Circle Health Group Limited

The Meriden Hospital

Inspection report

Walsgrave Hospital Site
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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

We carried out an unannounced comprehensive inspection of surgery services at this location on 23 August 2022. This was to follow up on the action plan the service provided in response to our previous urgent unannounced inspection in November 2021.

Our rating of this location improved. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and mostly kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- We found a small number of consumable equipment items were out of date.
- Some details within patient notes were not completed and medical records were not always filed correctly.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	See overall summary above for details. Our rating for this service improved because we found that it was safe, effective, caring, responsive to patients needs and was well-led.

Summary of findings

Contents

Summary of this inspection

Background to The Meriden Hospital

The Meriden Hospital is operated by Circle Health Group Limited. It is a private hospital located in Coventry; where they also provide care to NHS patients. 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 services within the hospital, including NHS patients receiving care in the cardiac catheter laboratory. Facilities at this hospital included three operating theatres, an outpatient department with a minor operating suite, a cardiac catheter laboratory which reopened in June 2022 and an endoscopy suite which had four bays. Diagnostic imaging facilities onsite included MRI (magnetic resonance imaging), CT (computerised tomography), X-ray and ultrasound. MRI and CT scans were available on site between 8am and 8pm. Out of hours, the service organised for scans to be conducted at the local acute hospital if required. X-ray and ultrasound services were available on site at all times and were provided through an on-call system out of hours.

The hospital provides surgery, outpatients and diagnostic imaging core services; however, we only inspected the surgery core service during this unannounced comprehensive inspection.

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

The Meriden have been inspected six times since they registered with the Care Quality Commission. The most recent inspection was in the unannounced inspection in November 2021 when surgery services rating went down to requires improvement overall. Prior to this, the last comprehensive inspection was in April 2018 when all services were rated as good.

The service is registered to provide the following regulated activities:

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

How we carried out this inspection

We completed an onsite visit to the service on 23 August 2022. The inspection team consisted of a lead inspector, a team inspector and a clinical fellow. The inspection team was overseen by Bernadette Hanney, Head of Hospital Inspection. We visited Charlecote ward, theatres and pre-operative assessment. We also visited the newly opened onsite pharmacy department. We spoke with 27 staff, including members of the executive team, heads of department, medical staff, nursing staff, operating department practitioners, allied health professionals and healthcare assistants. We reviewed 11 sets of patient records, 2 of which were for patients who were no longer inpatients but whom had been transferred to the local acute trust and 3 sets relating to the pre-operative assessment.

We completed interviews with members of the hospital leadership team remotely on 2 September 2022.

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.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- The service had implemented their own pharmacy within the service. This has significantly improved their to take home medications for patients and improved the service as a whole to inpatients.

Areas for improvement

There was no action the service MUST take 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 SHOULD take to improve:

- The service should continue reviewing documentation to ensure they meet professional standards.
- The service should consider how they complete their stock rotation to ensure their consumable products are in-date.
- The service should continue to ensure they demonstrate compliance with all risk assessments and safety checklists to ensure safe care and treatment of patients.

Our findings

Overview of ratings

Our ratings for this location are:

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

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 and made sure everyone completed it.

The mandatory training was comprehensive and met the needs of patients and staff. All staff undertook the core mandatory training which included (but not limited to) infection prevention and control, information governance, dementia awareness and fire safety training. Additional training, for example blood transfusion training was undertook by staff where this was applicable to them.

Nursing staff received and kept up to date with their mandatory training. Information received showed compliance was recorded as 96% for staff in the surgical services which was above their internal target of 95%. On the day of our inspection, staff were undergoing face to face training for manual handling.

Medical staff received and kept up to date with their mandatory training. Staff 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 was then reviewed annually during appraisal submissions.

Managers monitored mandatory training and alerted staff when they needed to update their training. The service also had a nurse educator who would ensure staff were in date with 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.

All staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of relevant safeguarding policies in place, which were based on national guidance and legislation and followed them if they had concerns.

Nursing staff received training specific for their role on how to recognise and report abuse. All wards and departments had achieved the 95% target for all levels of safeguarding training.

Medical staff received training specific for their role on how to recognise and report abuse. The service ensured all medical staff remained compliant with safeguarding training. All training was checked during the appraisal process. The resident medical officers (RMOs) were also trained in safeguarding through the agency.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff discussed examples of safeguarding concerns they had identified, and actions taken to ensure patients were safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware of the lead for safeguarding at the hospital and would discuss any concerns with them.

Staff followed safe procedures for children visiting the ward. Following the relaxation of some COVID-19 measures, visiting requirements had also relaxed and children were now allowed to visit patients. Training for all staff was a requirement and staff were aware of what actions to take should they suspect a child was at risk of harm.

