Circle Health Group Limited

The Meriden Hospital

Inspection report

Walsgrave Hospital Site
Clifford Bridge Road
Coventry
CV2 2LQ
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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	Requires Improvement
Are services safe?	Inadequate
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an urgent, unannounced focused inspection of this hospital on 16 November 2021 because we received information of concern from staff and patients about the safety and quality of service at this hospital. We also received four statutory notifications from the service between April to November 2021 for serious incidents, one of which had resulted in a patient death and one notifying us of a never event (no harm).

Our rating of this location went down. We rated it as requires improvement because:

- The service did not have enough staff to care for patients and keep them safe. The service did not always ensure all staff had completed the mandatory training. Staff did not always assess risks to patients in relation to venous thromboembolism (VTE) or act on them.
- Managers did not always make sure staff had the right competencies for the role they had.
- Leaders were not always approachable despite being visible. Staff did not always feel respected, supported or valued, with concerns around bullying and discrimination raised. Risks were not always identified, escalated or documented on the risk register. Governance processes were not always effective.

However:

- The service protected patients from abuse and controlled infection well. The service design, maintenance and use of facilities and premises kept people safe. The service generally managed safety incidents well and learned lessons from them and kept good care records.
- Most leaders had the skills and abilities to run the service. Most staff were aware of their roles and responsibilities.
- The service ensured it was easy for patients and relatives to give feedback.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	Our rating for this service went down. We rated the service as requires improvement overall because we rated safe as inadequate and effective and well-led as requires improvement. We did not inspect caring during this focused inspection and only inspected learning from complaints and concerns for responsive so could not rate this key question.

Summary of findings

Contents

Summary of this inspection

Background to The Meriden Hospital

BMI The Meriden Hospital is operated by BMI Healthcare Limited. In January 2020, Circle Health Group acquired GHG Healthcare Holdings Limited who are the indirect parent company of BMI Healthcare Limited. The hospital has one ward, Charlecote ward which has 48 beds. At the time of the inspection, the ward could admit a maximum of 42 patients as some of the rooms had been reallocated to other resources within the hospital, including pre-operative assessments. Facilities at this hospital included three operating theatres, an outpatient department with a minor operation suite and an endoscopy suite which had four bays. Shortly before our inspection, the cardiac catheter laboratory was decommissioned whilst this was renovated and updated. Diagnostic imaging facilities onsite included MRI (magnetic resonance imaging), CT (computerised tomography), X-ray and ultrasound. These services were not provided 24 hours per day but could be accessed in an emergency at other hospitals.

The hospital provides surgery, outpatients and diagnostic imaging core services, however we only looked at the surgery core service during this urgent, unannounced focused inspection.

The current registered manager had been in post since July 2021.

BMI The Meriden have been inspected five times since they registered with the Care Quality Commission. The most recent inspection was in April 2018 and they were rated as good overall.

How we carried out this inspection

We completed an onsite visit to the service on 16 November 2021. We visited Charlecote ward, theatres and pre-operative assessment. We spoke with 17 staff, including members of the executive team, heads of department, medical staff, nursing staff, operating department practitioners and healthcare assistants. We reviewed eight sets of patient records, two of which were for patients who were no longer inpatients but whom had been transferred to the local acute trust.

We completed interviews with members of the hospital leadership team remotely on 23 November 2021.

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

Areas for improvement

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

Action the service MUST take to improve:

- The service must ensure all risk assessments are completed in accordance with national guidance and corporate and local policy and documented appropriately. **Regulation 12 Safe care and treatment.**

Summary of this inspection

- The service must ensure pre-operative assessments are completed by suitably qualified, skilled and competent staff. **Regulation 12 Safe care and treatment.**
- The service must ensure staffing is actively assessed, reviewed and escalated appropriately to prevent placing patients at risk of harm. **Regulation 18 Staffing.**
- The service must ensure patients undergoing a procedure which they maintain responsibility for, both internally and externally, are always thoroughly risk assessed against their inclusion criteria and kept safe. **Regulation 12 Safe care and treatment.**
- The service must ensure that measurable action is taken to address bullying across the organisation. **Regulation 17 Good governance.**
- The service must ensure there is an appropriate process in place to ensure all service level agreements and contracts are monitored and maintained. **Regulation 17 Good governance.**
- The service must ensure effective risk and governance systems are implemented that supports safe, quality care. **Regulation 17 Good governance**.
- The service must ensure there is an effective and standardised process in place for all consultants to follow when concerns are raised about patients under their care. **Regulation 12 Safe care and treatment.**

Action the service SHOULD take to improve:

- The service should ensure that all equipment if maintained appropriately to ensure patients are kept safe. **Regulation 12 Safe care and treatment.**
- The service should ensure all incidents are reported in line with corporate and local policy to enable investigations to occur and lessons to be learnt. **Regulation 17 Good governance.**
- The service should ensure processes are in place to provide assurance that medicines requiring refrigeration are kept within their recommended temperature range. **Regulation 12 Safe care and treatment.**
- The service should ensure patients own controlled drugs are managed safety and effectively. **Regulation 12 Safe care and treatment.**
- The service should ensure all staff consistently consent patients for care and treatment in accordance with national guidance. **Regulation 11 Need for consent.**
- The service should consider how they cascade all relevant feedback and learning from complaints to all staff.

