cleaning all environmental areas. Housekeeping and clinical staff were trained to use green clean stickers to denote which areas or rooms were cleaned. We saw evidence of these in various areas. Since our last inspection staff had updated cleaning schedules to reflect correct recording, including steam cleaning every two months of fabric curtains and furnishings in reception and patient rooms. This was being done on our last inspection but not recorded by the housekeeping team. Staff now regularly audited the performance and recording of their cleaning schedules.

All areas had suitable furnishings which were clean and well-maintained. For example, vinyl covered floors and upholstered patient seating were impermeable and could be wiped clean.

We reviewed the service's latest IPC standard precautions theatre audit from May 2023. Their total score was 87 out of a possible 88 with only one required action for floors to be mopped.

Each area has specific cleaning needs taken into account. We saw each room or clinical area had a record displayed with evidence of cleaning. Cleaning of vents had been added to the cleaning schedule where applicable. Hospital leads had implemented weekly cleaning audits to ensure cleaning of all areas. Compliance was monitored as part of the cleaning audit.

Resuscitation trolleys in the wards and operating theatre were cleaned daily. Ward and theatre-based trolleys were checked by their respective teams. Two operating department practitioners (ODPs) checked the ward resuscitation equipment monthly as an extra check.

Good

Surgery

The resuscitation lead at the local NHS acute trust completed an independent audit on 31 January 2023. They found expired medication records, monthly checks, resuscitation trolleys and equipment were all compliant.

Nursing staff were responsible for cleaning all clinical equipment. This was cleaned effectively. No inappropriate items were stored in the nurses' store / clean utility room. The provider was assured all equipment stored was appropriately decontaminated and ready for use.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff in clinical uniform complied with arms 'bare below the elbows' policy, in accordance with national institute for health and care excellence (NICE) guidance. Patients we spoke with confirmed they saw staff washed their hands and used hand gel between patient interactions.

We observed public areas had posters and hand gel stations to promote COVID-19 awareness and hand hygiene.

Staff worked effectively to prevent, identify and treat surgical site infections (SSIs). For example, surgical patients were screened for healthcare acquired infections such as methicillin-resistant Staphylococcus aureus (MRSA) pre-operatively. Staff incorporated risk assessments into patient health records. The service's in-date SSI policy followed NICE guidance NG125. Quality reports we reviewed for 2022-2023 showed the service reported no SSIs.

Theatre environments were clean and fit for purpose. The two operating theatres had laminar airflow. Laminar airflow is used to separate volumes of air or prevent airborne contaminants from entering an area. Sterile services equipment, such as surgical instruments, was provided by the local NHS trust hospital under a service level agreement (SLA) and sterile supplies were stored safely.

At the time of our inspection the service were shortlisting to employ another full-time member of cleaning staff.

Environment and equipment

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

Premises access was via an automatic door and staff at reception had a clear line of sight to the entrance. The main hospital building was by internal, secured doors. Access to restricted areas such as administration and clinical storage, was controlled with digital key-pad locks. At the time of our inspection a swipe-in door system was being installed to be more IPC compliant. An SOP was being drafted about the front electric doors from reception into the hospital after someone pressed the emergency lock.

Fire exits and corridors were clear of obstructions. All fire extinguisher appliances we inspected were signposted and serviced within an appropriate timescale. The service had a fire procedure in place, and fire alarms were tested weekly. We saw the service's latest fire drill checklist, logbook and register dated 29 March 2023. They had met all the checklist requirements and staff had disseminated information. As a result, managers arranged fire marshall training to improve other staff member's knowledge.

On our last inspection in September 2022, we told the provider they must ensure all furnishings, including but not limited to fabric curtains are suitable for the purpose for which they are being used.

Good

Surgery

On this inspection we found significant improvement. The design of the environment followed national guidance. For example, disposable curtains were now installed in recovery, patient and consultation rooms. These were marked with expiry dates and changed every six months.

Since our last inspection staff had removed soft furnishings in reception. However, they had since been reinstated as the patients complained of the chairs being uncomfortable and quite deep. The service carried out patient experience surveys including questions about the reception area and furnishings.

We reviewed the service's latest environmental assessment audit from 13 March 2023. It found the reception area would benefit from higher chairs for orthopaedic patients awaiting hip or knee surgery to allow easier mobility from a seating position.

Staff consistently recorded safety checks of all specialist equipment.The theatres resuscitation trolley had a difficult airways trolley with more specialised equipment alongside in the event of a patient emergency. The hospital had wheelchairs in stock for patients but not in reception due to space constraints. Most consumable items we inspected were within expiry dates.

The service had enough suitable equipment to help them to safely care for patients. There were systems for recording the service and maintenance of equipment identified through a central asset register and equipment compliance stickers, which indicated the dates tests were due. Medical devices were serviced and maintained under an SLA with an external provider.

We inspected several pieces of equipment, which included defibrillators, suction machines, monitoring equipment, anaesthetic machines and intravenous pumps. All were serviced and maintained appropriately. The suction machine on the ward emergency resuscitation trolley now had a test sticker on it.

We reviewed the service's equipment post-maintenance report completed by engineering staff in April 2023. It found two items of unserviceable equipment which were being repaired.

Staff disposed of clinical waste safely. However, the quarterly waste management audit for March 2023 scored 75%. This was the lowest of the service's quality improvement audits for the period.

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.

All the service's resident medical officers (RMOs) were advanced life support (ALS) trained. The service's head of clinical services (HCS) was the designated resuscitation lead. The surgeon and anaesthetist were available on-call if patients needed to return to theatre. Theatre leads we asked understood how to respond to the deteriorating patient warning signs promptly as per their in-date rewritten policy.

