The Hospital Of St John And St Elizabeth

Hospital of St John & St Elizabeth

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

- Staff understood how to protect patients from abuse and managed safety well. The service controlled infection risk well. Staff tried to minimise risks to patients and acted on them. They managed medicines well. The service managed safety incidents well. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- 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 all staff were committed to improving services continually.

However:

- Some staff across the service did not complete their mandatory training. Within the hospice community team, only 76% of staff has completed life support training at the time of inspection. Porters within the hospital were given some end of life care (EOLC) training at their induction but only 64% had completed this. Following our first site inspection, the hospital began to deliver further EOLC tailored training to the porters, which 81% of these staff had completed by the time of the second site visit. The remaining staff were booked to complete this training.
- Some minor issues were found with infection prevention control (IPC) within urgent care. There was no handwashing poster displayed by the handwashing sink in the treatment room. No record of cleaning toys was kept. The hospital policy for reception staff dress code within the urgent care centre was not in line with the best infection prevention control practice, as staff were not required to be 'bare below the elbow' (BBE).
- In the hospice day centre and basement areas, there were some environmental issues such as lack of air conditioning and poor wheelchair access. However, the hospital was aware of these issues and were in the process of redesigning the areas with staff input, with plans and concept designs being drawn up.
- In urgent care, we found some emergency medicines in the resuscitation trolleys were stored incorrectly and did not match the daily stock list. However, the service rectified this immediately on the day of inspection.
- Not all staff in surgical services completed and updated risk assessments accurately.
- In the end of life service, staff did not always receive feedback from investigation of incidents. Although staff were aware of incidents that had occurred, we were not always assured that planned actions or recommendations from incident investigations were taken forward. Action plans as a result of incidents were not always clear and responsible people were not always assigned to ensure that learning was fully implemented across the service.
- There was no safeguarding flagging system in the electronic health records to identify adult patients who may be vulnerable. Senior leaders told us that they were working with the IT software team to incorporate this.

Summary of findings

- There had been a 43% increase in patient contacts to the social work team in the last year due to pressures from the pandemic, leaving the team feeling stretched. There was a feeling amongst staff we spoke with that whilst the team offered excellent support, they perhaps they did not have the capacity to support everyone. Senior staff told us that they were aware of the workload challenges of the team and another post focusing specifically on welfare benefits had been agreed.
- There were medical vacancies within the end of life care service. This reflected a national shortage of palliative care consultants, and the service had been trying to recruit into these vacancies for some time. The provider had identified insufficient consultant cover as a risk and was working with a local NHS trust to develop a joint consultant post to attract a greater number of applicants.
- The hospice community and hospice inpatient unit teams used different patient record systems, and IT systems and records across the hospital were not integrated. This led to some duplication, frustration and delays. Electronic patient records in urgent care were not integrated. The hospital was aware of these issues and were working to integrate systems and ultimately the creation of a hospital-wide patient record system.
- Staff monitored the effectiveness of some care and treatment, but not all audits were carried out in a systematic and meaningful way. They used the findings to make some improvements but action plans were not always clear.
- There was no separate multifaith room, although the service informed us that alternative quiet rooms were available on request. There were also no prayer mats available for patients.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Urgent and emergency services	Good 	This is the first time we rated this service. 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 collected safety information and used it to improve the service. • Staff provided good care and treatment and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, supported them to make decisions about their care, and had access to good information. • Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs and helped them understand their conditions. They provided emotional support to patients. • 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 to plan and manage services and all staff were committed to improving services continually. However:

Summary of findings

- There was no handwashing poster displayed by the handwashing sink in the treatment room.
- Staff told us that the box and toys in the treatment room for children were cleaned daily and after every use, but no record of cleaning of this was kept. We also found a picture book and a squeezable ball within the toy box, which would be difficult to disinfect. Staff were working to rectify this following this inspection and introduced a cleaning checklist.
- The hospital policy for reception staff dress code within the urgent care centre was not in line with the best infection prevention control practice, as staff were not required to be 'bare below the elbow' (BBE).
- There was no safeguarding flagging system in the electronic health records to identify adult patients who may be vulnerable. Senior leaders told us that they were working with the IT software team to incorporate this.
- We found some emergency medicines in the resuscitation trolleys were stored incorrectly and did not match the daily stock list. However, the service rectified this immediately on the day of inspection.
- Electronic patient records were not integrated with the hospital wide health record system.

Surgery

Good 

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

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff tried to minimise risks to patients, and kept care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them

Summary of findings

on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- 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 all staff were committed to improving services continually.

However:

- Some staff across the service did not complete their mandatory training.
- Not all staff completed and updated risk assessments accurately.
- Staff did not always receive feedback from investigation of incidents.

End of life care

Good

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

- 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 and acted on them. They managed medicines well. The service managed safety incidents well. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made

Summary of findings

sure staff were competent. Staff worked well together for the benefit of patients and supported them to make decisions about their care. Key services were available seven days a week.

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However:

- Porters within the hospital were given some end of life care (EOLC) training at their induction but only 64% had completed this. Following our first site inspection, the hospital began to deliver further EOLC tailored training to the porters, which 81% of these staff had completed by the time of the second site visit. The remaining staff were booked to complete this training.
- In the day centre and basement areas, there were some environmental issues such as lack of air conditioning and poor wheelchair access. However, the hospital was aware of these issues and were in the process of redesigning the areas with staff input, with plans and concept designs being drawn up.
- Life support training compliance was 100% for inpatient unit staff, but only 76% for community staff at the time of our inspection. The provider explained this was due to lack of face-to-face training sessions during the COVID-19 pandemic and training was booked for these staff.

Summary of findings

- There had been a 43% increase in patient contacts to the social work team in the last year due to pressures from the pandemic, leaving the team feeling stretched. There was a feeling amongst staff we spoke with that whilst the team offered excellent support, they perhaps they did not have the capacity to support everyone. Senior staff told us that they were aware of the workload challenges of the team and another post focusing specifically on welfare benefits had been agreed.
- There were medical vacancies within the service. This reflected a national shortage of palliative care consultants, and the service had been trying to recruit into these vacancies for some time. The provider had identified insufficient consultant cover as a risk and was working with a local NHS trust to develop a joint consultant post to attract a greater number of applicants.
- Although staff were aware of incidents that had occurred, we were not always assured that planned actions or recommendations from incident investigations were taken forward. Action plans as a result of incidents were not always clear and responsible people were not always assigned to ensure that learning was fully implemented across the service.
- The community and inpatient unit teams used different patient record systems, and IT systems and records across the hospital were not integrated. This led to some duplication, frustration and delays. The hospital was aware of these issues and were working to integrate systems and ultimately the creation of a hospital-wide patient record system.
- Staff monitored the effectiveness of some care and treatment, but not all audits were consistent. They used the findings to make some improvements but action plans were not always clear.
- There was no separate multifaith room, although the service informed us that alternative quiet rooms were available on request. There were also no prayer mats available for patients.

Summary of findings

Contents

Summary of this inspection

Background to Hospital of St John & St Elizabeth

The Hospital of St John and St Elizabeth is one of the UK's largest independent charitable hospitals, with any profits used to fund the on-site hospice. The hospital was founded in 1856 with Roman Catholic affiliation and is a registered charity. Facilities at the hospital include: a pre-assessment unit, four theatres, a recovery unit, a high dependency unit with level 2 care beds, a day surgery unit, endoscopy unit, a 23 bedded dedicated surgical ward, diagnostic imaging, outpatient department, and a walk-in urgent care centre. The hospice has 17 beds and is located within the main hospital.

The hospital was due to open a new surgical wing in October 2021 shortly after this inspection, the new wing would consolidate the surgical service into one area and add an additional two theatre units. A new area was also planned for urgent care and imaging, opening at a later stage.

The service provides surgery, medical care, end of life care, urgent care, outpatient and diagnostic services. The hospital is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Personal Care
- Surgical procedures
- Transport Services
- Treatment of disease, disorder or injury

The hospital has been inspected two times previously, with the most recent inspection taking place in March 2019. This was a focused inspection of Urgent Care services, as well as two wards and the high dependency unit. A comprehensive inspection took place in 2016. There were no outstanding enforcement actions from these inspections, but a number of areas were identified for improvement, even though a regulation had not been breached.

On this occasion, we inspected Surgery, Urgent Care and End of Life Care using our comprehensive inspection methodology.

The hospital provides day case surgery and inpatient care for private patients. The service offered a range of different surgical specialities, including orthopaedics, ophthalmology, gynaecology, cosmetic, gastro-intestinal and more. A resident medical officer (RMO) and a resident intensive treatment unit (ITU) fellow are on site 24 hours.

The hospital’s private urgent care centre, Casualty First, was launched in 2011. The centre treats patients from the age of one year. The urgent care centre is open from 8am on 8pm on weekdays, and 8am to 6pm on weekends. Patients can be referred to a specialist consultant and if required an admission facilitated.

The hospital's current registered manager has been in post since 31 May 2018.

Activity:

Summary of this inspection

- Between August 2020 and July 2021, surgical services saw a total of 6752 patients, with the majority of these being day cases (4648) and the rest being inpatients (2077). The most common day cases were endoscopy and colonoscopy procedures.
- Between January 2021 and July 2021, 2010 patients visited the urgent care centre.
- Between January 2021 and July 2021, there were 130 admissions to the inpatient hospice, 118 new referrals to the community team and 78 patients seen by the Hospice@Home team.
- The hospital worked with local NHS trusts as part of the national arrangement with independent healthcare providers during the COVID-19 pandemic.