Our findings

Overview of ratings

Our ratings for this location are:

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

Requires Improvement

Surgery

Safe	Inadequate
Effective	Inspected but not rated
Responsive	Inspected but not rated
Well-led	Requires Improvement

Are Surgery safe?

Inadequate

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills to all staff, however it was not ensured, that everyone completed it.

Mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules included areas that were key to staff for this service such as clinical medicines management, adult immediate life support, equality and diversity, fire safety, infection prevention and control awareness, safeguarding, moving, and handling and dementia awareness and consent.

The service provided 30 modules of training. While overall training compliance for all modules was 96.6% there were some aspects where figures fell below the set target. Nursing staff were compliant with 19 out of the 30 modules and theatre staff were compliant with 21 of the 30 modules.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service also had a nurse education trainer who supported staff with training requirements. Staff told us they were compliant with their mandatory training. However, evidence received from the service after the inspection showed some training modules were below the service target of 95%, the lowest being adult immediate life support for nursing staff was 63.6% and patient moving and handling for theatre staff was 81.3%. The pandemic had impacted on the compliance for face to face training, but the service had a plan in place to meet the target by the end of December 2021.

Most staff felt adequately trained for their roles. However, some staff had concerns about completing additional procedures for which specialised training was required. In one example, staff told us they felt they had not been adequately trained on post-operative care for aortic valve replacement procedures. In another example, not all staff felt they were competent in the preassessment process. In another example, staff told us by doing different procedures which they were unfamiliar with, without additional training, this had raised stress and anxiety amongst the workforce. Information received from the service post inspection identified the case of the patient undergoing the valve replacement did not go ahead as planned on site. Managers recognised the need to ensure staff have the right training and competency to care for patients undergoing unusual procedures at the location. However, in this case, it was stated there was no additional training requirements identified and staff would have all had the appropriate skills to provide the appropriate care and treatment to this patent post operatively.

Requires Improvement

Surgery

The service told us that consultants who practice under practicing privileges confirm adherence to mandatory training as specified in the Practicing Privileges Policy and as part of their initial application. This mandatory training is then reviewed annually during appraisal submissions.

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 vulnerable adults 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 staff had completed their vulnerable adults' level two and three training. However, the service did not quite meet their target of 95% compliance for safeguarding children level two. At the time of our inspection, 92% of ward staff were compliant with this training.

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

The service had safeguarding lead who was trained to level four. All staff knew who the safeguarding lead was.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to provide examples of safeguarding concerns which they had raised.

Staff followed safe procedures for children visiting the ward. However, at the time of the inspection visitors were not permitted to come on the ward due to COVID-19 safety restrictions.

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.

All areas we visited were visibly clean and tidy. They had suitable furnishings which were wipe clean and well-maintained. The service was compliant with national guidance on ventilation with laminar flow air changes in all theatres.

The service generally performed well with their IPC (infection prevention and control) audits including cleanliness.

We observed staff demonstrating good hand hygiene measures in accordance with the World Health Organisations (WHO) five moments for hand hygiene. The service completed regular hand hygiene audits which showed compliance ranged between 99 to 100%.

The service followed COVID-19 infection control for patients. Staff told us patients due to attend the service for a procedure completed a PCR (polymerase chain reaction) test 72 hours prior to attending. Following this they were advised to self-isolate until the day of their procedure. Patients were then required to provide evidence of a negative test on the day of admittance.

Staff used records to identify how well the service prevented infections. Staff worked effectively to prevent, identify and treat surgical site infections. The service had separate IPC and COVID-19 leads who monitored infections.

All staff followed infection control principles including the use of personal protective equipment (PPE) and bare below the elbow. Policies were regularly updated to ensure they were in line with national guidance.

Requires Improvement

Surgery

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

Information received after the inspection showed all staff who required a FFP3 mask were fit tested and had received donning and doffing training. We also received evidence of staff who were trained in fit testing staff members. However, during our inspection staff told us they had not received fit testing for their filtering facepiece (FFP3) masks and donning and doffing training.

Environment and equipment

The design, maintenance and use of facilities and premises kept people safe, equipment was mostly available when needed. Staff were trained to use them. Staff managed clinical waste well. However, not all equipment was in date for their electrical safety tests.

Staff carried out daily safety checks of specialist equipment. We reviewed 11 items of equipment and found nine items were in date with electrical testing and in good repair. However, two items were not in date with their electrical test. This was highlighted to the ward manager at the time who confirmed this should have been tested recently and would ensure this was immediately rectified.

The design of the environment followed national guidance. On the ward all the patient rooms were single occupancy rooms with an en suite.

The service had recently purchased more theatre trolleys to help them to safely care for patients. Prior to our inspection, we received information which highlighted concerns around the provision of equipment to enable staff to safely care for patients. On inspection, staff told us there had been more equipment purchased and some broken items had been replaced, however they still struggled with some items including observation machines. The executive director informed us there was a plan in place to improve the equipment within the hospital which included buying additional items such as observation machines, as well as upgrading other items which were considered to be old and needed to be replaced.

Staff disposed of clinical waste safely. We observed staff correctly segregating clinical and domestic waste. Waste bins were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line, however the temporary closure mechanism was not always used. The management and disposal of sharps and waste was completed in accordance with policy.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and were therefore unable to always remove or minimise risks. We were not assured all staff identified and quickly acted upon patients at risk of deterioration.