On our last inspection SLAs we saw stated the contracts were to be reviewed annually and the documents we saw were dated as due review in 2020.

On this inspection all the service's SLAs had been reviewed and updated or were in the process of being done. For example, pathology and microbiology services for processing blood samples and screening swabs was provided by the local NHS trust under an SLA.

Good

Surgery

Staff used a nationally recognised NEWS2 tool to identify deteriorating patients and escalated them appropriately. The HCS held NEWS2 training and escalation for staff. At the time of our inspection, they had only been in post for three weeks. The service's escalation process for deteriorating patients followed NICE guidelines 2020 (MIB205). Staff recorded and scored all inpatient observations.

The service had a formal SLA with the local NHS trust, if emergency transfer to the NHS was required. The emergency transfer pathway was kept at the nurses' station for easy reference. There were two unplanned transfers to another hospital for treatment between May 2022 and April 2023.

Staff completed risk assessments for each patient using recognised tools. For example, pressure areas, moving and handling, malnutrition universal screening tool (MUST) and venous thromboembolism (VTE) risk assessments. The service had a designated VTE champion. The date of the service's last patient fall was in February 2022. Surgical patients were screened for healthcare acquired infections and risk assessments were incorporated into the patient's health record.

Staff knew about and dealt with any specific risk issues. For example, we saw 'stop before you block' prompt posters displayed in anaesthetic rooms and a management of sepsis flow chart on the ward. Staff completed an inpatient sepsis screening and action tool. The service followed the sepsis six pathway and adhered to the acutely ill patients in hospital NICE clinical guideline 50.

Consultants had 24-hour access to mental health liaison and specialist mental health support via direct referral, if concerned about a patient's mental health.

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

Managers held daily 9.15am comm-cell safety huddles which were documented, scanned and sent to all staff. Themes discussed included clinical workload, staffing and operational risks. These huddles helped staff remove any risks and put in place future preventive measures.

We observed and saw evidence staff completed all world health organisation (WHO) five steps to safer surgery checklist sections at the time of our inspection. However, theatre staff did not always fully document their safety checks.

The theatre team completed the time out pre-procedure. They asked the patient if they had any allergies before anaesthesia, then answered the specific checklist prompt: "Does the patient have a known allergy? Yes/no". The theatre nurse signed the first part for consent instead of ward staff. Patient marking was called out in theatres and on WHO checklists – the operating department practitioner (ODP) completed second checks and marked all theatre patients. The service began monitoring and recording their WHO checklist compliance in January 2023. At the time of our inspection compliance was 100%.

However, we found some safety check processes were left blank such as the surgeon's site marking and the allergy box on the ward drug chart. This meant theatre staff were not always fully documenting their safety checks. The service's 100% WHO checklist compliance was not capturing these omissions, as they were not part of the checklist. We raised this with the clinical and theatre leads who took immediate action to amend.

Immediately after our inspection, leads updated the WHO surgical safety checklist to include surgeon's signature for site marking (as a new section). This section was not part of the original WHO checklist and was an addition the provider was trialling. As this was the trial's first month, the provider had not yet done a compliance audit.

Good

Surgery

The hospital conducted observational and documentation audits of compliance with world health organisation (WHO) safer surgery checks. We reviewed the service's latest five steps to safe surgery audits from March, April and May 2023. March and April were fully compliant but May dropped two points as the anaesthetist was not present at debrief procedures as they had three other injector staff on shift. No actions were required, and auditor comments were favourable.

Theatre teams adhered to the WHO checklist with a full sign-in and time-out, where the patient was checked by the operating department practitioner (ODP). Staff checked and counted all equipment; the scrub practitioner and surgeon followed all IPC precautions and fully completed the theatre board.

Staff accommodated day case patients assessed as unfit for discharge on the ward overnight with an RMO on site. The service had an extended stay patient risk staffing plan. On the day of our inspection one inpatient who had a knee replacement felt a bit sick, so the surgeon changed their medications and reviewed them at midday.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, 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. At the time of our follow up inspection the service had 14 ward registered general nurses (RGNs) and three ward healthcare assistants (HCAs).

Managers did not use an acuity tool to calculate ward staffing requirements but planned for one registered nurse to four patients and occasionally one to six, depending on patient acuity. Patients we spoke with told us staff were available at all times.

The service had high rates of bank staff but used no agency staff. Since our last inspection in September 2022 the service had dismissed non-compliant bank staff. This meant staff whose mandatory training was not up to date or who had not worked a shift in the last six months. As a result, the service had increased their numbers of both bank and contracted staff.

The hospital's performance and quality dashboard up to March 2023 stated they had 62 employees: 27 contracted and 35 bank staff comprising 56% of the total. Bank staff were mostly long-term, familiar with the service and worked at the local NHS trust.

The hospital employed eight substantive registered nurses, three operating department personnel and four healthcare assistants. Managers we spoke with told us there were 27 bank contracted staff overall. 82.4% of the service's ODP staff were bank and 50% of the service's total theatre RGNs. This meant sometimes over 50% of theatre staff were external to the service.

The provider monitored employee turnover, absenteeism and staff satisfaction. At the time of our inspection the service had six vacancies in total, but only one per staff group and recruitment was ongoing. From March to May 2023 five staff had left the service and 13 were appointed. Of the five who left, three were bank staff who failed to complete mandatory training and two were contracted staff. This meant their turnover rate was 9%.