How we carried out this inspection

We inspected this service using our comprehensive inspection methodology. We carried out the unannounced part of the inspection on 24 and 25 August 2021. We gave staff 24 working hours' notice we were coming to inspect to ensure the availability of senior staff. We returned for a further unannounced visit on the 8 September 2021.

During the inspection, we visited the operating theatres, surgical wards and units, the walk-in urgent care centre, the hospice inpatient unit and day centre, as well as the body store, chapel and staff areas. We spoke with 50 staff including registered nurses, health care assistants, allied health professionals, social workers, operating department practitioners, administrative staff, volunteers, porters, medical staff and senior managers. We spoke with 12 patients or relatives and reviewed 28 sets of patient records.

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

Outstanding practice

We found the following outstanding practice:

- During the COVID-19 pandemic, staff within the day hospice, volunteer team and ambulance transport service had worked together to help patients stuck at home feel supported and connected. As well as starting a telephone befriending service, they ensured that people in need were referred to food banks and that essential supplies and medicines were delivered to those in need.

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:

End of Life Care service

- The service must ensure that all audits are carried out in a systematic and meaningful way, with recommendations taken forward and improvements monitored. (Regulation 17)

Summary of this inspection

Action the service SHOULD take to improve:

Urgent Care service

- The service should review their practice to display handwashing information in line with infection prevention and control (IPC) guidelines. (Regulation 12)
- The service should review the content of the toy box to be compliant with (IPC) guidelines. The service should ensure that the practice of completing the cleaning checklist of the toy box is embedded well. (Regulation 12)
- The service should review the policy for reception staff dress code in line with the IPC best practice of bare below the elbow (BBE). (Regulation 12)
- The service should consider having a safeguarding flagging system in the electronic health records to identify adult patients who may be vulnerable.
- The service should ensure emergency medicines in the resuscitation trolleys are stored correctly. (Regulation 12)
- The service should consider integrating urgent care centre's electronic patient records with the hospital wide health record system.

Surgery service

- The service should ensure all staff in the surgical service complete risk assessments such as VTE assessments accurately. (Regulation 12)
- The service should ensure all staff receive feedback when reporting an incident. (Regulation 12)

End of Life Care service

- The service should continue to mitigate and address the risk of insufficient consultant cover. (Regulation 18)
- The service should ensure that all incidents have a clear action plan with responsible persons assigned to ensure that learning is fully embedded across the service. (Regulation 12)
- The service should monitor whether the planned increased capacity of the social work team is sufficient to meet demand.
- The service should consider how to better meet the needs of patients of other faiths.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Urgent and emergency services

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

Are Urgent and emergency services safe?

Good

This is the first time we rated safe at this service. We rated it as good.

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. Topics for both medical and nursing staff included: fire safety, infection control, information governance, manual handling, safeguarding adults and safeguarding children. Mandatory training completion rates for all staff was 91%.

The deputy chief nurse for the urgent care centre monitored mandatory training and alerted staff when they needed to update their training.

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.

Nursing and medical staff received training specific for their role on how to recognise and report abuse. Safeguarding was part of the hospital's mandatory training programme, and 100% of nursing and medical staff were compliant with level three safeguarding children and adults training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Both nursing and medical staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. Although staff would detail any safeguarding concerns within the doctor's notes, there was no flagging system in the electronic health records to identify patients who may be vulnerable. Senior leaders told us that they were working with the IT software team to incorporate this.

Staff had access to the up-to-date hospital safeguarding policy on the intranet and knew who the hospital safeguarding lead was and how to contact them if required. There were no safeguarding alerts in the last 12 months.

Staff followed safe procedures for children visiting the urgent care centre. The unit worked closely with the hospital paediatric advance nurse practitioner to ensure safe practice within the unit. The urgent care centre had access to the Child Protection Information-Sharing project (CP-IS).

The hospital was also part of the private hospital safeguarding network, a North West London collaboration of clinical commissioning groups with private hospitals.

There was a chaperone policy and we saw signs throughout the urgent care centre advising patients how to access a chaperone should they wish to do so.

Cleanliness, infection control and hygiene

The service controlled infection risk well for the most part. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. We observed social distancing within the urgent care centre and staff followed infection control principles including the use of personal protective equipment (PPE).

There were antibacterial gel dispensers throughout the UCC and hand washing basins in each bay and consultation room. Disposable curtains were in use in the bays and they were clean and fit for purpose. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. For children, a small toy box was kept within the treatment room. Although staff told us that the box and toys were cleaned daily and after every use, no cleaning record was kept for this. At our follow-up unannounced inspection, we saw that the toy box was cleaned on the day and labelled with a green 'I am clean' sticker. Staff told us that they were in the process of updating the nurse's daily checklist to include the toy box cleaning. We also found a picture book and a squeezable ball within the box, which would be difficult to disinfect. We informed staff and they said that they would remove these items from the box.

We observed posters in the triage room and the consultation rooms displaying hand washing techniques and particularly the "World Health Organisation, 5 moments of hand hygiene". These were in line with infection control's good practice standards. However, there was no handwashing poster displayed by the handwash sink in the treatment room.

The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training as part of an annual programme. The urgent care centre had an IPC link nurse who acted as a link between the department and the hospital infection control team. The urgent care centre infection control nurse was responsible for performing IPC audits such as hand washing and 'bare below the elbows' (BBE). Between August 2020 and July 2021 hand hygiene and BBE audit results were 100%. Except for the reception staff, all clinical staff we observed adhered to the BBE dress code. The hospital dress code policy stated that reception staff were required to wear a corporate uniform including wearing full sleeves in non-clinical areas. Though a reception area could be regarded as a non-clinical area, the urgent care centre's reception was within the clinical area. We also observed that the reception staff entered the treatment room (a further clinical area) to access the printer by the door in that room. Following this inspection, senior leaders informed, that they were aware of this and a new uniform for the reception team was being introduced.

There were safe systems for managing waste and clinical specimens. Sharps bins were used appropriately; the containers were dated and signed when full to ensure disposal. None of the bins were full during our inspection. Between January 2021 and July 2021, the sharps audit results were 100%.

At the last inspection, we found that not all staff were clear about their areas of responsibility regarding cleaning. At this inspection, we found that all staff including reception staff were clear about their cleaning responsibilities. At the last inspection, we told the provider to ensure patients at risk of infection or infectious patients were isolated and policies on managing infectious patients were implemented without delay. At this inspection, we found that staff had a clear understanding of how to isolate patients at risk of infection. Staff told us how they isolated a patient who attended the urgent care centre (UCC) with COVID- 19 symptoms, which was in line with the hospital policy. Between August 2020 and July 2021, the COVID-19 self-assessment audit showed 100% compliance.

Environment and equipment

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

The design of the environment followed national guidance. The service was clean and well-lit with natural light. There was enough space for patients and staff alike in clinical areas. Except for the weighing scale in the triage room, all equipment we checked had been serviced and labelled to indicate the next review date. We checked the weighing scale again on our unannounced visit and found it to be serviced. All disposable equipment was readily available, in date and stored appropriately.

There was one adult and one paediatric resuscitation trolley within the treatment room. The trolley was checked daily and was fit for purpose. We checked all equipment and it was within date. However, we found that the top of both the resuscitation trolleys was cluttered with PPE and visors. We informed staff about this. At the follow-up unannounced inspection, we saw that the centre had rectified this and a separate box was placed within the treatment room, clearly labelled as PPE for resuscitation. The service had enough suitable equipment to help them safely care for patients. Staff disposed of clinical waste safely.

The environmental audit included all rooms, dirty utility, public and general areas. Between August 2020 and July 2021, the audit results were between 77.8% and 92.3%. We saw that actions were taken where there was non-compliance. Staff told us that the main reason for low compliance was due to discolouration of the floor under the waste bins in each room and this issue will be resolved once the unit will move to the new location.

Assessing and responding to patient risk

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

A national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating and who would stay in the urgent care centre for a longer period while waiting for further treatment or be admitted as an inpatient.

Staff told us that since the COVID-19 pandemic, patients were seen via pre-booked appointments and triaged over the phone by the doctor. Any walk-in patients were asked to first call the urgent care centre and could be seen on the day depending on the urgency of their illness. The hospital had an acute emergency policy, which was used if a patient was

assessed by the urgent care centre and a decision had been made that the centre could not meet their needs. The patient would be transferred by blue light ambulance to another hospital. Between January 2021 and July 2021, 2010 patients visited the urgent care centre. In the same reporting period between 88% and 99% of patients were triaged and seen by a doctor within 15 minutes of arriving at the urgent care centre.

The service had a pathway in place for suspected sepsis and staff were able to clearly outline the steps taken in the event of suspected sepsis. There was 100% compliance with annual sepsis training.

We reviewed the doctor's handover document which included the urgent care centre exclusion criteria. Patients under the age of one, a patient who needed an ambulance to get to the centre, head injuries with loss of consciousness and vomiting, acute myocardial infarct (MI) and stroke patients were not seen at the centre.

If the doctors in the urgent care centre required more expertise assistance, they had access to an intensivist consultant and a resident medical officer (RMO) twenty-four hours a day, seven days a week. They also had access to other specialists, for example, paediatrics, cardiology and orthopaedics. Medical staff were trained in advanced life support (ALS) and advance paediatric life support (APLS). Nursing staff were trained in immediate life support (ILS) and paediatric immediate life support (PILS). Staff shared key information to keep patients safe when handing over their care to others. All patients who attended the urgent care centre were given a discharge summary. A detailed referral letter was also provided for patients referred to any specialist.

Staffing

The service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers gave bank and agency staff a full induction.