Ward staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. We reviewed five sets of notes on the ward and found most observations had been recorded accurately and the national early warning score (NEWS) completed. However, one patient had observations performed at 10.30am on the day of inspection and was found to have a NEWS score of four. This had not been escalated to the nurse looking after the patient. We discussed with the nurse in the afternoon who acknowledged this should have been escalated at the time, and another set of observations performed shortly after. The staff member looking after the patient was aware the patients baseline observations (those completed during their pre-operative assessment) scored a three so considered this to be little change from their usual status, however escalation of the score should have taken place. Information received after the inspection showed the service regularly audited their NEWS scoring and observation performance. The last three audits completed between March to November 2021 demonstrated a compliance of between 99 to 100%.

Requires Improvement

Surgery

Staff knew about and dealt with most risk issues**.** However, we identified some concerns with risk assessments for venous thromboembolism (VTE). We reviewed five set of notes on the post-operative ward, two sets of notes did not demonstrate that a VTE assessment had been completed. Both of these patients had an anticoagulant prescribed despite no assessment being completed. We also reviewed two sets of historic notes. Both included patients who had been transferred to the acute NHS hospital. One patient had a VTE assessment completed on their initial admission. However, the patient was transferred out for a possible pulmonary embolism. On a following admission back to the service we noted the patient did not receive a VTE assessment. Within the second example, we were unable to locate a VTE assessment and could not evidence any anticoagulants being prescribed. We were unable to determine if this patient had required prophylaxis treatment at the time of their admission. In addition to this the use and prescribing of TED (Thrombo-Embolic Deterrent) stockings was inconsistent. Information we reviewed after the inspection showed the service regularly audited compliance with VTE assessments. However, compliance was found to be consistently low, between 67-76% and was rated as red on the RAG rating (red, amber, green). Reminders were constantly given to staff reminding them to complete these assessments, however, these did not appear to be evident in a sustained improvement.

The service was considered to be a level zero provider (ward level care only) as they did not have additional systems or processes in place on site to support patients who deteriorated, for example they did not have a critical care outreach team or high dependency unit on site. There was a service level agreement in place for patients to be transferred to the local acute hospital if they deteriorated.

Staff told us deteriorating patients were assessed by a consultant and a decision made to transfer to NHS if necessary but that this decision could be made without a consultant (by the resident medical officer or nursing staff) if the patient was assessed as requiring urgent escalation under a 999 emergency. However, staff raised concerns about the delays with accessing consultants when patients were identified as deteriorating. Concerns were verbally raised with managers however this was not reported as an incident. They also told us of an occasion when a consultant told staff they were not to be contacted in any circumstance which included any concerns over a deteriorating patient, we alerted the provider to this. We also reviewed a root cause analysis of a patient who deteriorated following their procedure and saw there was a significant delay for a consultant to review the patient despite numerous contacts by the staff to raise their concerns.

The service displayed ‘stop before you block’ signs in theatres to prompt nursing and medical staff to review the procedure.

We observed good practice in relation to carrying out essential safety checks prior to patients undergoing their procedure. Staff used the WHO safer surgery checklist to ensure it was safe to proceed through each stage of the operation and all staff engaged. We reviewed six WHO checklists and found all were completed comprehensively. Information we received after the inspection showed the service audited their WHO completion on a monthly basis. Compliance was between 96 to 100%.

During our inspection we observed the daily safety huddle attended by 13 of the nursing and medical staff. The staff in attendance included management team and senior leadership team. Staff discussed the number and complexity of any procedures for the day, staffing, staff sickness, patients who had stayed overnight, recruitment, governance reports, maintenance work being carried out and adult life support trained staff available for the day.

There was an inclusion and exclusion criteria in place for staff to follow for admitting patients for planned procedures. However, we found this criteria was not always adhered to. Staff told us consultants often insisted on patients being admitted for surgery despite not meeting the inclusion criteria. We raised our concerns about this after our inspection and requested assurance from the senior leadership team in relation to this. Information provided showed there was evidence

of some consultants refusing to operate on patients at this location as they did not meet the criteria, however the audit conducted did not look for patients who had been operated on against the criteria. In an interview with the executive director, they acknowledged there was some inconsistency with the inclusion and exclusion criteria and therefore there was an intent given to review this and make it more standardised with less opportunity to deviate from this.

Staff told us when patients were operated on outside of the inclusion criteria, consultants and anaesthetists would recommend the patient undergo 'extended recovery'. Staff told us this was where patients stayed in the recovery area for longer and the anaesthetist provided oversight of their recovery until satisfied they were safe to return to the ward. However, concerns were raised in relation to this as staff did not always observe anaesthetists providing this oversight as they were required to provide assistance during other operations. An executive director acknowledged there was no formal process for this in place at the time of our inspection and the corporate chief nurse was reviewing this to see how this could be safely implemented.

Where patients did not meet the inclusion criteria at this service, some patients were provided with the option to have their procedures completed at the local acute hospital before transferring back to the service for their post-operative care. Staff raised their concerns about this due to the on-going risk of deterioration in the post-operative period. Staff also told us of a patient who had undergone this pathway for their procedure and had to return to the local acute trust due to deteriorating on return. After the inspection, we raised our concerns with senior leadership team and asked for urgent assurance on how patients on this pathway were kept safe. The executive director informed us they had suspended this pathway temporarily whilst they completed a review.