The service's MAC minutes for February 2023 noted they had appointed two preoperative assessment nurses to have pre-operative assessment clinics five days a week, along with two further nurses, one contracted and one bank.

Good

Surgery

The service had lost 22 working days to COVID-19 related sickness from March to May 2023.

The clinical services lead was a registered nurse who also worked clinically on the wards when required to support.

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

Medical staffing

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

The service had enough medical staff to keep patients safe. Their consultants/RMOs were self-employed. There were 3 locum RMOs who worked in rotation. The RMO was on site 24 hours a day when patients required overnight stay.

Theatre staff rotas we reviewed showed staffing met Association of Anaesthetists of Great Britain and Ireland, (AAGBI) and The Association for Perioperative Practice (AfPP) recommendations.

On the day of our inspection the theatre was fully staffed. The theatre team staffing allocation was two ODPs, two scrub and a recovery nurse. This meant they were very safe, with a similar process to NHS trusts where the recovery nurse escorted patients into theatre. A team of five was the service standard for all specialties. Leads told us their service target was to increase contracted ODPs and theatre RGNs.

Managers could access locums when they needed additional medical staff. For example, if the RMO became unwell.

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

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. Records, including medicine prescription charts were predominantly on paper.

We reviewed ten sets of patient paper records. Medical and nursing records were held securely in a single folder. They were detailed, with appropriate nursing risk assessments and individualised care plans. For example, in relation to pressure area care and moving and handling.

We reviewed the service's latest patient pathway audit from March 2023 which examined five sets of patient notes. The service achieved 100% compliance in all 15 expectations. An action plan was implemented with instructions given to department leads and completed by June 2023.

Staff had completed consent information in patient records we checked. We also observed good practice where staff printed the patient's name and identifiable information atop each sheet rather than using a sticker label.

We saw lockable records cabinets on the ward to ensure records were stored securely when in use. Records were scanned into an electronic system when patients were discharged. Archived paper records were stored in boxes in a file room with a key-pad lock.

The operating theatre register was completed comprehensively.

Medicines

The service used systems and processes to safely prescribe, administer and store medicines. However, staff on inspection did not always fully record and sign the controlled drugs register book correctly.

There were medicines management policies in place. Staff followed systems and processes to prescribe and administer medicines safely.

We reviewed the service's latest medicines management and controlled drugs audits actioned on 11 April 2023. Both fully met the criteria and scored the maximum total score. The action plan outlined no actions were needed but feedback noted no boxes on the front sheet to write the auditor's name or date. The auditor made two minor recommendations and the audit did not reveal any significant deficiencies.

There was a system in place to control and monitor the use of private prescription pads. Staff logged all these on a sheet with only one pad out at any one time. Private prescriptions were now in triplicate with patient, file and pad copies, so staff could track them easier. No staff were allowed to remove the pad from the ward area where the surgeon/RMO must complete the prescription.

Staff managed and stored medicines safely. Since our last inspection in September 2022 the provider had reviewed storage of intravenous fluids so batches were not mixed and stored according to best practice.

Staff recorded and monitored ambient room temperatures consistently, where medicines were stored, in accordance with the provider's policy. The provider was assured all medicines were stored in accordance with manufacturer's instructions.

Refrigerated medicines were stored in theatres. We reviewed monthly fridge temperature records were completed by staff for all previous months.

We saw controlled drugs (CDs) were stored securely in a designated cupboard. This fridge had a breakdown list of medicines and when they expired which staff checked regularly.

However, staff on inspection did not always complete the CD register book correctly. We found inconsistencies, gaps and no signatures in their completion of the supplied, administered and destroyed sections. There was also a discrepancy with how much and to where ketamine was discarded. We saw one medication related incident involving the total amount of a bottled CD not corresponding to the CD book. This meant the service could not always track CDs to ensure they were used appropriately and were not mislaid.

The theatre manager admitted their CD book was not always signed by theatre anaesthetists before they were needed elsewhere. The service also needed a new CD book as theirs was full and dog-eared. The service held no clinical staff days to check CDs. We address these issues with the theatre manager and clinical lead who resolved them promptly.

Post-inspection the service took immediate action to address these issues. For example, they ordered a new CD book. The head of clinical services emailed all the anaesthetists to remind them how to complete it correctly. Leads created a compliance document staff would check alongside the CD book for assurance. The service also planned to improve their CD audits by RAG rating the findings accordingly as part of their medicines management.

The service's previous CD register audits in January and March 2023 indicated 98% completion compliance.

Medicines were supplied by three external providers in pre-made packs to ensure contingency. The service had an agreed disposal process for both controlled drugs and other medicines which were returned to a local pharmacy.

We reviewed medication-related incidents from November 2022 to May 2023 and found two incidents concerning low stock. On 27 April 2023 the service did not have enough gentamycin to complete their joint list (AMR 190), despite being identified prior and escalated. Staff were reminded to inform management of low stock a week before levels became low. On 18 May 2023 the service had insufficient stocks of teicoplanin to proceed with their list . A delivery was due later that date and staff were reminded to order this every two weeks.

Staff could easily report medicines and healthcare products regulatory agency (MHRA) national patient safety drug alerts using a QR code system which took them directly to the reporting system.

Managers we spoke with explained the resident medical officer (RMO) reviewed (reconciled) patients' medicines on admission and provided specific advice to patients and carers about their medicines.

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

The service's adverse incident reporting policy was now in date and reviewed.

Staff we spoke with knew what incidents to report and how to report them. They gave specific examples of incidents and near misses they had reported, in line with the service's policy. There were no serious patient harm incidents reported in the 12 months before our inspection; incidents were mostly regarding administration errors. Learning was shared via a staff newsletter.