There were two whole-time equivalent (WTE) nurses and three doctors in post at the time of our inspection. The service was open from 8am to 8pm on a weekday and 8am to 6pm on weekends and was staffed by two doctors and one nurse at all times. The clinical lead told us that there were enough nursing and medical staff to keep patients safe, as currently patients were seen via appointment system only.

At the time of the inspection, urgent care centre was working reduced hours and an appointment only system, hence required fewer staff to manage the department. The service had a vacancy rate of 10% and was actively recruiting more staff for the new urgent care centre. The service had low sickness rates. Between January 2021 and July 2021, the overall staff sickness rate was 0.66%. Managers could access locums when they needed additional medical staff. Between August 2020 and July 2021, the use of locum staff was 8%.

Managers limited their use of locum, bank and agency staff and requested staff familiar with the service. Managers made sure all locum, bank and agency staff had a full induction and understood the service.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and available to all staff providing care. However, electronic patient records were not integrated with the hospital-wide health record system.

Patient notes were comprehensive. Apart from the initial registration, covid-19 screening forms and prescription charts, which were paper-based and later scanned into the system, the service used an electronic system to record patient records. This included their triage information, care plans, nursing and medical decisions and risk assessments. We looked at 10 sets of patient records. All were dated and showed detailed step-by-step accounts of the patients' time in the centre. All patient records had been written in line with General Medical Council guidelines (GMC) and Nursing and Midwifery Council (NMC) guidance. Pathology and imaging results were also stored electronically. Records were stored securely. A six-monthly records audit was part of the service's audit programme. Health records audit in August 2021 showed 100% compliance with most standards. There was an action plan for standards with low compliance.

Although the records were easily accessible to staff within the centre, the electronic record system did not link with the rest of the hospital health record system. Staff told us that they would provide all details within the referral or discharge letter. This risk was on the hospital risk register.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, we found some emergency medicines in the resuscitation trolleys were stored incorrectly and did not match the daily stock list.

Staff followed systems and processes when safely prescribing, administering, recording medicines. Medicines were stored safely including controlled drugs (CD). We reviewed the TTA (To Take Away) prescriptions that were previously issued to discharged patients and noted that they were appropriately prescribed and managed in line with the organisational governance policy. Medicines stock management was carried out by nursing staff weekly including expiry date checks. We saw that stock medicines were all in date and TTA medicines were appropriately managed. CD stock audits were done by the pharmacy team quarterly.

Emergency medicines were stored in tamper-evident trolleys and stored in an easily accessible area.We checked the medicines kept within the adult and children resuscitation trolleys. Regular checks were carried out by staff and appropriate documentation was completed. Although all medicines were in date and a daily checklist was completed by the nursing staff, we found that not all emergency medicines within the adult resuscitation trolley matched the daily stock list. For example, the checklist stated that emergency medicines were kept in a blue box in the fourth drawer of the trolley, however, there was no 'blue box' with the trolley, instead, a green box labelled as the cardiac box was used to store the emergency medicines. We found that there were only two adrenaline 1 mg (= 10 ml 1:10,000) as a prefilled syringe, instead of six syringes as indicated on the checklist. We also found a glyceryl trinitrate (GTN) spray, a Ventolin spray, aspirin tablets and clopidogrel tablets in the first drawer and there was no record of these medicines within the daily checks. Staff told us that the medicines in the first drawer were checked as part of other medicines kept in the cupboards, which could lead to confusion for bank and agency staff that may not be familiar with the department. Within the children's resuscitation trolley we found that lignocaine and flumazenil vials were not sorted within the cardiac box and the checklist indicated that those were available within the adult resuscitation trolley, which meant that in an emergency staff would not have easy access to all medicines required. We informed the staff of our concerns and the discrepancies found. Senior leaders informed us that they would rectify these issues immediately. Senior leaders also informed us that, standardisation of all resuscitation trolleys within the hospital was on the corporate risk register and something that the hospital was working on. At the follow-up unannounced inspection, we checked the trolleys again and found all medicines sorted correctly.

Good

Urgent and emergency services

At the follow-up inspection, we found a bag of intravenous fluid (IV) mannitol 10% 500ml bag in the paediatric trolley that was not on the approved list, but staff told us that they wanted to add this to the list of medicines to be kept in the paediatric trolley and were in the process of reviewing the content list.

The ambient room temperature of the treatment room was monitored daily to ensure temperatures did not exceed recommendations for the safe storage of medicines and vaccines. The fridge temperatures were also monitored daily and were within range. Both these temperatures were noted down in daily logbooks.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Between August 2020 and August 2021, 14 clinical and non-clinical incidents were reported in the service. The majority of these incidents (seven) resulted in 'no harm', six incidents resulted in 'low harm' and one (non-clinical) incident resulted in 'moderate harm'. Staff were able to provide learning from incidents, for example, a pathway was introduced for burns patients in response to an incident where a patient with severe burns attended the urgent care centre.

Staff understood the duty of candour. Duty of candour is a statutory duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff received feedback from the investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

Safety Thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff.

The service continually monitored safety performance. Staff used the key performance indicators data to further improve services.

Are Urgent and emergency services effective?

Good

This is the first time we rated effective at this service. We rated it as good.

Evidence-based care and treatment

Good

Urgent and emergency services

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. The UCC had various policies based on the National Institute for Health and Care Excellence (NICE) and other national guidelines. For example, there were guidelines directly from the resuscitation council UK related to Advanced Life Support anaphylaxis.

We observed examples of local audits that had been carried out in the UCC. These included controlled drugs and cleanliness audits. Results of these audits and any learning were shared on the notice board by the nursing station and were available on a shared drive.

Nutrition and hydration

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

The service did not use a nutritional risk assessment tool as patients were not likely to spend over two hours in the centre. However, where patients were required to stay in the centre staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

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 'Wong-Baker FACES' pain rating scale for children and a numerical rating scale for adults to measure pain from zero to ten. On this scale, zero meant no pain and ten was extreme pain. Staff gave pain relief in line with individual needs and best practice.

The centre conducted pain assessment audits in March 2021 and August 2021, with respective results of 28% and 66%. The clinical lead told us that to improve results, following the March 2021 audit, they implemented changes to the electronic health records software and moved around the pain scoring field to ensure doctors documented a pain score in their notes. The next step was to make the pain scoring a mandatory field before the doctors could discharge a patient. We reviewed 10 patient records that showed that appropriate actions were taken in relation to pain triggers to make patients more comfortable, in all but one case. All patients we spoke with were satisfied that their pain was well controlled.

Patient outcomes

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

Good

Urgent and emergency services

Staff carried out a comprehensive programme of repeated audits to check improvement over time. Staff used information from the audits to improve care and treatment. The centre did not participate in any national audits related to emergency care as they did not qualify as an emergency department. The service did however collate data on referrals for further treatment, admissions to inpatient areas, patients assessed, treated and discharged home, and the average time in the department.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. We spoke with the newly appointed doctor, who told us that they felt supported by the induction process.

Managers supported 100% staff in the last year to develop through yearly, constructive appraisals of their work. Senior leaders supported medical and nursing staff to develop through regular, constructive clinical supervision of their work. Staff were provided with clinical supervision and supported through revalidation to maintain their registration. All doctors in the urgent care centre were directly employed and had their GMC registration checked on an annual basis as part of the clinical governance process. Senior leaders made sure staff attended team meetings or had access to full notes when they could not attend.

Clinical staff received additional paediatric training in childhood immunisation, travel vaccination covering paediatrics, teen attention deficit hyperactivity disorder (ADHD) associated with high social media use, and meningitis and encephalitis.

The unit was supported by specialist paediatric nurses and paediatric advanced clinical practitioner from the main hospital.

One patient that we spoke with informed us that they had been to the service several times before due to the effective nature of the service and the competency of staff.

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 told us they enjoyed working with their colleagues and were complimentary about the support they received from one another. There were monthly governance meetings that were attended by the pharmacy and diagnostic and imaging department. The monthly staff meetings were joint meetings attended by doctors and nursing staff. We observed evidence of doctors and nurses working effectively together.

The clinic asked every patient for their consent to share information with their GP. This was to ensure the GP was aware of the treatment received at the urgent care centre.

Seven-day services

Good

Urgent and emergency services

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

Staff could call for support from doctors and other disciplines and diagnostic services during operational hours, seven days a week.

Health Promotion

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

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

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. All clinical staff received consent training on a three-yearly basis.

Staff recorded consent in the patients' records. All 10 records we checked had verbal consent documented where applicable. The urgent care centre did not routinely accept patients that were deemed to lack capacity regarding treatment decisions. Staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA).

Are Urgent and emergency services caring?

Good

This is the first time we rated caring at this service. We rated it as good.

Compassionate care

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

The four patients we spoke with all provided positive feedback about the care and treatment they received from the staff in the centre. They were treated with compassion, kindness, dignity and respect, including when receiving personal care. We observed receptionists, clinicians and nursing staff alike introducing themselves to patients and patients responding positively to this. Patients told us they felt listened to and said all staff were "wonderful" and "helpful".

Good

Urgent and emergency services

All consultations and treatment were carried out in individual rooms. Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The feedback from the urgent care centre patient survey in quarter two 2021 showed, 98% of patients answered 'completely' when asked if they felt they were treated with respect and dignity.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff being sensitive to the needs of patients. For example, when one patient needed their test results urgently, we observed a doctor reassuring the patient immediately and dealing with their query promptly.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. All patients we spoke with told us that the treatment was clearly explained to them and they felt involved in making informed decisions about their treatment.