Prior to the inspection we received information which indicated pre-operative assessments were not completed by qualified staff. During inspection, staff raised similar concerns about this. This had impacted on some patients when attending for their planned procedures. Information received prior to the inspection showed there had been 12 procedures between June to August 2021 which had been cancelled on the day. Of these, four were as a direct result of concerns with the pre-operative assessment which was conducted. Although this is of concern, it was noted that the service had identified these concerns on admission and therefore no patient harm was noted. We raised this as a concern with the senior leadership team after the inspection and requested further assurance on how they would keep patients safe during this vital assessment. Information received identified that all staff were assessed as having the required qualifications, training and skills for this role. Managers told us staff in this department were provided with training to support competency, however this was not mandatory for staff. Following the inspection and feedback from staff, the service delivered a bespoke package of training and competency assessments for all staff working in the department.

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

Nurse staffing

The service did not have enough staff to keep patients safe from avoidable harm. There was a reliance on agency and bank staff to improve staffing numbers. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The service did not always have enough staff to keep patients safe. Managers told us there were several nursing vacancies within the service. Information received after the inspection showed the wards were 32% off their full establishment and theatres were 24% off their full establishment. Some staff had been recently recruited through an overseas recruitment drive; they were due to start soon. However, there were still challenges to maintaining safe staffing levels at all times.

Requires Improvement

Surgery

There was a significant number of staff absences due to sickness including some long term absence. This increased pressures in some areas to maintain safe staffing levels. Information showed staffing sickness was 6% for registered staff and 14% unregistered staff on the wards.

Managers calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift. The service used a staffing tool to inform their planned staffing numbers for shifts within the service and would adapt the planned staffing numbers depending on the acuity of patients and demand on the service. However, staff told us there had been occasions recently when additional staff could not be provided to cover these requirements. Information received after the inspection showed there were a number of shifts which had been requested for agency staff but had not yet received confirmation for fulfilling these. Further information received during the factual accuracy stage identified all shifts (apart from one) had been covered by agency staff. The one which had not been covered was deemed to longer require an additional staff member.

Staff raised concerns over the numbers of staff planned for each night shift. Two registered staff were allocated to each night shift. Staff told us this felt unsafe, especially when evening operating lists were in process. This meant only one member of staff would regularly be left on the ward to manage the needs of patients. This also meant breaks were not always taken by staff. We raised this as a concern after our inspection and requested assurance on how they intended to ensure patients were kept safe during night shifts. The service had currently decided to temporarily suspend evening operating lists. In addition to this, the senior leadership team told us they had added a healthcare assistant to each night shift to mitigate the risk further. These members of staff had been provided by a different location for the short-term management of this uplift in staff due to reduced staffing levels at this service in relation to high levels of sickness absence.

The service had high rates of bank and agency nurses. Staff told us they always tried to ensure agency and bank staff were on shifts with substantive members of staff, but this was not always the case. We reviewed off duties and found there were shifts with just agency or bank staff on shift. These seemed to mainly, but not exclusively be on night shifts.

Managers did not limit their use of bank and agency staff, however they tried to request staff familiar with the service. As there were staffing vacancies, there was a reliance on the use of bank and agency staff. Managers tried to block book agency staff to ensure consistency within the service however this was not always possible, especially when needing to book additional shifts on a short notice term. Staff told us a new agency had recently been used. They had concerns that some agency staff supplied had not worked in surgical care or an acute hospital setting for a significant period of time. We asked staff if they raised this as an incident, however they had not. We raised this with the senior leadership team following our inspection. They informed us this had been an exception and would ensure no other staff with a lack of surgical experience would be accepted.

Managers made sure all bank and agency staff had a full induction and understood the service. The service mainly used three agencies to improve their staffing levels. There were contracts in place to ensure all staff had the right checks and training prior to arriving for a shift. Once at the service, all agency and bank staff had a local induction of the area. We saw evidence of completed induction forms for recent agency staff.

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. New medical staff underwent an induction to the service.

Requires Improvement

Surgery

The service had enough medical staff to keep patients safe. Each patient was admitted to the hospital under the care of a named consultant with the relevant experience in that area of care and treatment. Consultants led and delivered the surgical service at the hospital under practicing privileges. The hospital had granted 220 consultants practising privileges, including but not limited to: anaesthetists, specialist surgeons such as orthopaedic, ear nose and throat, gynaecology and urology.

The practicing privileges policy required consultants to visit their patients at least daily during admission and be available for their patients out of hours in the event of an emergency. The policy identified agreed timeframes should be made for each consultant to be available for emergencies. This information was then stored in their personal files. Staff raised concerns as this meant there was inconsistency within the expectations of consultants. They also raised the concern around not knowing what specific conditions were in place in relation to each of the 220 consultants. This added to the risk of delaying patient care and treatment when a patient was deteriorating.

Day to day medical cover was supplied by the resident medical officer (RMO) who provided 24 hours a day, seven days a week service, on a rotational basis. RMOs were employed through a formal contract with an agency. The agency ensured staff had completed essential training and competencies prior to starting their roles. They worked a one week on, one week off rota. RMOs had varied levels of experience with some RMOs being the equivalent of a junior doctor in foundation year one (FY1).