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 clean and had suitable furnishings which were 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 for cleanliness. The service conducted monthly audits of cleanliness. Results were given a RAG (red, amber and green) rating according to compliance. All areas recorded a green compliance rate for the last three audits. Where areas of non-compliance were identified, these were immediately addressed and re-audited.

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 100% compliance since December 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE) and were bare below the elbow. We observed staff adhering to the local policies in all areas we visited.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. There was a service level agreement (SLA) in place to decontaminate the surgical equipment. There was an effective process in place to ensure all equipment required for surgical procedures was reprocessed and available in good time.

All areas underwent regular flushing, and this was recorded. Any concerns staff had in relation to water safety was raised and reviewed by members of the executive team. Water safety was regularly discussed at the Infection Prevention and Control Committee (IPCC) meetings.

Good

Surgery

Staff worked effectively to prevent, identify and treat surgical site infections. There had been 13 surgical site infections (SSI) recorded since December 2021. Information provided after the inspection showed that most of the SSIs were superficial and treated successfully with antibiotics. However, there was 1 patient who had a deeper infection following neurosurgery. Following readmission to the service and further surgery, the patient was transferred to the local acute for ongoing care and treatment.

Staff used records to identify how well the service prevented infections. All patients were screened for the risk of infections on admission to hospital. The hospital followed national guidance in relation to MRSA screening and COVID-19 screening when admitted for their procedures. Patients were also screened for the risk of variant Creutzfeldt Jacob Disease (vCJD) during pre-operative assessment appointments. If other potential risk factors were identified, staff followed up on these risks and requested further advice from the IPC lead on site.

Environment and equipment

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

Patients could reach call bells and staff responded quickly when called. We observed staff ensuring patients had their call bells when leaving their rooms.

The design of the environment followed national guidance. The theatre suite followed the national building note (HBN) 26: facilities for surgical procedures. The theatres were well maintained and were not cluttered. The patient rooms on the wards were single occupancy rooms, each with their own ensuite facilities. All clinical areas were in line with HBN 00-09 infection control in the built environment.

Staff carried out daily safety checks of specialist equipment. All resuscitation equipment checked on the day of inspection was in date with their servicing and electrical safety tests. Evidence of regular checks completed by staff was available with no gaps identified. Other specialist equipment including (but not limited to) the blood gas machine and handheld point of care testing machines were in date with servicing and, where applicable, electrical safety testing. In total we reviewed 20 electrical items and found they were all in date with their servicing and electrical safety tests.

We reviewed a selection of consumable items such as syringes, blood bottles, dressings and lines and found most to be in date. We did however identify several 3 way taps which were in the clean utility of the ward which were past their expiry date. The ward manager immediately rectified this and removed from the storage area.

There was a tracking system for recording and reporting of specific implants and equipment to the national joint registry. We saw all equipment, implants and prosthesis were tracked and traced. All records had clear evidence of this with batch numbers recorded.

The service had enough suitable equipment to help them to safely care for patients. Most staff told us they had enough equipment to ensure they were able to provide safe care and treatment. Observation machines were the only item which staff believed they required more of. However, there had been no examples where the lack of an available observation machine had led to an adverse incident. Further information received after the inspection acknowledged the requirement for additional observation machines. An additional 6 observation machines had been ordered prior to our inspection and were now in place at the service.

In theatres, there was an instrument coordinator in place who ensured any specific or bespoke equipment which was required by a surgeon was available for when the patient was booked in for their procedure.

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. The management and disposal of sharps and waste was completed in accordance with policy. However, we did observe the door to the dirty utility on the ward area was locked. This could present as a barrier to staff when attempting to dispose of waste and body fluids.

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospital continued to use the National Early Warning Score 2 (NEWS2) for the detection and response of deteriorating patients. We reviewed 6 sets of notes for patients admitted on the ward and observed observations were recorded accurately and the NEWS score calculated for each set of observations. Staff were knowledgeable about the actions required if they identified a patient with a high NEWS2 score. On the day of our inspection, none of the patients whose observation charts we reviewed had a high NEWS score.

Staff completed risk assessments for each patient on admission, using recognised tools, and reviewed this regularly, including after any incident. These risk assessments included but were not limited to risk of skin damage, malnutrition risks and falls risk. Where any risks were identified, staff put appropriate measures in place to reduce the risk to the patient.

Staff knew about and dealt with any specific risk issues. The service had improved their compliance with completing risk assessments for venous thromboembolism (VTE). We reviewed 6 complete sets of patient notes and found all had a VTE risk assessment completed on admission and when appropriate, the patients were prescribed thrombosis prophylaxis. The hospital's own audits showed compliance was 97 to 99% compliance since March 2022. This was a significant improvement since the previous inspection.