Treatment costs and initial consultation fees were available on the hospital website and the doctor discussed those with the patients prior to commencing any treatment. The receptionist team would ensure that patients understood the initial consultation price. We asked two patients who confirmed that the total cost and what was included in the cost was clearly explained to them at the outset. One patient told us that "the doctor clearly explained about the treatment cost and there were no hidden surprises".

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All patient would receive an email after their appointment to give feedback. The feedback from the urgent care centre patient survey was positive. For example, patient survey in quarter two 2021 showed, 92.2% of patients were 'extremely likely' or 'likely' to recommend the service.

Are Urgent and emergency services responsive?

Good

This is the first time we rated responsive at this service. We rated it as good.

Good

Urgent and emergency services

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.

Since the COVID-19 pandemic, the urgent care centre was running an appointment only service. The clinical lead informed us that there were plans to offer a mixed walk-in and appointment service when the unit moved to the new building next year.

Facilities and premises were appropriate for the services being delivered. The service had systems to help care for patients in need of additional support or specialist intervention.

There was a paediatric attendance policy. The clinical lead told us it was rare, but any paediatric patients who did not attend appointments were contacted via phone by the reception staff.

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.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Although all information leaflets were in English, the service informed us translation requests could be met. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could access the service when they needed it and received the right care in a timely way.

Between January 2021 and July 2021, 2010 patients visited the urgent care centre. Over the same reporting period, between 56% and 87% patients spent less than two hours in the centre, whilst between 6% and 19% patients spent between two to four hours in the centre, and between 5% and 29% patients spent more than four hours in the department. Senior leaders informed us it was rare that patients spend more than four hours in the urgent care centre. They told us the IT system required clinical staff to log the patients' leaving time on the system and due to delays in this action, there were inaccurate records of extended waits in the centre. We saw actions had been taken to address this, such as conversations with staff and improvements of the recording system.

Between January 2021 and July 2021, between 1% and 5% of patients were redirected from the urgent care centre to the NHS. The senior staff in the unit informed us that the main reasons for sending patients to the NHS were either due to patient funding or the patient not meeting the inclusion criteria.

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.

Good

Urgent and emergency services

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. The service had a complaints policy and staff knew to treat concerns and complaints seriously. Leaders explained how they would always address any concerns immediately and aim to resolve them. Between January 2021 and July 2021, there were seven formal complaints about the service. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Are Urgent and emergency services well-led?

Good

This is the first time we rated well-led at this service. 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.

There was a clear management structure which staff were aware of. This meant that leadership and management responsibilities and accountabilities were explicit and clearly understood. The service was led by the clinical lead and deputy chief nurse. The clinical lead and deputy chief nurse were visible and approachable in the service for patients and staff. Staff we spoke to were positive about the leadership of the clinic. They supported staff to develop their skills and felt appreciated in their roles.

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. Leaders and staff understood and knew how to apply them and monitor progress.

Staff were passionate about doing the best job for the patient and were proud of the work they did in the service. Staff we spoke with told us that the hospital was committed to delivering safe and effective clinical care.

The new urgent care centre was planned to open in early 2022. The new facility will have a dedicated entrance to reduce infection risk in the main hospital, as well as two separate waiting areas, one for adults and one for paediatrics. There will be a dedicated triage room, treatment suite, point of care testing area, recovery and assessment bay, staff rest room and clean and dirty utilities. The unit will also have separate patient and staff toilets, increased storage facilities and closer proximity to a plaster room in the outpatient department. The unit will be located adjacent to the imaging department, allowing for a more seamless journey for patients requiring imaging investigations.

Culture

Good

Urgent and emergency services

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

Staff we met were welcoming, friendly and helpful. It was evident they were happy in their roles. Staff we spoke to told us the culture of the service was like being a family and they genuinely enjoyed coming to work. The service provided opportunities for career development and training. During our inspection, we noticed senior staff were visible in the service and knew staff across the department. Staff of all levels confirmed that the senior staff were very "hands on" and "approachable". We observed good team working amongst staff of all levels. The medical staff worked well with the nursing staff.

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.

Clinical governance meetings were held every month. The clinical governance committee discussed incidents, complaints and departmental changes. The service fed into the hospital wide clinical governance committee that met quarterly. There were regular staff meetings and the medical advisory committee (MAC) meetings. Clinical issues, patient feedback, staffing, complaints and incidents were discussed and reviewed at relevant meetings, including the MAC.

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.

The urgent care centre had a risk register which recorded specific local risks to the service. All recorded risks were graded according to severity and controls were documented, with actions required before the next review date. All actions were assigned to a responsible individual. Risks were regularly reviewed. The service had plans to cope with unexpected events, including adverse reactions during procedures. There was a risk management policy and the service undertook risk assessments, for example control of substances hazardous to health (COSHH) risk assessments.

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 secure.

All patient contact was recorded mainly on a computerised system, once treatment was completed, any paper notes, for example, prescription charts from the day of treatment were scanned onto the patient record and the hard copies were then shredded appropriately. All staff had received information governance training. The information systems were secure.

Good

Urgent and emergency services

The service had access to pathology and diagnostic imaging. All staff had access to the hospital intranet where all service policies were stored online. On discharge, patients received a printout of all treatment received which they could share with their GP if they wanted to.

Engagement

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

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. All patients were asked to complete a provider feedback questionnaire about their experience. This feedback was audited, shared with staff and used to drive improvement. There was a group on a virtual messaging platform that all urgent care centre staff were part of to aid better staff communication and engagement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

All staff we spoke with were extremely positive about the new urgent care centre. The leadership team told us how they have incorporated lessons learned from the current layout of the urgent care centre into the new build, in particular they were proud to offer a separate waiting area for children and better facilities for staff.

Good

Surgery

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

Are Surgery 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. However, not all staff across all areas had completed it.

Nursing and other non-medical staff received mandatory training in fire safety, safeguarding, information governance, infection control and basic or intermediate life support. We found the mandatory training to be comprehensive meeting the needs of patients and staff. Compliance rates were variable in theatres and the surgical ward. The lowest compliance rates were for staff in St. Elizabeth ward in fire safety and life support training, being 64% and 63% respectively. Managerial staff we spoke with explained that these training sessions were delivered face to face. Due to the COVID-19 pandemic, these were restricted in availability due to room capacity.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw evidence of sepsis awareness posters and the hospital had a sepsis policy, however nursing staff we spoke with explained that they received sepsis training through local team meetings or learning sessions. Staff we spoke with could tell us about how they would recognise sepsis and escalate any concerns, a Sepsis audit for the period between August 2020 and August 2021 was undertaken which found that across the hospital 93% of clinical staff had completed the sepsis training.

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.

Nursing staff and other non-medical staff received training specific for their role on how to recognise and report abuse. All clinical staff had level two training for children and adults. At the time of inspection, 100% of staff in St. Elizabeth ward and 92% of staff in theatres had completed this training. Medical staff employed through practising privileges were required to show that they completed adequate training on an annual basis and we saw evidence to prove this. Staff could give

examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The service generally performed well for cleanliness, in the most recent Patient-Led Assessment of the Care Environment (PLACE) the organisation scored 98.6% (NHS England, 2019). Staff conducted monthly audits of all areas which checked compliance against the provider's policy for cleanliness, infection control and environmental maintenance. The July 2021 audit showed St. Elizabeth ward and the high dependency unit scored 96%. The theatres and the recovery unit scored 86.5% and 88.5% respectively, these areas scored lower due to environmental damage and dust being present on some low-use surfaces. The department was undergoing significant renovation during the time of the inspection and a new surgical wing with theatres and recovery unit was being constructed due to open in October 2021.

There was a pre-assessment team which organised patients to be screened for micro-organisms such as MRSA and c-difficile. Patients were asked to self-isolate prior to surgery in line with national COVID-19 guidance. Staff worked effectively to prevent, identify and treat surgical site infections and the service had not reported any surgical site infections within the previous 12 months. Staff followed infection control principles including the use of personal protective equipment (PPE) in all areas. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The management and decontamination of flexible endoscopes complied with the Health Technical Memorandum 01-06 (Department of Health, 2016).

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. The design of the environment followed national guidance. The service had suitable facilities to meet the needs of patients' families. Staff carried out daily safety checks of specialist equipment. Anaesthetic equipment was being checked regularly in line with Association of Anaesthetists of Great Britain and Ireland guidelines 2012. Emergency equipment was stored and checked regularly in line with national guidance. The service had systems in place for the accurate recording and reporting of implants, surgical instruments and equipment as required by the Medicines and Healthcare products Regulatory Agency. The service had enough suitable equipment to help them to safely care for patients. Staff disposed of clinical waste safely in line with national guidance.

Assessing and responding to patient risk

Staff identified and quickly acted upon patients at risk of deterioration. The service aimed to remove or minimised risks, however not all staff completed and updated risk assessments accurately.

Good

Surgery

The hospital had a clear admission policy which set out a safe and agreed criteria for the types of patients that were able to be treated. There was a pre-operative assessment policy which set out the roles and responsibilities of staff. Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. There was a high dependency unit which provided level 2 beds because major cosmetic and orthopaedic surgery was carried out the service. The hospital had service level agreements in place for the transfer of acutely unwell patients or those requiring escalation to nearby NHS and independent hospitals which were better equipped to care for such patients. There had not been any transfers to NHS hospitals in the previous 12 months.

Staff completed risk assessments for each patient on admission, using a recognised tool, however not all staff fully or accurately completed venous thromboembolism (VTE) risk assessments. An audit regarding VTE risk assessment compliance was conducted in August 2021 which showed that the ward was overall 83% compliant, which was below the provider target of 90%. Most of the issues were related to completing documentation accurately, however there were two instances where patient co-morbidities or medical history were not considered when risk assessing and there was an action plan to address this.