The service always had a doctor available during evenings and weekends. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. They provided support to the clinical team in the event of an emergency or with patients requiring additional medical support. They also completed routine investigations of patients. The RMO was trained in advanced life support and held a bleep for immediate response, for example, in the case of cardiac arrest. Nursing staff told us the RMOs were approachable and responsive when required, however they were mindful about disturbing them in the evening unless absolutely necessary as this could impact the service they provided during the day.

Records

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

We viewed five sets of records. Records were paper based. Patient notes were comprehensive, and all staff could access them easily. Staff also used national assessment tools such as national early warning scores (NEWS). All records were legible, and the entries, dated, timed, signed and the designation of the person making the entry was identified.

When patients transferred to a new team, there were no delays in staff accessing their records. There were no concerns about availability to records since the findings at our last inspection.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe, administer, record. However medicines were not always stored or disposed of correctly.

Requires Improvement

Surgery

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. A pharmacy staff member confirmed medicines reconciliation was undertaken for new admissions and high-risk patients on weekdays. Patients admitted at the weekend were reviewed on a Monday morning. Following risk assessments some patients were seen face to face for medication reviews by the hospital's own pharmacy assistant.

Pharmacy staff told us that patients height, BMI (body mass index), weight and allergies were reviewed. We looked at four patients' charts, all had the relevant details documented on them and had reviews completed.

The service had an agreement with the local NHS trust to provide pharmacy support. However, we learnt of an example of delays in the processing of medication requests and a lack of stock of some medications that had caused complaints from patients and delays in discharges. Staff had reported this locally however had not incident reported when significant issues were experienced. The service had a new process in place to reduce these delays and prescribing was to be agreed on admission and not on discharge. The NHS trust also provided any medications which were not stocked at the service.

The service had appropriate facilities for storing medication in line with the local policy. However, staff we spoke to were unable to demonstrate how fridge temperatures were taken and accurately recorded. This service could not provide assurance that medicines requiring refrigeration were kept within their recommended temperature range.

Controlled drugs including those belonging to patients were stored securely and only nursing staff had access to them. The service recorded all controlled drugs including those prescribed on discharge. Patients own controlled drugs were stored in the controlled drug storage, these were stored securely and recorded but were not returned to the patient take home on discharge which caused a build-up of medication in the cupboard which staff was a risk. There was not a procedure in place to ensure these were disposed of safely.

Staff did not encourage patients to bring their own medications into hospital with them and there was no process in place for patient to self-administer their medications. Staff told us of an incident where a patient had bought their own pain relief in with them when having a procedure and did not disclose this to staff. This resulted in the patient accidentally overdosing and requiring urgent medical attention to reverse the overdose. Staff told us learning had taken place as a result of this and they were more thorough with their admitting processes to ensure patients had not bought any medication with them. Staff were not aware of any other incidents occurring since this.

The service audited medications monthly, quarterly, and annually. Medication and missed doses audits were done monthly. Data provided by the service after our inspection showed that pain management audits had improved from 74% for March 2021 to 98% in September 2021. Audits showed that patients were being prescribed and administered analgesia appropriately to meet their needs.

Staff followed current national practice to check patients had the correct medicines. We reviewed three medicines charts and these were completed in line with local guidelines. Stock levels of some pain relieving medicines had not been managed effectively. Stock levels were reviewed following an incident where the service had ran out of one medicine.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Requires Improvement

Surgery

Incidents

The service mostly managed patient safety incidents well. 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. However, staff did not always report all incidents and near misses.

Staff knew what incidents to report and how to report them. Between March and August 2021 there were 312 incidents reported. The majority of these were graded as low or no harm. There were two incidents graded higher than this during this period, one was moderate, and one was recorded as a death.

Staff mostly raised clinically related concerns and reported incidents and near misses in line with local policy. However, staff told us they did not always raise incidents around 'non clinical incidents' which included things such as staffing concerns, bullying incidents or concerns around patients being accepted for procedures who did not meet the inclusion criteria.

The service had one never event which occurred in the theatres. This was a wrong site block and occurred shortly before our inspection. There was initial confusion at first if this was a never event due to conflicting information provided by the corporate team. However, this has now been formally reported as a never event and an investigation had commenced.

Managers shared learning about never events with their staff and across the trust. Staff told us that learning from incidents was shared and learning from the provider corporate team were shared in flash alerts and there was a secure social media and email group.

Managers told us they shared learning with their staff about never events that happened within the providers other services. We saw minutes of clinical governance meetings where this was recorded. However, not all staff were aware of this and were unable to provide examples of learning from other services.

Staff reported serious incidents clearly and in line with local policy and Regulation 18 CQC (Registration) Regulations 2009, notification of other incidents. There were two serious incidents recorded between March and August 2021. These were reported and investigated according to local policy. Senior leaders have also reported two further serious incidents to the CQC since August 2021, one of which was a never event (no harm) and one was recorded as severe harm.

Most staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff were familiar with the duty of candour and the concept of being open and transparent when things went wrong. We saw evidence of duty of candour being exercised appropriately.

Staff received feedback from investigation of incidents. Staff were all aware a significant incident which had occurred earlier in the year and feedback from this investigation had been discussed. Staff met to discuss the feedback and look at improvements to patient care. However, staff were not all able evidence changes had been made as a result of feedback.