The provider also reported serious incidents attributed to third party providers (not Kinvara Private Hospital incidents) and applied the learning to improve safety at the service. Staff teams discussed human factors on a training week to learn lessons from never events at local acute hospital trusts.

We reviewed the service's incidents from the last six months, from November 2022 to May 2023. They had four low and three moderate level of harm incidents; all the rest were no harm. We saw examples of shared learning from all these incidents. The week of our inspection the service had an environmental incident about a male changing rooms leak. This had been localised and fixed with no patient or clinical impact.

Staff understood the duty of candour (DoC). The DoC policy was specific and relevant to the services provided. The MD had rewritten a DoC policy and summarised for staff who did not have time to review. We saw the clinical lead had recently sent a DoC letter to a patient who sustained a friction burn on their neck.

The service's last never event was in theatres in 2021 involving a retained object in gynaecology. A GP device was now checked. An RCA was completed with learning disseminated to the team through monthly meetings.

Theatre's top three common incident themes were patient cancellation in theatres, wrong date of birth and no ted stockings.

Each department had its own business continuity plan.

Good

Surgery

There was a system in place which ensured actions from patient safety alerts were implemented and monitored.

We saw the service's evidence of the latest back up emergency generators test. This was a copy of their preventive maintenance visit report from October 2022. This recommended during the next service the coolant would need to be checked as some discolouration was noted.

Is the service effective?

Good

Our rating of effective improved. 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. For example, of 42 policies we reviewed, none had exceeded the review date. This meant we were assured staff had access to policies that reflected current best practice, national guidance and local arrangements.

Senior and clinical leaders had completed a programme of policy review in December 2022.

Managers and staff we asked told us there was a full audit schedule for the year, to check staff followed policies and guidance. The service undertook regular audits of their resus trolley checks, infection prevention control (IPC), cleaning performance and recording, expired drugs check, and private prescriptions management. Managers explained audit results were presented to staff at departmental meetings.

We reviewed the service's audit schedules for 2023 and 2024. Managers were halfway through the former which consisted of 33 audits completed either monthly, quarterly, yearly or bi-annually. Upon completion, department leads were responsible for completing action plans where relevant.

Staff we spoke with could articulate results of recent audit activities or changes made as the result of recent audits.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs. 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. A choice of ready-meals, including for example, vegetarian, vegan, and gluten-free options was offered to patients and these were reheated in the ward kitchen.

The hospital was rated five out of five for food hygiene compliance.

Mealtimes were specified but flexible according to patient needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We saw certification that two staff members had completed their nutrition and hydration level 2 and 3 training as part of their health and social care diplomas in May 2023.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff we spoke with explained patients were fasted for 6 hours prior to surgery and could drink clear fluids up to 2 hours prior to surgery.

All patients we spoke with were satisfied with the quality of food and drinks provided. Staff asked patients to complete a food satisfaction questionnaire as part of their feedback survey. This outlined their preferences, dietary needs and any improvements they wished to make. We saw an outcome report from ten patient questionnaires, none of whom suggested any improvements.

We reviewed the service's nutrition and hydration audit from May 2023 which noted no issues or actions for improvement.

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. The service completed quarterly pain management audits. At the time of our inspection the latest audit for May 2023 was complete and would next be reviewed in October 2023. Senior management team (SMT) members prepared and discussed actions plans at their meetings which included key information.

Patients we asked told us they received pain relief soon after requesting it.

Patient outcomes

Staff consistently monitored the effectiveness of care and treatment.

The service participated in relevant national clinical audits. For example, they submitted data to the orthopaedics national joint registry (NJR) and NHS digital breast and cosmetic implant registry. Leads had contacted or applied to join others including the getting it right first time (GIRFT) orthopaedic audit.

We reviewed the latest available data from the NJR for the ten-year period August 2012 to August 2022. Hips and knee patient records were analysed. The submitted data showed national averages within the expected range of compliance.

The service monitored their mortality, infection and readmission rates. Their mortality rate was zero up to May 2023 and within the national average for revision surgery.

We reviewed the service's latest performance and quality dashboard from January to March 2023. Their three highest day case and inpatient surgery specialties were gynaecology, orthopaedics and general surgery.

The provider did not collect Patient Reported Outcomes Measures (PROMs) programme data, which measures patient improvement following surgery. The registered manager told us they would consider collecting this data in future.

The provider had submitted data to the private healthcare information network (PHIN) since November 2021. This included information on unplanned transfers, unplanned returns to theatre, unplanned readmissions within 31 days, infections rates, mortalities, patient satisfaction and the number of patients seen. PHIN ensures robust information is received about private healthcare to improve quality data and transparency. The hospital was not an outlier.

Good

Surgery

We reviewed the service's sustainability model and audit approved in February 2023. This consisted of ten factors relating to staff, process and organisational issues that helped staff to sustain change in healthcare. The hospital was implementing two initiatives; improved recruitment and streamlined surgery scheduling. Both initiatives had improvement analysis with priority areas outlined for sustaining them. This was next due for review in August 2023.

Competent staff

The service ensured all staff were competent for their roles. Managers provided support and development. Bank staff still supplied nearly half of the workforce.

Managers gave all new staff a full induction tailored to their role before they started work. All nurses and other new starters completed a competency programme during probation. We reviewed these competency templates which were all specific and relevant to the services provided.

On our last inspection we told hospital leads they must ensure systems and processes are in place to ensure staff are suitably qualified, competent, skilled and experienced. We also told the provider they must ensure all staff, including but not limited to bank staff receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out their duties.