Staff completed, or arranged, psychological assessments and risk assessments for patients that had mental health needs which presented after they were admitted. Staff shared key information to keep patients safe when handing over their care to others, shift changes and handovers included all necessary key information to keep patients safe. In the previous inspection conducted in October 2016, staff did not always complete the World Health Organisation (WHO) surgical safety checklist. In this inspection evidence we reviewed showed staff completed the WHO surgical safety checklist and conducted regular audits to monitor compliance, results for the period of May to July 2021 varied between 87% and 100%. The service had a sepsis escalation pathway and staff had access to a sepsis care bundle. Staff were able to escalate concerns regarding a patient to the resident medical officer or intensive care fellow.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. The number of nurses and healthcare assistants usually matched the planned numbers. Both St. Elizabeth ward and theatres had low and reducing vacancy rates. St. Elizabeth ward had low turnover rate (10%), however the theatres had a moderate turnover rate (23%) this was attributed to the changes in working contracts for theatre which was implemented shortly before this inspection. Both St. Elizabeth ward and theatres had had low sickness rates. St. Elizabeth ward had a high rate of bank and agency nurses use (34%) and theatres had a moderate rate (17%). Managers told us that they tried to limit their use of bank and agency staff and requested staff familiar with the service but use of bank staff was higher due to staff unable to work due to the COVID-19 pandemic. 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.

Good

Surgery

The service had enough medical staff to keep patients safe. Surgery at the hospital was consultant driven and led. Most medical staff employed by the hospital were through practising privileges which was managed by the medical governance team which employed consultant liaison managers to ensure consultants remained compliant with their employment contracts. The hospital employed a smaller number of resident medical officers and Intensive Care Unit fellows which were able to see patients on a 24-hour basis. The resident medical staff were able to contact consultant staff if needed. The service always had a consultant on call during evenings and weekends. The service had low vacancy rates for resident medical staff. Managers could access locums when they needed additional medical staff.

Records

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

The service primarily used paper-based records and had limited electronic record systems. Patient notes were comprehensive, and all staff could access them easily. Records were stored securely. When patients transferred to a new team, there were no delays in staff accessing their records. St. Elizabeth ward conducted monthly documentation audits to check compliance with provider policy and professional guidance, results for the period of January 2021 to July 2021 ranged between 83% and 95%. The service conducted audits to check VTE risk assessments were recorded accurately, results for August 2021 showed 73% and 82% compliance. Nursing staff we spoke with told us that it was difficult to get medical staff to complete the risk assessments in line with provider policy and they felt the issue could be resolved if the hospital adopted electronic record keeping.

Medicines

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

In the previous inspection conducted in June 2017, controlled drugs were not always recorded to the required standard and medicines were not always stored appropriately. In this inspection staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Controlled drugs and other medicines stored on site were checked daily. Audits were carried out to check compliance against the provider's policy for the storage and management of controlled drugs. Results for January 2021 showed St. Elizabeth ward was 100% compliant and results for April 2021 showed the theatres ranging between 91% and 97% compliant. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff followed current national practice to check patients had the correct medicines. The service had systems to ensure staff knew about safety alerts and incidents, to ensure that patients received their medicines safely. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of 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. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. From August 2020 to July 2021, the service reported 166 incidents. Out of these, 115 incidents resulted in 'no harm', 48 incidents resulted in 'low harm' and three incidents resulted

Good

Surgery

in 'moderate harm'. Staff raised concerns and reported incidents and near misses in line with /provider policy. Managers shared learning about past never events with their staff. Staff reported serious incidents clearly and in line with local policy. Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff did not always receive feedback from investigation of incidents. Managers debriefed and supported staff after any serious incident.

Safety thermometer

The service used monitoring results well to improve safety. The service collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. The hospital, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems. The hospital had a quality dashboard which monitored pressure ulcers, falls and VTE, as well as other measures such as infection rates.

Are Surgery effective?

Good

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

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. There was a central governance team which ensured that relevant national and professional guidance, such as from National Institute for Health and Care Excellence (NICE), were disseminated to local leaders who would then discuss them in team meetings and apply them where needed. We evidence to show that 100% of medical device implants were registered with the national implant registry. Audits were regularly conducted to check working practices against written policy. Results of these audits and any learning were shared with staff in meetings and were available on a shared drive. The service has a pre-admissions team which ensured patients had the relevant pre-operative tests and were provided information on preparation for surgery.

Nutrition and hydration

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

Good

Surgery

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Patients waiting to have surgery were not left nil by mouth for long periods.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Staff prescribed, administered and recorded pain relief accurately. Local managers of inpatient wards conducted audits to check compliance for pain management for surgical patients, an audit for St. Andrews ward for April to August 2021 showed high compliance.

Patient outcomes

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

The service collected patient reported outcome measures (PROMS) as requested to providers by the Royal College of Surgeons. A PROM is a series of questions that patients are asked in order to gauge their views on their own health, they are the patient's own assessment of their health and health-related quality of life. Data for the period of August 2020 to August 2021 showed 99% non-cosmetic and 85% cosmetic patients returned the PROMS. Outcomes for patients were positive, consistent and met expectations. Managers and staff used the results to improve patients' outcomes. The hospital had eight unplanned admissions within 29 days of discharge and six unplanned admissions within 72 hours, out of these there were six that were attributable to surgical services. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits. The hospital was accredited by United Kingdom Accreditation Service (UKAS) for the laboratory services and COVID-19 testing.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. 100% of staff had received their appraisal by August 2021. Managerial staff and clinical educator staff supported the learning and development needs of staff. Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. Managers identified poor staff performance promptly and supported staff to improve.

Good

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.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. We saw that there were established meetings for breast and orthopaedic specialties, there was evidence which showed the commencement of meetings for spine and gastro-intestinal specialties. MDT meetings were led by consultants, but other clinical staff were welcome to attend for learning and participation. Clinical staff told us they enjoyed working with their colleagues and were complimentary about the support they received from one another. We observed good working relationships between different clinical and non-clinical staffing groups. Staff worked with external organisations when required to care for patients.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants on a regular basis and were able to see the resident medical officer at any time. Staff could call for support from doctors and other disciplines, including dietetic, physiotherapy, speech and language therapy and diagnostic tests, seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units. Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

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 understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We reviewed 10 patient records and found them all to contain evidence that the patient had been consented in line with national guidance. The service undertook regular documentation audits which also looked at the consent process, the results for the period of May to July 2021 showed that patients had been consented appropriately, however patients were not always provided with a copy of their consent form. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. Nursing staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. There had been no use of Deprivation of Liberty Safeguards in the period between August 2020 and August 2021.

Good

Surgery

Are Surgery caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them well and with kindness. The results of the patient satisfaction survey for the period of July to September 2021 showed 95% of patients would recommend the service and showed 100% of patients were satisfied with the quality of care provided. We were shown numerous examples of positive patient comments regarding the care and service. Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff supported patients to make advanced decisions about their care. Patients gave positive feedback about the service.

Are Surgery responsive?

Good

Surgery

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of the local population. Facilities and premises were appropriate for the services being delivered. Staff could access mental health support for patients with mental health problems, learning disabilities and dementia. The service had systems to help care for patients in need of additional support or specialist intervention such as when patients required care beyond that of level 2 critical care. The service participated in the national COVID-19 pandemic response to relieve pressure on the NHS by taking on elective surgical cases.

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff supported patients living with dementia and learning disabilities by using appropriate tools. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in English only, but staff were able to get translations if needed. Managers made sure staff, patients, relatives and carers could get help from interpreters or signers when needed. Patients were given a choice of food and drink to meet their cultural and religious preferences. The chaplaincy team provided spiritual support for different faiths, although the hospital has a catholic heritage. The hospital did not have a multi-faith prayer space or quiet room for people of no religious affiliation. Patients and visitors had access to a Christian chapel and people of other faiths were able to pray at the back of the chapel, however there were no provisions to support them such as prayer mats.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment when it best suited their needs. Managers and staff worked to make sure patients did not stay longer than they needed to. The service utilised one dedicated surgical ward and was able to use another ward which was not in regular use, staff said it was rare for surgical patients to be placed outside these specific wards but if they were managers made sure they had arrangements for surgical staff to review any surgical patients. Managers told us that operations were rarely cancelled, and it was only done so because of patient choice or an emergency situation related to staff. Managers made sure they rearranged any cancelled operations as soon as possible, and monitored patient moves between wards so they were kept to a minimum. The service moved patients only when there was a clear medical reason or in their best interest. Staff did

not move patients between wards at night. Managers and staff worked with patients to make sure that they planned the patients discharge for a convenient time considering patient needs such as mental health, family availability and social care needs. Managers monitored the number of discharges and if they happened according to what was planned. We saw evidence that showed patients usually were discharged as soon as they were medically fit, but the hospital was flexible in facilitating discharge arrangements and timings, factoring in whether the patient felt ready to be discharged.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. In the hospital's 2020/21 complaints report we saw that there were 141 complaints reported in 2020, out of which none were directly attributed to surgical services. The report explained the main themes of the complaints received by the hospital were regarding finance, patients' consultant, nursing care and administrative issues.

Are Surgery well-led?

Good

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

Leadership

Leaders had the skills and abilities needed 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.