Managers investigated incidents and involved patients and their families. However, we were aware of concerns raised in relation to one serious incident where significant challenge was being made in relation to the investigation. Managers told us support from the corporate team was requested with this investigation.

Managers debriefed and supported staff after any serious incident. Staff were positive about the debrief process in place following serious incidents and discussed at length a serious incident which had impacted most of the staff within the ward setting.

Requires Improvement

Surgery

Are Surgery effective?

Inspected but not rated

Competent staff

The service did not always make sure staff were competent for their roles.

Not all staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Some staff who currently worked in the pre-operative assessment clinics had raised concerns around working in these clinics with no prior training to enable them to do this role. One staff member told us they were not sure if the assessments they had completed were adequate.

Managers ensured staff attended team meetings or had access to full notes when they could not attend. We observed examples of the minutes produced and shared with staff.

Managers had responded to identify training needs for their staff working in pre-assessment clinics and organised the training for them. However, at the time of our inspection they were unsure as to when training would be provided. The training requirements for staff members had been escalated as a priority for those currently working in the clinics. Following our inspection, we raised our concerns around untrained staff completing pre-operative assessments and took immediate action to gain assurance from the service about their pre-operative assessment processes. An action plan was submitted which contained details of imminent training for staff which was due to commence the week commencing 22 November 2021. Copies of the competency documents which staff would need to complete were also submitted to provide assurance of what staff will be trained in. The competency documents were similar for qualified and unqualified staff members working in these clinics. The only difference appeared to be around the expectation for qualified staff to complete examinations of the respiratory and cardiovascular system as part of the assessment. We requested further information following this for details of who would be assessing the competency of staff members completing the pre-operative assessment competencies. Information provided informed us the corporate clinical educator was responsible for signing off staff competencies alongside a designated anaesthetist who would sign off the examination competencies of the qualified staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. However, they did not consistently follow 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 told us most of the patients who were cared for by the service had capacity to make decisions for themselves. However, on the rare occasions they had patients who they had concerns about, they were aware of the steps to take to assess for capacity.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff also told us in these circumstances they used a consent form which was specifically aimed for consenting patients who lacked capacity. This was a rare occurrence though at this location.

Staff raised concerns about how patients were consented for treatment. Staff told us most patients were consented on the day of their operation which also included those undergoing a cosmetic procedure. Staff were aware of the

requirement for a two-week cooling off period from decision to undergo a procedure to undergoing the procedure, however had concerns around this being adhered to. In addition to this, the information which was verbally discussed with patients was usually minimal. We asked staff if they incident reported examples where poor consent process was observed, however staff told us they did not always do this unless they had concerns about patient safety. The services own audits also confirmed this had been an ongoing concern. The last audit was completed in July 2021 and showed 80% compliance with the consent process.

We reviewed seven consent forms and found all consent forms had adequate amounts of information contained on them to enable patients to make informed decisions. None of the consent forms we reviewed were for patients who were undergoing a cosmetic procedure; however, we noted the date of the consent forms was within days or on the day of the planned procedure.

Are Surgery responsive?

Inspected but not rated

During this inspection we looked at specific aspects of the responsive domain. Please see the overall summary for more information.

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 and investigated them. However, staff were not always aware of the outcomes of complaints and did not always receive the lessons learnt.

Prior to our inspection, concerns had been raised about the complaints process at the service. Information suggested staff were not always updated on the outcomes of complaints as well as patients not being able to get through to the hospital to complain verbally. During our inspection we found there was information displayed for patients and members of the public about how to raise a concern or complaint. Staff understood the policy on complaints and knew how to handle them. Complaints were responded to in a timely manner.

Managers investigated complaints and identified themes. Information we received before the inspection showed there were 77 complaints raised between March to August 2021. This was 0.5% of patients who used services. There had been increase in the number of complaints in August 2021 compared to the previous month. The main themes were:

- Unhappy with the outcome of consultation.
- Behaviours of staff.
- Delayed results and/or communication.

There was one complaint which went to a stage two review in May 2021.

Some staff told us they did not always receive feedback and learning from complaints. There was a standing agenda item for all departmental meetings where incidents and complaints were to be discussed, however we found this was mainly dedicated to incident feedback. Within ward areas, staff were able to recall one significant complaint which had been submitted and where there had been a discussion. However, the feedback centred more around the serious incident which this related to rather than the complaint which had been submitted.

Requires Improvement

Surgery

Are Surgery well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Most leaders had the skills and abilities to run the service. They mostly understood and managed the priorities and issues the service faced. They were visible however not all were approachable.

Prior to our inspection, we received complaints which raised concerns over the leadership within the hospital. Concerns included leaders being unapproachable, failing to respond to concerns raised by staff as well as being responsible for departments which they had no qualifications for. During our inspection, we found staff corroborated the information we had received. Staff had concerns around some of the leaders. Staff told us they had tried to raise concerns previously, but no action had been taken and this had at times left them in an unfavourable and compromised position.

The hospital had a clear leadership structure in place. The executive director (ED), who was also the registered manager, was supported by the director of clinical services and operations manager. There was also a network of heads of department (HODs) who supported the director of clinical services and operations manager. Although all staff told us the leadership team were visible, not all of them were approachable.