Staff received sepsis awareness training and completed sepsis screening for patients when concerns were raised. Staff had access to point of care testing facilities which now included lactate testing which is a key component of the 'Sepsis Six' bundle. There is strong evidence that the prompt delivery of 'basic' aspects of care detailed in the Sepsis Six bundle prevents much more extensive treatment and has been shown to be associated with significant mortality reductions when applied within the first hour. At the time of our inspection, there were no patients who were showing signs of potential sepsis.

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 had access to a blood gas machine and a handheld blood analyser (point of care testing) if there were concerns over a patients status after their procedure. Results of these tests would be considered by doctors if they had concerns over the patient deteriorating.

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. This policy had not changed since our previous inspection despite identifying some concerns in relation to this. However, staff told us the

senior leadership team had reviewed the distance which consultants lived from the hospital. If consultants lived further than 30 minutes away from the hospital, consultants would be requested to stay closer when they had patients admitted or their practicing privileges were reviewed. Staff told us there had been some consultants who were no longer providing a service at the hospital following this exercise.

We observed pre-operative assessment staff completing comprehensive assessments of patients who were due to undergo surgery. Staff discussed the types of anaesthetic, completed blood tests and MRSA screening. Patients were given the opportunity to ask questions during their appointments and we also provided with information leaflets to ensure they understood issues discussed during their appointment, including VTE and pressure ulcer prevention.

Pre-operative assessment staff followed the corporate policy BMI NURMan06 Pre-Operative Assessment when reviewing patients prior to surgery. Within this policy, there was an inclusion criteria which used to assess the suitability of patients to receive care at this location. Staff told us since our last inspection, all staff adhered to this and there were no longer any concerns about pressures being placed upon them to go against this criteria.

Following the inspection in November 2021, the service reviewed their complex pathway between the acute hospital and their location. The senior leadership team decided this pathway was no longer required, and a final decision made in April 2022 to stop this pathway. During our inspection staff told us how relieved they were when the decision was made to stop this pathway. Patients who had been on the waiting list to undergo a procedure on this complex pathway were given the opportunity to use another location within the corporate provider.

We observed theatre staff completing the World Health Organisation (WHO) 'five steps to safer surgery' checklist for procedures. We also reviewed 6 sets of notes and reviewed the WHO checklists for each patient. Four of the forms had been fully completed. The remaining 2 had the majority of the forms completed, with the exception of confirming staff had checked the patients allergies prior to surgery. The service regularly completed audits of their WHO checklist completion; information received after the inspection showed 97 to 100% compliance was recorded since April 2022.

The service had access to mental health liaison and specialist mental health support. However due to the rigorous pre-operative assessment, staff told us it was rare for them to require any mental health support for their patients.

Staff shared key information to keep patients safe when handing over their care to others. We observed two patients being handed over to recovery staff following their procedures. These were detailed and ensured the recovery staff had all essential details to manage the patient safely.

Shift changes and handovers included all necessary key information to keep patients safe. The service had a safety huddle with all heads of department and the senior leadership team in the morning. This ensured any potential risks to patients were identified and action could be taken to mitigate the risk. The service identified there was an opportunity to improve communication about potential risks to patients using the hospital and implemented a further clinical huddle at 3pm. This was attended by clinical leads and looked ahead to the evening to identify any potential risks or if there were patients of concern on the ward.

The service had implemented a sticker system when a patient underwent an X-ray. This was a clear method to identify when a patient had received their X-ray and when staff would need to review these.

Good

Surgery

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. The senior leadership team had worked hard on recruitment since our previous inspection. Ward staffing had significantly improved with no vacancies now reported. Within theatres, there were 2 operating department practitioner (ODP) vacancies, however plans were in place to fill these imminently.

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. Ward managers used staffing tools to ensure staffing met the requirements for safe staffing. Staff to patient ratio remained no higher than 1 nurse to 6 patients. In addition to this was 3 healthcare assistants (HCAs) to support patient care. Staffing levels during the night shift remained 2 registered staff members and 1 HCA. Theatres staff in advance according to the lists which operated. Each theatre had an ODP, scrub nurse, 2 HCAs and surgeon.

The ward manager could adjust staffing levels daily according to the needs of patients. Managers reviewed the acuity of the wards regularly and discussed any additional risks during the safety hub meetings. If complex patients with additional needs were admitted, additional staff could be requested.

The number of nurses and healthcare assistants matched the planned numbers. All areas were fully staffed on the day of our inspection. Information requested after the inspection showed actual staffing had met the planned staffing numbers during July 2022.

The service had low turnover rates and low sickness rates. There were no areas which raised concerns about the numbers of staff on sick leave or staff leaving the service.