On this inspection we found significant improvement.

All new starters had the following checks: disclosure barring service (DBS), two references, CV, mandatory training, evidence of registration for example with the health and care professions council (HCPC), general medical council (GMC) or nursing and midwifery council (NMC), and immunisation history. Consultant staff had been upgraded to enhanced DBS checks. Staff who did not meet mandatory training compliance were managed appropriately, with discussions recorded.

Compliance checklists were added to all staff files and submitted documents were checked by the human resources (HR) lead and hospital director. We reviewed nine staff employee files, and all had evidence of the above compliance.

Managers had started staff appraisals, supervisions and clinical supervisions. At the time of our inspection all substantive staff (except for one on maternity leave) had had an appraisal in the last three months. Operating theatre staff in their probationary period who did not yet need an appraisal still had their monthly, quarterly and six monthly reviews.

There was an appraisal system in place to monitor and support substantive staff's performance. Leads confirmed bank staff appraisals were completed yearly or after 20 shifts. Contracted staff had regular one-to-one meetings fortnightly and annual appraisals. All staff competencies were completed within 12 months and reviewed annually.

However, as of May 2023 of the 39 total contracted and bank staff, 18 had no appraisal completed. This was an overall compliance of 53.8%. The provider did not have an appraisal target. 12 of these 18 staff were bank who had completed 20 shifts, although an appraisal system was now in place for these staff. As of May 2023, 30 of 39 contract and bank staff had no one-to-one supervision completed since their last appraisal. However, all staff had completed or were due to complete their competencies.

Post inspection service leads clarified not all staff were eligible for appraisal if they were new starters or had not completed their minimum number of shifts. We saw evidence only three or four staff were overdue their appraisal, making overall compliance over 80%.

Good

Surgery

On our last inspection in September 2022, managers explained monitoring of bank staff performance had been through informal discussions and was not documented. This repeat issue meant we could still not be assured all bank staff poor performance was identified promptly, and bank staff were supported to improve.

On the day of our inspection staff were reminded to bring their learning and development plans to their one-to-ones.

Managers we spoke with told us they supported substantive nursing staff through regular face-to-face meetings, as well as regularly one-to-ones and appraisals. Nurses had a formal programme of clinical supervision in place where this information fed into their training schedule.

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 worked across health care disciplines and with other agencies when required to care for patients. For example, if imaging services were required, the provider requested a radiographer from an agency or local NHS trust bank.

We observed a theatre team brief which all the team including a RMO and anaesthetist attended. The RMO was present with a view to understand the ward care post-theatre transfer. Staff discussed the patients on that half day's list and communicated well. The list was reprinted in a different colour if there were any patient changes.

However, the briefing document had no patient identifiable information, just numbers. The theatre list did have this information, so staff had to cross-reference.

We observed a comm-cell meeting. Staff shared information and updates on a social messaging group.

Seven-day services

Key services were not available seven days a week to support timely patient care.

The hospital was operational on weekdays only. Consultants led daily ward rounds on the wards.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Pharmacy supplies services were provided by service level agreement (SLA) with another provider. The ward held a small stock of over labelled medicines for patients to take home if required out of hours, and these were dispensed and checked by ward staff and RMO.

Health promotion

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

The service had relevant information promoting healthy lifestyles at reception such as smoking cessation.

Staff assessed each patient's health as part of their pre-operative assessment and provided support for any individual needs to live a healthier lifestyle.

Good

Surgery

Staff provided procedure-specific information leaflets such as lipoedema support. The service was an evidence-based specialist provider of this sub-specialty with funding from a local hospice. This facilitated informed consent and enhanced patient recovery by providing better understanding of what to expect and their role in their own recovery. Patients we spoke with confirmed they received useful verbal and written information prior to admission.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. The hospital consent policy described consent as a two-stage process.

Staff recorded consent in the patients' records. Patients we spoke with told us they were provided with sufficient verbal and written information, to enable them to give informed consent.

The service audited their consent documentation against the consent policy. We reviewed the latest audit from May 2023 which identified no issues.

The service had a mental capacity act and deprivation of liberties policy in place.

At the time of our inspection staff had documented no patients as having fluctuating capacity. They explained their previous medical history and eligibility criteria flagged any patients who may need a mental capacity assessment before being suitable to be referred.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. For example, the provider had a procedure in place to support surgeons in their assessment of patients and identification of when a referral to psychological service was required, for patients that request cosmetic surgery. This was in accordance with NICE guidance.

Staff we spoke with explained patients were individually risk assessed against specified admission criteria and the hospital rarely had patients subject to Deprivation of Liberties Orders (DoLS).

Is the service caring?

Good

We did not previously rate caring. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness and took account of their individual needs.

Patients we spoke with told us staff were discreet and responsive and said they were treated well and with kindness. We also observed positive feedback from patients in thank you cards displayed.

Good

Surgery

On our last inspection in September 2022, we told the provider they must assess the use of closed-circuit television (CCTV) cameras in all patient-accessible areas to ensure its use does not unnecessarily compromise patient's privacy and dignity.

On this inspection staff had considered patient's privacy and dignity by disabling any cameras in unnecessary areas. Managers had put actions in place to protect patient's privacy and dignity. For example, cameras were now disabled from the operating theatre corridor angled to theatre two's entrance. They filmed footage of anyone accessing the CD room for security purposes only. Service leads had performed a risk assessment for the remaining cameras to assess if patients' privacy and dignity would be compromised. Patients told us staff maintained and considered their privacy and dignity at all times. For example, staff pulled curtains closed in between patient cubicles and accompanied post-operative patients to the bathroom and waited away from the door in case they needed help.