There was a clear organisational structure within the service, with strong local leaders in place to support the development of each area. Staff were aware of who their local leaders were and told us they could identify and felt comfortable approaching senior executive level leaders. The surgical service was ultimately managed by the chief nurse and deputy chief nurse. A ward manager led the surgical ward and the service recently appointed a head of surgical services who was envisioned to lead theatres, recovery, the high dependency unit, pre-assessment and day surgery. The leadership team were open and approachable and had open door policies which allowed colleagues to talk to them privately whenever they were available. Staff we spoke to were positive about the leadership of the service, they told us that recent changes to leadership roles improved staff morale. Most staff told us they felt supported in their roles by their immediate line managers, including for their learning and development needs.

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.

Good

Surgery

There was a clear vision to what the service wanted to achieve and a planned strategy on how to achieve it. The service was focussed on establishing the new surgical wing of the hospital with phase one opening in October 2021 and phase two completing the project in early 2022. The service aimed to increase capacity and generate more activity by attracting more patients and consultants through the new facilities being built. Senior managers explained they wanted to consolidate the role of the new head of surgical services and aimed to further develop the skills of theatre staff to facilitate the increased activity in targeted surgical specialities. The service was also working towards accrediting their endoscopy service. Staff we spoke with told us they had been consulted regarding the service's vision and strategy and felt involved in decision making. Progress was monitored by measuring aims and objectives against a planned framework which was overseen by the hospital board.

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.

Most staff felt supported, respected and valued. Staff felt positive about working in the hospital. There was a culture centred on the needs and experience of people who used the service. The culture encouraged staff to be open and honest with each other and the people who used the service. Most staff felt safe to raise concerns about the service without repercussion. Managers understood their responsibilities under duty of candour and provided support and training to staff when required. There were systems in place which allowed staff to access career development opportunities. There were mental health first-aiders and freedom to speak up guardians for staff to talk to about concerns and worries. Most staff described their working relationship with colleagues to be positive and we found there to be a positive culture of teamwork between different staffing groups.

Governance

Leaders operated effective governance processes, throughout the service. 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.

Clinical governance meetings were held every month. The clinical governance committee discussed incidents, complaints and departmental changes. The service fed into the hospital wide clinical governance committee that met quarterly. There were regular staff meetings and the medical advisory committee (MAC) meetings. Clinical issues, patient feedback, staffing, complaints and incidents were discussed and reviewed at relevant meetings, including the MAC. Practising privileges were monitored by the medical director and the medical governance team, who ensures consultants were compliant with their contracts.

Management of risk, issues and performance

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

The service had a risk register which recorded specific local risks, and these were able to be escalated to the corporate risk register if needed. All recorded risks were graded according to severity and controls were documented, with actions

required before the next review date. All actions were assigned to a responsible individual. Risks were regularly reviewed. The service had plans to cope with unexpected events, including adverse reactions during procedures. There was a risk management policy and the service undertook risk assessments, for example control of substances hazardous to health (COSHH) risk assessments.

Information Management

The service collected reliable data and analysed it. The information systems were secure but not fully integrated.

Leaders had access to performance measures about quality, operations and finances, and used it to improve the service. Patient information and records were stored securely in all areas we visited, but different IT systems and paper-based patient records were used across the hospital. This meant that staff did not always have immediate access to information they needed and this led to increased time required for some tasks. The hospital was aware of these issues and were working to improve IT systems and introduce a hospital-wide electronic patient record system. The service had access to pathology and diagnostic imaging. All staff had access to the hospital intranet where all service policies were stored online. On discharge, patients received a printout of all treatment received which they could share with their GP if they wanted to.

Engagement

Leaders and staff actively and openly engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. All patients were asked to complete a provider feedback questionnaire about their experience. This feedback was audited, shared with staff and used to drive improvement. All staff had access to support and supervision if necessary, and staff felt they were supported with their wellbeing during COVID-19. The hospital ensured regular communication through various channels with staff and had an awards system to recognise colleagues who went above and beyond. Staff felt they were consulted on changes regarding the build of the new surgical wing. We were provided with examples of positive staff engagement initiatives such as; engagement meetings between the executive leadership team and theatre staff, regular engagement sessions during the pandemic period, hospital wide executive team engagement sessions, engagement session between microbiology staff and hospital staff to address vaccine hesitancy.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving the service.

Managers encouraged a culture of improving the service for the benefit of patients and staff. We saw evidence of improvement and learning on a local level in different areas such as the redesigning of booking forms in theatres, the introduction of pre-admission IT system and implementation of the quality dashboard. The hospital set out improvement projects in it's three year strategy document. The hospital had a standard operating procedure for continuous improvement which set out the procedure to be undertaken to ensure implementation of lessons learned from incidents, inspection reports and outcome of audits or review. Staff we spoke with told us they felt comfortable in discussing ideas for improvement, but often did not have the time to undertake any projects.

Good

End of life care

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

Are End of life care safe?

Good

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

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training. This included volunteers who used the same online training system as other staff. Porters within the hospital were given some end of life care training at their induction. However, there was only a record of 64% of porters completing this. This meant not all porters had an in-depth understanding of this part of their role. Following our first site inspection, the hospital began to deliver further end of life care tailored training to the porters, which 81% of these staff had completed by the time of the second site visit. The remaining staff were booked to complete this training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All clinical staff had level two training for children and adults, apart from those working directly with bereaved children who had completed level three training for children. At the time of inspection, 100% of staff in the inpatient unit and 95% of staff in the community teams had completed this training. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. All team leaders or managers had level three safeguarding training, and the hospital had appointed safeguarding leads for both children and adults. The hospital had internal processes for the regular review of safeguarding concerns, at a regular safeguarding committee.

Cleanliness, infection control and hygiene

Good

End of life care

Staff used infection control measures when visiting patients in the inpatient unit and transporting patients after death.

The inpatient unit areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. The service generally performed well for cleanliness. The environmental audit for the inpatient unit showed between 84.9% and 94.5% compliance for the 12 months prior to our inspection. If any infection prevention control (IPC) audits scored below 90% compliance, the frequency of audits was increased. We saw that IPC issues were picked up and resolved.

The service took appropriate measures to reduce the risk of COVID-19 transmission. This included regular testing of both patients and staff, social distancing within the hospital, and use of appropriate personal protective equipment (PPE). The inpatient unit scored 100% in the COVID-19 self-assessments for the 12 months prior to our inspection, and between 95% and 100% in the hand hygiene/bare below the elbow audits in the same period.

The body store was visibly clean. There were systems and processes in place to manage the risk of infection. Appropriate procedures, forms and checklists were used in the event of death to identify and protect staff from infectious disease or radioactive materials. The body store was cleaned on a weekly basis by the housekeeping team, but this excluded the fridge. Porters were asked to clean trays in the fridge after each body was collected with a disinfectant wipe. In a December 2020 audit retrospectively reviewing 30 deaths, there was evidence trays in the body store had been cleaned in 90% of cases.

Environment and equipment

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

The design of the environment followed national guidance in the inpatient unit, which had been recently refurbished. In the day centre and basement areas, there were some environmental issues such as lack of air conditioning and poor wheelchair access. The hospital was aware of these issues and were in the process of redesigning the areas with staff input, with plans and concept designs being drawn up.

The body store had capacity for 12 deceased patients. Bodies in a range of sizes could be stored. There were arrangements with neighbouring mortuaries in case of emergencies. Daily temperature logs were maintained and the fridges were linked by alarm to the switchboard for temperature control.

The service had enough suitable equipment to help them to safely care for patients. Staff had access to syringe drivers to provide end of life patients with anticipatory medication. The service used syringe drivers that met national safety standards. We were told there were no problems in accessing syringe drivers whenever they were needed for patients.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Good

End of life care

Staff completed risk assessments for each patient on admission to the inpatient unit, using a recognised tool, and reviewed this regularly, including after any incident. Ambulance drivers completed a risk assessment for each patient being transported in their vehicles, which was reviewed before each journey.

Clinical staff used a document based on the five priorities of care (One Chance to Get it Right, 2014) with patients who had been identified as being in the dying phase to monitor any discomfort and record their symptoms. This document included prompts for staff to consider whether patients had increased needs in terms of symptom or pain control. For patients where the progression of their illness was clear, the amount of medical intervention was reduced to a minimum. Care plans were based on ensuring patients remained as comfortable as possible at all times.

Staff shared key information to keep patients safe when handing over their care to others. There was a process in place for patients who required urgent transfer to other centres. Life support training compliance was 100% for inpatient unit staff, but only 76% for community staff at the time of our inspection. This was due to lack of face-to-face training sessions during the COVID-19 pandemic and training was booked for these staff.

Nurse and allied health professional staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, there had been a 43% increase in patient contacts to the social work team in the last year, leaving the team feeling stretched.

The service had enough nursing and support staff to keep patients safe. In the inpatient unit, there were two band 6 vacancies and one band 5 vacancy at the time of inspection. The hospital had added this to the risk register and all posts were out to recruitment. There was also one staff nurse vacancy in the day hospice but as they had not been fully operational during COVID-19, this had not been an issue. There were no vacancies in the community team, ambulance transport service or lymphoedema service. Two healthcare assistant posts had been created and recruited into in the Hospice@Home team due to rising demand during COVID-19, demonstrated by a 30% increase in referrals between January and June 2021. Across the service, the vacancy rate at the time of our inspection stood at 10%.

The service had low turnover and sickness rates. Most shifts were filled by the service's own bank staff rather than agency staff. These staff were familiar with the service.

The social work team managed bereavement office functions and bereavement support. This team consisted of four people, two of whom were part-time. Over the past year, there had been a 43% increase in patient contacts to this team, leaving them feeling stretched. The bereavement services coordinator was also about to leave their post and this job was out to advert. Senior staff told us that they were aware of the workload challenges of the team. Another post focusing specifically on welfare benefits had been agreed to help the team cover the increased workload.