Most of the leaders had the skills and abilities to run the service. The new ED had an extensive background within management and all staff believed they had the skills and abilities to lead the service.

The leadership team had gone through many changes during the last 12 months which had impacted staff within the hospital. The previous ED left the role and there were temporary EDs employed. This had caused uncertainty within the staff group and staff were reluctant to approach them with any concerns. The current ED had been in post for four months when we inspected and all staff without exception had commented on the positive impact they had already made to the running of the service. Staff were hopeful further changes to improve the service would be made.

Culture

Not all staff felt respected, supported and valued. Concerns had been raised about behaviours and attitudes in relation to equality and diversity in daily work. The service had not always had an open culture where staff could raise concerns without fear. However, all staff we spoke with were focused on the needs of patients receiving care.

Prior to our inspection, we received information of concern around the culture within the service and claims of bullying and physical aggression between staff. This had resulted in staff leaving the service due to being unable to withstand any further negativity. During our inspection, staff provided further details around the culture within the service which corroborated most of the information we received. In addition to this, staff also told us there had been incidents of racism and sex discrimination. Staff had reported these incidents verbally to their managers however no action had been taken. Staff from all levels told us about staff who had left following incidents of bullying and discrimination which had not been appropriately addressed.

Most staff told us they did not feel respected, valued or supported by some of the senior leaders and some of the medical staff within the service. However, they were positive about the support and respect they received from their peers. Staff

told us some of the consultants had pressurised them at times to accept patients for surgery who did not meet the hospital inclusion criteria. Staff were at times fearful to discuss the concerns directly with the surgeons responsible. Some staff told us of examples where other members of staff had approached them as they were seen as strong members of the team to discuss the concerns on their behalf.

Up until recently, staff told us no action was taken to address any behaviour and performance that was inconsistent with the vison and values in relation to managers or any of the consultants. However, since the new ED had started, there had been a distinct change in the response to poor performance including poor behaviour. On the day of our inspection we were aware that some action was being taken in response to concerns over behaviour and performance. During an interview with the ED it was confirmed that appropriate action had been taken in relation to this member of staff which was proportionate to the concerns raised. The ED had previous experience with managing this type of staff behaviour and did not see seniority or position within the service as a reason not to take action.

Staff we spoke with were dedicated to providing care and treatment to patients which was centred on them receiving a positive experience. Despite a number of challenges which staff faced at the moment, all staff told us they were proud to work for the service.

The service had a Freedom to Speak Up Guardian in place. All staff were aware of who the guardian was, but none of the staff we spoke with on the day of inspection had approached them with any concerns. During an interview with the guardian for the service, they confirmed that prior to the current ED taking up the role, they received very little contact from staff members. This was believed to be in relation to concerns not being acted upon. However, since the ED started, they had received a number of contacts from staff who all raised concerns about the culture within the service. This was believed to be in relation to staff having more confidence that any areas of concern would be reviewed and acted upon accordingly.

Despite the concerns which were raised with us before and during our inspection, the service's own staff survey in March 2021 identified some positive aspects. Overall, the rating demonstrated staff believed the service was a positive place to work and had some positive comments on their local leaders. However, it did also identify similar concerns around senior leadership and concerns impacting staff wanting to continue to work at the service. One of the highest corroborated indicators was around staff would leave if they had a different job to go to.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. However, we found these processes were not always effective. Staff were clear about their roles and accountabilities but did not always understand how this impacted the service as a whole. Staff were given regular opportunities to meet and discuss aspects of the service.

There was a process in place to ensure most service level agreements (SLA) in place were monitored and managed appropriately. The service had a number of SLAs in place with third party providers which covered services such as laboratory investigations and escalation of care if a patient became unwell. However, we found there was a lack of oversight for one of the SLAs which was in place.

We found there was an agreement in place for a pathway for patients to undergo operations within the local acute trust before being transferred back to the service for post-operative care. Following our inspection, we requested further information about the agreement which was in place for this specific pathway as we had concerns around patient safety. The information we received showed this agreement was out of date (expiry date 31 March 2020) and had the previous executive director's details on as the commissioner for this service. The ED told us they had suspended this pathway

whilst they reviewed this to ensure patients were kept safe and staff had the appropriate skills and competencies to care for patients returning to the service. Although there were no immediate risks to patients due to the suspension of the service, we continued to have concerns around the potential for risk to patients and therefore requested the service shared the updated agreement and any associated plans for training with us prior to resuming this pathway.

The service was undergoing some changes to some of their governance processes due to the corporate changes when Circle Healthcare acquired BMI Healthcare Limited. This meant at the time of our inspection the service had a Medical Advisory Committee chair and a clinical chair. Both were responsible for the effective running and oversight of the medical advisory committee (MAC). Going forward, the clinical chair would take up the position of chairing the MAC, with the previous MAC chair becoming their deputy. The role of the MAC was to advise the ED on key governance processes which involved the medical staff at the hospital. This included granting or reviewing practicing privileges, escalation of any clinical or consultant concerns, reviewing key medical policies and performance. The committee met quarterly and followed a set agenda to ensure a consistent process. However, concerns were raised around the missed opportunity to address the issues within medical staff and their behaviours and practices. We reviewed minutes of MAC meetings and found there were members of the committee who were aware of these issues, but these minutes did not appear to demonstrate they had raised these issues and concerns. This supported what staff told us about no action being taken when concerns were raised.