The clinical lead had also updated their privacy and dignity policy to include CCTV management and incorporated which staff personnel could view the video footage; the RM and chief executive officer (CEO) only. The policy clarified the process by which footage could be accessed and viewed, how long the footage would be stored, and an annual audit to ensure policy compliance. Patients were told in their welcome letter and all correspondence CCTV security cameras were in operation in patient accessible or transit areas for the purpose of safety and security.

Emotional support

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

Patients told us staff gave them emotional support. For example, one patient diagnosed with post-traumatic stress disorder (PTSD) was supported with their anxiety when crying and prescribed appropriate anxiety-allieviating medication.

The reception area played calming music and patients could request a chaperone as per the service's in-date chaperone policy.

Visiting times were between 6pm and 8pm but could be flexible according to patient wishes.

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.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. For example, we saw patient survey results for quarter 1 of 2023 and testimonial feedback on the website showed consistently high patient satisfaction results.

We saw the service's quarterly performance and quality dashboard from January to March 2023. This showed from 34 responses, 94% of respondents were extremely likely to recommend the service to their friends and family.

Staff involved patients in decisions about their care and treatment. For example, patients told us they felt fully informed about their treatment plans and discharge arrangements at all stages. One patient was given a choice of catheter after discussing all potential pros and cons of insertion with staff.

Good

Surgery

Staff we spoke with gave us examples of how they used patient feedback to improve daily practice. For example, staff increased vegetarian and vegan meal choices and were installing a new roadside sign to make locating the premises easier for patients and visitors.

The service received a five-star review on a search engine website the day before our inspection. Leads were encouraged to share this feedback with individual staff members.

Is the service responsive?

Good

Our rating of responsive improved. 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 provider promoted a positive working relationship with other health providers in the area. For example, a range of services were available for NHS patients where commissioners had identified capacity shortfalls.

Facilities and premises were appropriate for the services being delivered.

The hospital car park provided free parking spaces.

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.

The service had an in-date equality, diversity and inclusion policy.

Staff we spoke with told us how they made adjustments for patients who were particularly anxious due to phobias. For example, they ensured patients were given extra appointment time and put first on the theatre list to minimise distress.

Staff gave examples of how they supported patients living with learning disabilities by ensuring their carer was present to meet them from theatre after surgery.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff had been trained to use a regional interpretation service. Pre-assessment staff identified individual needs such as hearing, sight or language difficulties or disabilities. Translation services were available by prior arrangement, for patients where English was not their first language, and the contact number was displayed on the wards.

Good

Surgery

Patients were given a choice of food and drink to meet their cultural and religious preferences. Since our last inspection in September 2022 staff had installed patient boards above beds in all en-suite rooms. This helped staff meet patient's individual needs, for example with three categories of mobility assessment. Patients told us nurses asked their preferred name and anything they could do to make the patient's stay more comfortable.

Wards and departments were accessible for patients with limited mobility and people who used a wheelchair. Toilet facilities were available throughout the hospital for patients, carers and relatives including those living with a disability.

Patients were provided with printed information regarding risks and benefits of surgery and could review this before their procedure.

Access and flow

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

The hospital was operational Monday to Friday 7.30am to 5pm for day cases and until 8pm for afternoon day cases. The hospital remained operational overnight if accommodating inpatients. Overnight occupancy was usually fewer than eight patients and unplanned overnight patients were very rare.

The service had 13 did not attend (DNA) appointments from January to March 2023. This averaged just over four per month which was a small proportion of their overall activity.

The service's latest number of cancelled day surgery operations due to patients being considered inappropriate at their pre-operative assessment was three in the two weeks before our inspection. Two of these patient cancellations were due to bicarbonate results and one was due to new diabetic drugs.

Cancellation rates for non-clinical reasons such as list over-running, equipment issues or short notice consultant sickness, were low. The service's total number of elective cancellations for April 2023 was 62. Of these two were due to a lack of equipment as the clinical reason. For patients cancelled on the same day, the patient was informed by the consultant, anaesthetist or RMO and rebooked if possible. For patients cancelled at pre-operative assessment, the pre-operative nurse informed the patient or relevant third party. If the patient self-cancelled, they were removed from the theatre list and the relevant staff, and third parties were informed. Cancelled patients were rebooked as soon as possible.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service tracked their planned inpatient's length of stay. This helped them identify opportunities for efficiency improvements.

Managers and staff worked to ensure they started discharge planning as early as possible, at pre-assessment. Staff we spoke with explained medicines to take home were prescribed and dispensed from the ward to facilitate prompt discharge.

Learning from complaints and concerns

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

Patients we spoke with told us they knew how to complain or raise concerns.

Good

Surgery

Service staff underwent complaints analysis to implement changes and learning points. Learning and themes from complaints formed part of the service's sustainability audit at least yearly. This ensured complaints were handled correctly as per their key performance indicators such as an acknowledgement to the complainant within three working days, the total time taken to resolve and if a root cause analysis was conducted.

At the time of our inspection the service's last complaint was from 9 February 2023 about the long fasting time. This had been closed at stage one. The clinical lead explained their sustainability audit had helped reduce their yearly number of complaints.

Staff we spoke with understood the policy on complaints and knew how to handle them. The in-date complaints policy was reviewed, rewritten and specific to the service.

The service received few complaints. At the time of our inspection the service had not received a complaint for 94 days. Managers investigated complaints and identified themes. Governance meeting minutes reported the main themes of complaints were medical care, satisfaction with outcome, and cosmetic appearance. We reviewed the last three complaints received by the service from February 2023 and April 2022; one was clinical and two non-clinical.