Medical staffing

The service did not have enough permanent 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. This was an identified risk and the provider was working to recruit into vacant consultant posts. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Good

End of life care

The actual establishment of medical staff did not match the planned number. The service currently relied on a locum consultant, locum junior doctor and bank junior doctor to cover shifts within the service. These locum staff were familiar with the service. This reflected a national shortage of palliative care consultants, and the service had been trying to recruit into this vacancy for some time. The provider had identified insufficient consultant cover as a risk and was working with a local NHS trust to develop a 1.6 whole-time equivalent (WTE) joint consultant post to attract a greater number of applicants. The service was currently using a locum consultant to cover these vacancies, who had covered 49% of shifts over the last 12 months. Staff told us there was usually sufficient medical cover in general across the service, with more junior medical staff available for day-to-day support. The service always had a consultant on call during evenings and weekends.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and stored securely. However, the community and inpatient unit teams used different patient record systems which could lead to duplication.

In the inpatient unit, the majority of records were paper based. In the community, staff used an electronic system. Although both systems contained all the required information, the use of two systems could lead to some confusion and duplication, especially with patients admitted out of usual working hours. Staff in the community team were aware of this issue and were training staff in the inpatient unit in how to use the electronic system.

Record keeping had improved since the time of our last inspection. Patient notes were comprehensive. We reviewed eight sets of records for patients who were receiving palliative and end of life care. Records were clear and detailed, and included discussions with patients and relatives to ensure individual needs and choices were being met. Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were kept at the front of paper based notes in the inpatient unit. Documentation audits were completed on a monthly basis, with actions taken where issues were found.

Medicines

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

Patients receiving end of life care were prescribed anticipatory medicines in line with local policy to manage symptoms that may be present at the end of life. Prescribing medicines in anticipation can avoid a lapse in symptom control, which could otherwise cause distress for the person who is dying and those close to them. The drugs prescribed were appropriate to the individualised anticipated needs of the dying person and were prescribed in advance to ensure that symptoms such as pain, agitation and nausea could be managed. There was a specialist pharmacist who worked on the inpatient unit, with on-call support available outside of working hours.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines audits and reporting of incidents ensured that any issues with medicines were rectified and patients received their medicines safely. In the event of a syringe driver being used, an additional chart was used to monitor the site and rate of infusion, as well as the battery and maintenance of the device. We saw five charts in use and correctly filled out by nursing staff to optimise patient safety and pain relief. Nursing staff had to undergo a syringe driver competency assessment prior to utilising these devices in practice.

Incidents

Good

End of life care

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but we were not always assured that all identified actions were taken forwards. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them, raising them in line with provider policy. From August 2020 to July 2021, the service reported 166 incidents. Out of these, 115 incidents resulted in 'no harm', 48 incidents resulted in 'low harm' and three incidents resulted in 'moderate harm'. All staff were aware of incidents that had occurred, but we were not always assured that planned actions or recommendations from incident investigations were taken forward. Action plans as a result of incidents were not always clear and responsible people were not always assigned to ensure that learning was fully implemented across the service.

Staff understood the duty of candour. Duty of candour is a statutory duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw examples where this had occurred.

Safety thermometer

The service used monitoring results well to improve safety. The service collected safety information and shared it with staff, patients and visitors.

The service continually monitored safety performance. The hospital, unlike NHS trusts, was not required to use the national safety thermometer to monitor areas such as venous thromboembolism (VTE). However, services are required to have equivalent systems. The hospital had a quality dashboard which monitored pressure ulcers, falls and VTE, as well as other measures such as infection rates. This was available electronically and key metrics were displayed in the inpatient unit. All incidents in these categories were reviewed and discussed in governance meetings to identify any lapses in care.

Are End of life care effective?

Good

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

Evidence-based care and treatment

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

We saw that end of life care policies referenced appropriate updated guidelines from National Institute for Health and Care Excellence (NICE) and other bodies where appropriate. The service used a personalised care plan based on the five priorities of care (One Chance To Get It Right, 2014). This document included holistic prompts for staff to consider in the daily review of the patient. In January 2021, the service conducted an audit of the use of the personalised care plan and found evidence that this was an effective way to ensure those of the end of life were receiving good care. Several adjustments were suggested to improve the audit tool measured the effectiveness of the care plans, but the service did not submit evidence of any subsequent audits.

Good

End of life care

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. The hospital accommodated individual patient requests in relation to food and tailored menu options accordingly. There was good access to dietetic support for patients at the end of life. A dietitian attended the weekly specialist team multidisciplinary team (MDT) meeting and referrals to the speech and language therapist were also made for patients who found it difficult to eat solid food. In addition, the ambulance transport service had been enlisted to take shopping to people in the community struggling to access food during COVID-19 and staff in the day hospice could make referrals to food banks where required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. At the time of the last inspection, we found issues with the completion of malnutrition universal scoring tool (MUST) assessments in records. At the time of this inspection, these were complete in all records we looked at. The documentation audit also checked completion of MUST assessments in 10 records each month and found all were fully complete so far in 2021.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients received pain relief soon after requesting it. Patients that we spoke with were happy that their pain was well controlled. Appropriate actions were taken in relation to pain triggers. Staff prescribed, administered and recorded pain relief accurately. Some patients had syringe drivers, which delivered measured doses of drugs over the course of 24 hours. The service also strived to manage other side effects such as nausea, fatigue and vomiting.

Complementary therapies were also available to patients to help manage symptoms and side effects, although these had been limited by COVID-19. The complementary therapies team offered reflexology, massage and acupuncture to patients, their relatives and staff.

Patient outcomes

Staff monitored the effectiveness of some care and treatment, but not all audits were consistent. They used the findings to make some improvements but action plans were not always clear.

Managers and staff carried out some audits within the service. However, there was no sense that all audits were carried out systematically or with regularity. Day-to-day audits such as documentation and infection prevention control were recorded on an electronic system and we saw that these were completed regularly. However, other audits were sporadic and staff were not always able to action that recommended actions had been carried out. For example, the preferred place of death (PPD) was not routinely used as a key performance indicator at the time of inspection and no audits were

yet complete in the lymphoedema service. Where audits had been undertaken, they lacked a robust action plan with people assigned to ensure actions were completed and findings were re-audited. Other examples are mentioned elsewhere in this report under relevant headings. The service recognised this and part of their strategy was to develop dashboards to track the progress of clinical and non-clinical work.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Junior doctors felt they had sufficient consultant contact and support when considering more complex cases. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work. All staff within the service had received an appraisal in the last year. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

End of life care was discussed at staff induction sessions, but there was no further training for staff in the wider hospital. Staff from the inpatient unit would go to support staff on the general wards when patients were identified as being at end of life.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. There was good attendance at the weekly MDT meetings for both the inpatient unit and community teams. We observed one such meeting and saw discussion of the patients was holistic, tailored and sensitive, covering areas such as: pain and symptom management, capacity and safeguarding concerns, family needs and support, emotional, spiritual and psychological needs, preferred place of care and death, and advance care planning.

Staff worked across health care disciplines and with other agencies when required to care for patients. All staff reported feeling valued and respected, with only positive comments about their colleagues. The service worked well with other external organisations as required, but staff in the community team noted that relationships with GPs had suffered somewhat during COVID-19 as face-to-face contact had been limited.

Seven-day services

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

Staff could call for support from doctors and other disciplines, 24 hours a day, seven days a week. There was an on-site residential medical officer (RMO) and medical staff experienced in palliative care on call. Nurses on the inpatient unit confirmed that they were able to flag up issues directly to doctors out-of-hours and had no problem accessing support or advice.

The hospice day centre had been closed during the COVID-19 pandemic but was planning to reopen in October with social distancing and testing in place for patients. The ambulance transport service was available between 8.30am and

Good

End of life care

4.30pm on weekdays to collect patients from hospital, take patients to appointments or to deliver shopping or medication to people's homes. The chaplain carried a contact telephone and told us he was available at all times for urgent matters, with volunteers supporting the service on days he was not on site. He told us there were arrangements with local faith leaders to provide support for those of other faiths if required at short notice.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support. Exercise classes had continued virtually for patients of the hospice day centre during COVID-19. Staff assessed each patient's health when admitted. People in the palliative phase of their illness were identified and supported to live well, with appropriate interventions from different health professionals and therapists, such as dietitians and complementary therapists.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

The provider told us staff undertook Mental Capacity Act (MCA) 2005 training as part of adult safeguarding and consent training. For consent training, levels of staff compliance stood at 93% in the inpatient unit and 91% in the community team. Most staff had some understanding of how and when to assess whether a patient had the capacity to make decisions about their care, but social workers and medical staff were commonly sought out for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. All Do not attempt cardio-pulmonary resuscitation (DNACPR) forms we saw were fully complete, detailing the reason it was in place and appropriate discussion. All were signed by a doctor and verified by a consultant. A DNACPR audit from August 2020 showed most documentation was of a good standard, but this was not repeated regularly to show sustained good practice.

Are End of life care caring?