When granting practicing privileges, consultants were required to agree to the corporate practicing privileges policy which set out the expectations of them. This included expectations around follow up care for patients. The policy currently required each consultant to agree a time frame with the MAC (clinical) chair and ED which was documented within their file. Staff raised concerns around this as some had previously experienced challenges when requesting support from a consultant. We found this policy did not support staff to access the support which was required due to the lack of a standardised approach for all consultants. The policy was also out of date and was due to be relaunched in January 2022 following a significant update.

The clinical chair met regularly with the ED to discuss issues and concerns raised at the MAC as well as any incidents and complaints. Meeting minutes and information was shared with all medical staff who had practicing privileges at the hospital. However, staff raised concerns as they rarely received feedback from the MAC meetings and did not know who their representative was for their specialty.

There was a governance framework in place which had four sub-committees of health and safety, medicines management, infection prevention and control and the MAC all feeding into the clinical governance meetings. Clinical governance meetings were held monthly and were chaired by the director of clinical services (DCS). A report was produced which was shared with all heads of department. This included updates from the corporate clinical directors. These were informative and contained key information about governance and performance of the service. Although there was this framework in place, this did not always effectively identify and manage governance issues within the hospital. An example of this was in relation to pre-operative assessments. Within some of the documents shared with us by the service, information around cancelled operations and complaints were discussed which was related to the quality of patient assessments. However there did not appear to be any effective management of this or details of plans for how this would be managed or monitored. We therefore had concerns around how effective this framework was.

Staff told us team meetings were regularly held and had been throughout the pandemic. There had been occasions when meetings were postponed or cancelled in some areas due to staff availability. However, heads of department always

ensured the information was shared with their staff members and opportunities given to staff for any issues which required escalating to be raised. We saw minutes from team meetings and found they followed a set agenda. The agenda included infection control, health and safety, staffing and vacancies, clinical governance, incidents and complaints, general update and hospital activity update, director of clinical services report and any other business.

Management of risk, issues and performance

Risks were not always identified and escalated. Relevant risks and issues did not always have identified actions to reduce their impact.

Heads of departments managed their departmental risk registers and regularly reviewed them. These showed very few risks within each department despite staff raising concerns and risks with us during the inspection. Staffing was one of the main risks which staff told us about in the ward areas, however this was not present on their departmental risk register. Staff also had concerns around their equipment provision which they deemed a risk, however this also was not present on the risk register. Further information received after the inspection identified a process where risks which were hospital wide were removed from departmental risk registers so focus could be maintained on those risks which were being managed by local leaders.

Departmental risk registers fed into the hospitals overarching register. The top risk was in relation to the ageing fire alarm system and the impact this had on the safety of patients and potential disruption to the service. This risk was graded as medium on the risk register. There were nine risks on the hospital risk register in total, with staffing being recorded as a low risk. We found the risk register did not accurately reflect all of the risks which we identified during our inspection, especially in relation to the concerns which had been raised about staffing. Concerns identified around the behaviours and performance and also the pre-operative assessment concerns were not present on the risk register. Following our onsite visit, we had an interview arranged with the ED and DCS (director of clinical services) who had indicated they would review the risk register in light of our inspection and feedback. This was due to take place at the planned clinical governance meeting due to be held on 25 November 2021.

The service underwent an internal quality audit which reviewed the service's compliance against the key lines of enquiry used by the CQC. This audit took place between 28 June and 1 July 2021. This identified the service were compliant with effective, caring and responsive. However, there were areas identified within safe and well-led which required some improvements, which meant they achieved partial compliance for these. We reviewed the report for this audit following our inspection and found some of the concerns we found, were highlighted on this audit. An action plan was completed by the service with key dates for actions to be completed by. However, as we identified some continued concerns and issues, some of the areas identified were not being addressed in a timely manner and were not being completed in the designated time scales. One example of this was around the prescribing of anticoagulation therapy. There were some ongoing inconsistencies with prescribing of anticoagulants as well as the assessment of patients who may require this treatment.

The service had undergone two GIRFT (getting it right first time) reviews of their services. These reviews were launched to identify examples of innovation, high quality and effective services. However, they also identified any variation or divergence from evidence-based practice. The reviews were completed in relation to orthopaedic and spinal procedures, both of which were completed on 20 September 2021. Staff told us both areas received a positive review by the assessor. However, both areas had some areas to improve on. One area within the orthopaedic review highlighted the service needed to collate data on surgical site infections as well as reviewing readmission rates. Timelines for completing these recommendations was not included in the reports. After the inspection the provider told us that data had been collated with hip and knee infection rates being 0% for 2021. Readmissions for 2021 were 0%.

Requires Improvement

Surgery

The service had a quality and risk manager who had oversight of serious incident investigations, complaints reviews and audit processes.

Safety huddles were conducted each morning at 9am. This involved the hospital management team and the heads of department. Each member gave an update of any risks to their areas or departments on that day and any help which was required. This also gave staff the opportunity to escalate any new or arising risks in their department. An example of this on the huddle we observed was the infection prevention and control lead highlighting three new infections they were investigating. Another example was the risk to staffing for the ward area due to long term sickness.