Managers responded promptly to complaints. The complaint response letters we reviewed were open and honest, and offered compensation where there were less satisfactory patient outcomes.

The service had an independent adjudication service as part of their complaints process; this was reflected in their policy. Patients were given this policy as soon as they complained for clarity of the process and timeline. The service gave themselves 20 working days to complete a full investigation response.

Managers shared feedback from complaints with staff and learning was used to improve the service. A learning record was included with all complaint logs outlining learning points and changes to implement.

Staff could give examples of how they used patient feedback to improve daily practice. For example, the provider introduced a wider choice of meals as a result of the 'you said – we did' initiative.

Since our last inspection in September 2022 the team decided a quarterly rather than yearly patient survey would be more beneficial for patients and help implement change quicker. Staff tried to ensure patients completed surveys post-operatively or at their follow up appointments as some were referred from external providers so did not return. 2023 survey results were very positive, with most questions scoring 100%. For example, for question 3 all patients agreed the staff were courteous, helpful and punctual.

Is the service well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. Although some senior leaders were recently appointed, the leadership team was well embedded. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

Good

Surgery

Since our last inspection in September 2022 senior management team members had made concerted efforts to be more visible and approachable. For example, their photos and organisational (leadership) structure were displayed in the main reception and clinical areas. This was now clear, specific and relevant to the services provided.

The service had appointed a new head of clinical services (HCS) and facilities manager. The HCS was highly experienced and supported the hospital manager in facilitating good governance.

Housekeeping staff were now directly managed by the facilities manager for daily performance monitoring. This ensured a clear line of reporting and accountability.

The hospital director held daily communication cell meetings with their heads of department to facilitate better communication and respond faster to issues. Managers discussed any issues at SMT meetings every two weeks such as their sustainability audit performance.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders.

Leads confirmed they now had a formalised vision and strategy for what the provider wanted to achieve and workable plans to turn it into action.

The hospital's mission statement was 'to provide compassionate, high-quality and personalised healthcare to our community'. Their six values were purpose, communication, feedback, teamwork, diversity and engagement.

Hospital leads had consulted with staff to request their views on what they felt the hospital's values should be before formally publishing their mission statement, values and four behaviours developed in an open forum.

A hospital newsletter publication had restarted from March 2023. This informed all staff of the service's strategy and action plan progress. Leads also sought staff feedback on the effectiveness of their hospital newsletter in delivering their values and strategy.

Culture

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

Staff and clinicians we spoke with told us they were proud of the organisation as a place to work and spoke highly of the teamwork.

Mandatory training compliance for equality, diversity and human rights training was 98.3%. Only one bank staff member was overdue or had not provided evidence of training.

The service had in-date, reviewed and rewritten policies for whistleblowing and abusive behaviour. Staff were encouraged to speak up and raise concerns directly with their managers or to the named freedom to speak up guardian. A few staff had completed this training. We heard the guardian received a low volume of issues as supervision was informally ongoing as a smaller family-run service. Any good or bad comments and feedback were shared in the hospital newsletter.

Good

Surgery

Patients we spoke with told us they felt confident and comfortable to raise any concerns with staff.

All the staff team attended a training week in March 2023 where each day had a different focus to address CQC's five key questions. On day two one staff nurse led a talk on safer patient care and human factors. The teams reflected on their practices and discussed how important it was to raise issues. This included a long discussion about culture which they felt is a huge part of human factors and letting staff feel they can raise issues. Staff frequently discussed human factors in their departments and would review this training again in quarter 3.

Governance

Leaders operated effective governance processes, throughout the service. **They had regular opportunities to meet, discuss and learn from the performance of the service**.

The service's key governance roles were displayed in the main reception area. We saw the hospital's organisational structure. Five heads of department reported to the clinical lead and CEO as well as the consultant body.

At the time of our inspection the service's governance system was under review. Their meeting structure consisted of daily comms cell, monthly clinical governance, and medical advisory committee (MAC) meetings.

Since our last inspection the clinical lead had rewritten all the service's policies and procedures, so they were specific, relevant to the location and reviewed in accordance with dates. They reviewed all policies to address any lack of robust governance systems and processes for assurance of quality care and services. They were then updated, digitised and made available as version controlled documents on the staff intranet. They told us three policies in particular received priority: namely IPC, medicines management, and privacy and dignity. Leads planned to convert all policies to become digital by 1 June 2023.

At the time of our inspection the statement of purpose which described the provider's services was being reviewed.

A staff files audit was conducted quarterly to assess compliance with their practicing privileges policy. All staff wishing to work or gain practicing privileges at the hospital, including consultants were required to submit all their documents online through a website portal. This ensured documents were correctly submitted. The service audited their consultant's compliance with practicing privileges.

The service's process to manage consultant practising privileges was now robust and all consultants practiced with formal Medical Advisory Committee (MAC) approval. The service held monthly MAC meetings from January to March 2023. At the time of our inspection these meetings had reverted to quarterly as attendees had achieved all they needed to. All general surgeons were invited to join the MAC as representatives along with all active specialties, and in March 2023 two had confirmed membership. The committee considered potential conflicts of interest and took measures to prevent these. For example, any decisions made by the registered manager would be ratified by the MAC

We reviewed the last four sets of MAC meeting minutes. These highlighted any actions in bold. Actions from the March 2023 minutes included a buddy system for consultants to provide cover arrangements, and first surgical assistant's indemnity insurance for private patients.