Good

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

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We spoke to two patients and one relative who were positive about the service,

saying the nursing staff were “amazing” and that they cared about families as well as patients. Patients said staff treated them well and with kindness. We were given multiple examples of arrangements being made for patients at the end of life, to support their needs and wishes, including weddings, visits to the seaside and facilitation of events and celebrations. The service could apply for grants to help patients realise their dying wishes. Staff went above and beyond their duty to facilitate the wishes of patients and families, for example in ensuring that family members of patients who were dying had audio recordings of their loved ones. During COVID-19, volunteers and day hospice staff had started a community befriender service to make regular phone calls to those who may be stuck and home and required support and a listening ear. Between September 2020 and July 2021, all 17 patients who responded to the inpatient unit survey said they would be 'extremely likely' or 'likely' to recommend the hospice to friends and family, and their overall experience was ‘very good’ or ‘good’.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations, although they told us this had been some time ago. There was psychological support available for patients through the team of four social workers. Patient contacts to this team had increased 43% in the last year due to COVID-19. There was a feeling amongst staff we spoke with that whilst the team offered excellent support, they perhaps they did not have the capacity to support all patients for the length of time required. No figures were provided as to the number of referrals received by team when these were requested, but senior staff told us that they were aware of the workload challenges. Another post focusing specifically on welfare benefits had been agreed to help the team cover the increased workload.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the importance of finding out about the spiritual needs of patients and their families and knew how to refer people to the chaplaincy service. Although the hospital has a catholic heritage, the chaplaincy service provided spiritual and emotional support to patients and their relatives, irrespective of their individual faith or lack thereof. The chaplain also visited patients in the community when required. The chaplain acted as a bridge to people’s local faith communities to enable them to reconnect before discharge, or make funeral arrangements. The chaplaincy service did not collect data on number of referrals from people of different faiths but the chaplain did not report any issues with spiritual support provision.

Understanding and involvement of patients and those close to them

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

Staff supported patients to make advanced decisions about their care. The eight patient records we viewed demonstrated that discussions took place between clinicians and patients, where possible, and where appropriate with relatives of the patients. The service was able to evidence that it asked patients what mattered most to them and this led each patient discussion in weekly MDT meetings. The service had access to an electronic system that enabled patients to create an urgent care plan where they could express their wishes and preferences for how and where they wished to be treated and cared for. This care plan could be shared electronically with all the healthcare providers working around the patient, ensuring continuity of care between different providers. The completion of advance care plans was audited, but this was irregular and there was limited evidence that actions had been taken as a result of these audits.

Good

End of life care

The service offered bereavement support to families. There was a formal policy regarding bereavement support for staff to follow. There was a bereavement group run by volunteers that met on a monthly basis prior to COVID-19. This continued through virtual means such as calls and messages. There was one part-time bereavement services coordinator, but they were about to leave their post and this job was out to advert. In addition, there was another part-time social worker who coordinated work with bereaved children who were known to the service or living within the wider borough. The service had run a summer activities programme for these children in 2021. Over the past year, there had been an increase in requests for bereavement support due to COVID-19, meaning that the workload did not always feel manageable and some outreach work was no longer possible. The service did not undertake a bereavement survey but told us this was planned for October 2021. In December 2020, a retrospective audit of 28 patients showed that 75% of families had been offered bereavement follow-up. It was not clear what actions had been taken as a result of this finding.

Are End of life care responsive?

Good

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

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the needs of the local population. Referrals were mainly accepted from local boroughs, but out-of-area referrals could also be considered by the team if a patient had local links or family. The service had established working relationships with local GPs and community teams, although this was more problematic during COVID-19 due to reductions in face-to-face appointments and limitations on joint visiting. The community team were considering initiatives such as virtual teaching sessions on symptom control with district nurses.

Facilities and premises were appropriate for the services being delivered. Relatives were able to visit patients in the inpatient unit and stay overnight if a patient was at end of life, with appropriate COVID-19 control measures in place.

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.

The chaplaincy team provided spiritual support for different faiths, although the hospital has a catholic heritage. The chaplaincy service did not collect figures such as the number of daily contacts for each faith, so we were unable to review this information, but the chaplain did not report any issues with spiritual support provision. He had a network of connections with faith leaders from other religious traditions who visited patients of other religions if required. The hospital chapel had Christian symbolism but the chaplain explained this was also used for people of other faiths as there was no separate multifaith room. The service later told us quiet rooms could be made available on request. There were also no prayer mats available for patients.

Good

End of life care

The viewing room attached to the body store was neutral in decoration. Relatives could return to view the body in the dedicated viewing room before it was moved to the funeral director. Staff were aware of the adjustments required to deal with deaths of those from different faiths and cultures. There was written advice for families on registering a death, viewing and funeral arrangements and where to get extra information and support. The service did not currently audit completion of medical certificates of death, but told us that they would start to complete incident reports for any instances where this was a problem.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed, with pathways for urgent referrals available across the service. Staff worked to make sure that they started discharge planning as early as possible. The Hospice@Home team supported the rapid discharge of patients, providing a bridging service until formal support could be put into place, or providing emergency respite care. There was a discharge coordinator in the inpatient hospice team who coordinated rapid discharge arrangements, including sourcing equipment, oxygen and medication, as well as ensuring there was an advance care plan and DNACPR in place. Between May and July 2021, there were 64 deaths recorded across the inpatient hospice and community teams. Of these, 10 patients were unwilling or unable to state their preferred place of death (PPD). Of the remaining 54 patients, 94.4% (51) died in their PPD.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. There had been three formal complaints relating to end of life care in 2020. Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice, such as the introduction of a safe checklist for patient property following a complaint from a relative. The service was signed up to an independent review service for resolution of formal complaints.

Are End of life care well-led?

Good

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

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Good

End of life care

There was a clear organisational structure within the service, with strong local leaders now in place to support the development of each area. The Assistant Director of Nursing for the Hospice had overall leadership responsibility and was then supported by a lead for community services, a ward manager on the inpatient unit, a lead social worker and a newly recruited day hospice manager, who was due to start in post shortly after the inspection. Most staff told us they felt supported by their immediate line managers and local leaders, and most were also positive about the senior management team. Some staff felt that leaders could be more visible across the whole service. Staff were supported to develop into senior roles, with several examples of successful internal promotion apparent during our inspection.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services. Leaders and staff understood and knew how to apply them and monitor progress.

The service had a vision and strategy for achieving the priorities and delivering good quality care, broken down into four strategic objectives: Care more, achieve more, do more and serve more. These focused on areas such as redevelopment of the day hospice and hospice basement areas, increasing fundraising and awareness and reaching a wider range of patients. Staff we spoke with were clear about the future direction of the service.

Culture

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

Staff were clearly committed to providing good end of life care for patients. The majority of staff felt valued by their managers, who appreciated how hard they worked. They were proud of the work their colleagues and department did. There were some small pockets of discontent, but the feeling on the whole was that any historical cultural issues had been tackled and the service was now a positive place to work. Staff were aware of the need to support each other after a death and there was access to formal support where required. The hospital had recently trained up six mental health first aiders to act as an additional point of contact and support for staff experiencing any mental health issues. There were also six Freedom to Speak Up champions to support staff in raising patient safety concerns confidentially.

Governance

On the whole, leaders operated effective governance processes throughout the service, although some opportunities for learning from audits and incidents were potentially missed. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet and discuss the performance of the service.

There were a range of governance meetings in order to monitor performance of the service, including local team meetings, including chaplaincy team meetings, and wider hospice governance meetings. Operational issues, complaints, incidents and general communications were shared and discussed at these meetings. There was also a dedicated audit meeting, but we were not assured that all audits were carried out in a systematic and meaningful way. Action plans as a result of incidents and audits were not always clear and people were not assigned to carry out recommendations to ensure that learning was fully implemented.

Good

End of life care

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The local risk register was reviewed regularly. All recorded risks were graded according to severity and controls were documented, with actions required before the next review date. All actions were assigned to a responsible individual. The only live risk related to potential staff shortages, which was an issue at the time of the last inspection but ongoing actions were being taken to mitigate this. A further five managed risks were listed, including the environment and staff lone working. Senior staff had oversight of the risks and there were processes to escalate any emerging risks appropriately.

Information Management

The service collected reliable data and analysed it. The information systems were secure but not fully integrated. Data or notifications were consistently submitted to external organisations as required.

Leaders had access to performance measures about quality, operations and finances, and used it to improve the service. Patient information and records were stored securely in all areas we visited, but different IT systems and some paper-based records were used across the hospital. This led to some duplication, frustration and delays. The hospital was aware of these issues and were working to integrate systems and ultimately towards the creation of a hospital-wide patient record system.

The service used a clinical system that informed GPs, hospitals, ambulance crews, 111 providers, care homes, hospices and out of hours services about patients' wishes for urgent and end of life care. Evidence from the creator of this system showed that patients were more likely to die in their preferred place of death if they had a DNACPR decision recorded on this system than those who did not.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service invited patient involvement through satisfaction surveys and gathering of feedback. Prior to COVID-19, the service had facilitated bereavement days and a hospice user group, which were in the process of restarting. For example, the social workers had recently put on a summer activities programme for bereaved children. However, the response rate for the inpatient unit survey was not high, with only 17 patients responding between September 2020 and July 2021. The hospital explained that this was in part due to the COVID-19 pandemic and provided assurances about how they gathered patient feedback.

All staff had access to support and supervision if necessary, and staff felt they were supported with their wellbeing during COVID-19. The hospital ensured regular communication through various channels with staff and had an awards system to recognise colleagues who went above and beyond. Staff felt they were consulted on changes, such as the plans to refurbish the day hospice and basement.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

Good

End of life care

The hospital had taken the feedback from our previous inspection and used this to drive improvements in areas such as documentation, and took immediate action in response to issues identified during the course of this inspection visit. Staff were committed and passionate about improving the service they provided.

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
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Local audits in the end of life care core service were sporadic and staff were not always able to action that recommended actions had been carried out. Where audits had been undertaken, they lacked a robust action plan with people assigned to ensure actions were completed and findings were re-audited.