At the time of our inspection all active consultants' practising privileges were in-date and being reviewed. Service leads asked surgeons to send their logbooks to ensure their work at the hospital reflected that elsewhere. MAC meeting minutes we saw evidenced reviews of named consultant's practising privileges. For example, the February 2023 minutes included a practicing privileges update for their 51 active consultants.

The service also held regular diarised, fortnightly senior management team (SMT) meetings. The service's staff engagement meetings were sometimes combined with training days as an open forum.

This meant we were now assured managers and staff had regular opportunities to meet, discuss governance and learn from the performance of the service.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified issues and actions for risks to reduce their impact. The service had plans to cope with unexpected events. However, leads could not evidence they escalated or included all top risks for review on the risk register.

On our last inspection we told hospital leads they must ensure all identified risks affecting the service in line with local policy are escalated to the risk register.

On this inspection we found significant improvement.

The hospital risk management and major incident policies were no longer overdue review. They were in-date, had been rewritten and reviewed.

There was now an approved business continuity plan in place. We reviewed this plan which was specific and relevant to the services provided.

The service had a risk register in place with all significant risks included on the risk register. For example, risk associated with under-indemnified consultants, lack of a business continuity plan, lack of robust governance systems and processes, and lack of oversight of bank staff performance. The service's risk register was updated with particular reference to practicing privileges, mandatory training, appraisals and to ensure staff were suitably trained and qualified.

The risk register was available on the management staff portal. The register was more robust with in-depth learning and feedback. The clinical lead showed us the register which included their sustainability audit as an added column with a due date 12 months after the risks were identified. The significant risk factors we identified on our last inspection had been addressed with controls in place. All risks were red, amber and green (RAG) rated, scored and reviewed accordingly; urgently, monthly or six monthly.

We sat with the hospital director and reviewed their top three risks. Staffing levels, including bank staff was a risk scored 12 out of a possible 25 due to leads recognising the importance of competencies until they were all appraised. Bank staff training provision was also scored 12, and a pharmacy supply risk was upgraded by the hospital director to 12 as a business critical risk.

Another of the service's risks was around practicing privileges documentation not capturing all permanent information. This risk was scored eight and reviewed monthly. Leads had implemented several changes to mitigate. For example, after a year any consultants had their privileges revoked. The clinical lead had written a new policy and created a compliance database for practicing privileges. This helped ensure all consultants met the requirements.

However, the provider sent us the service's latest risk register post-inspection with the top three risks missing we had discussed in person with the clinical lead. This register's top two risks were around practicing privileges and business continuity plan updates, both scoring nine out of a possible 25. This meant we were unsure when or how the other top risks were monitored or reviewed. We could not be assured all identified risks affecting the service were escalated to the risk register.

As the service dealt with third party providers, patient lists could be cancelled last minute and beyond their control. Leads had regular meetings and felt they had better collaboration with these providers than during our last inspection.

The provider had a dedicated finance manager who provided detailed information on revenue, operating costs and resource utilisation.

Information Management

The service collected data and analysed it. Staff could always find the data they needed, in easily accessible formats. The information systems were secure. Data or notifications were submitted to external organisations as required.

The provider assessed the effective utilisation of healthcare technologies, such as electronic patient records, (EPR), E-clinic and data analytics.

The service had an in-date information management policy.

At the time of our inspection staff compliance with information governance training was 95%. Only three of 59 staff were overdue, two of which were bank staff.

Patient health care records and medicine prescription charts were on paper, which were scanned on to an electronic system following discharge. The paper records were then archived alphabetically in a locked room. The registered manager told us these would be kept on site for a minimum of six years.

We observed good adherence to the principles of information governance. For example, in reception and administration areas, computer screens were password protected and closed when unattended.

Since our last inspection in September 2022 the service's closed-circuit television (CCTV) policy had been reviewed and rewritten by the clinical lead. This showed on a plan where the cameras were located. Staff had considered patient's privacy and dignity by disabling any cameras in unnecessary areas.

Discharge letters and communications to GPs were sent by consultant's secretaries by post or electronically.

Engagement

Leaders and staff actively and openly engaged with patients, staff, and local organisations to plan and manage services.

The hospital's website provided a wide range of information about the clinical services available.

Staff we spoke with told us managers engaged with them and were very supportive.

Good

Surgery

We saw examples of the service's public and patient engagement. For example, they held a menopause matters webinar with a specialist doctor, a lipoedema evening and webinar with Mr Karri and various charity events.

Managers were visible in the departments, which gave patients and visitors opportunities to express their views and opinions face to face.

Managers used the morning comm-cell meetings to share information and discuss the day's business.

Staff received a newsletter which contained, for example, business news, staff service recognition (employee of the month), mental health awareness information, learning from the staff survey, and policy awareness.

The provider also promoted staff wellbeing and the hospital had a mental health first aider, to provide support and guidance to colleagues. Staff could nominate colleagues for a shining star award each month.

We reviewed a 'you said…we did' poster with examples of how managers respond to staff feedback. A water cooler was installed on the week of our inspection to save ward staff walking to reception.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service provided examples of innovative practice to improve service and experience. We saw the service's innovations for 2023. Leads were implementing enhanced recovery pathways for joint replacement. They were also the only hospital in the UK to use an electronic point of sale (EPOS Now) cloud-based software to monitor their inventory levels. This provider specialises in EPOS systems and integrated payment solutions.

They had partnered with a fingerprint blood test provider to offer patients choice for home blood testing.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff on inspection did not always fully complete and sign the controlled drugs (CDs) register book correctly, omitting any inconsistencies or gaps so they can fully track CDs.