The service had low rates of bank and agency nurses. Since the previous inspection, the ward had seen several their bank staff convert to permanent contracts for the service. Due to successful recruitment, there was minimal requirement to use agency staff. Staff told us where previously they had used three members of agency staff a day, they now used three agency staff members per week maximum now.

Managers limited their use of bank and agency staff and requested staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service. When agency staff were used, they ensured they were agency staff members who were familiar to the service. The theatres had three staff who they completed block bookings for to ensure consistency within 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. New medical staff underwent an induction to the service.

Good

Surgery

The service had enough medical staff to keep patients safe. Patients were admitted for their treatment under a named consultant with the relevant experience and expertise in that area of care and treatment. Consultants led and delivered the surgical service at the hospital under practicing privileges. The hospital still had 200 consultants working under practising privileges, including but not limited to: anaesthetists, specialist surgeons such as orthopaedic, ear nose and throat and urology.

Day to day medical cover continued to be delivered by the resident medical officer (RMO). The RMO was required to provide 24 hours a day, 7 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 1 week on, 1 week off rota. RMOs had varied levels of experience with some RMOs being the equivalent of a junior doctor in foundation year 1 (FY1). The RMO who was on duty at the time of the inspection was a relatively new doctor to the service.

The service continued to always have a consultant on call during evenings and weekends. The RMO was the doctor responsible for the care of the patients in the absence of the consultant. They provided the immediate 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. If further support was required, the consultant in charge of the patients care would be available either by telephone or in person.

Managers made sure all new medical staff had a full induction to the service before they started work. RMOs employed by the service underwent significant training by the agency who supplied them, and they were provided with a local induction once they arrived at the service.

Records

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

Patient notes were comprehensive and all staff could access them easily. All clinical notes were paper based. We reviewed 11 sets of notes in total (six sets of notes for patients who had undergone their surgery, 3 sets for patients who were perioperative and two sets of notes of patients who had transferred out of the hospital during their admission). All notes appeared comprehensive and staff could easily access them. Most of the entries were legible and all had entries signed, dated and names printed. Within the 2 sets of notes for patients who had now discharged, we found items were not always filed in order. The service completed their own record audits and found the last 3 audits from January to March 2022 all recorded 80% compliance. The area for improvement identified was around the use of 'SBARD' (situation, background, assessment, recommendation and decision) forms. No other areas of non-compliance were identified through the services own audits.

When patients were admitted to the service, there were no delays in staff accessing their records. All staff told us they had timely access to patient records. In the event of patients being transferred to the local acute hospital, all paperwork was copied and sent with the patient.

Records were stored securely. All patient records were stored in the ward office which was controlled by key code entry. Observation records were kept inside each patient room on the wards.

Medicines

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

Good

Surgery

Staff followed systems and processes to prescribe and administer medicines safely. We reviewed 6 medication charts and found medicines were prescribed and administered in line with policies and best practice. Antimicrobials were prescribed according to best practice with a stop or review date being indicated and all prescriptions had an indication documented.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The hospital had increased the size of the pharmacy team, and this enabled staff to review patient records on admission and provide advice on their medication. Staff told us there were plans in place for members of the pharmacy team to provide advice to patients and their carers about their medication when they discharged from the hospital.

Staff completed medicines records accurately and kept them up to date. All prescription charts had weights and allergies recorded.

Staff stored and managed all medicines and prescribing documents safely, including controlled drugs. Since the previous inspection, the service had installed their own pharmacy which was located on the ward. This had improved the management of medicines, especially medicines which were prescribed for patients to take home. Controlled drugs were stored in line with legislation and regular checks performed. Medication fridges were all within their temperature ranges and we observed documents recording check on this. Staff were knowledgeable about actions to take if they found the medication fridges out of temperature range.

Staff learned from safety alerts and incidents to improve practice. Safety alerts were managed centrally and cascaded to areas through either pharmacy staff or ward/department managers to relevant areas.

The service conducted audits which looked at management administration and storage of medicines on a quarterly basis. Audit results showed the theatres achieved 100% compliance for the past three audits. The wards achieved 97 - 99% compliance for the last three audits. An action plan had been completed to improve on the areas that were not fully complaint.

Incidents

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

Staff knew what incidents to report and how to report them. Between January and July 2022, the service recorded 297 incidents in total. Most incidents raised continued to be graded no harm (197 incidents) and low harm (99 incidents). There was 1 moderate graded incident and no severe harm or deaths. The main theme from the incidents reported was around clinical care and communication.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Staff told us the incident reporting culture had improved since the previous inspection with all incidents now recorded on the reporting system, which included non-clinical incidents such as staffing concerns.

There were no never events reported at the service since the last inspection in November 2021.

Good

Surgery

Managers shared learning with their staff about incidents and never events that happened elsewhere. There was evidence that changes had been made as a result of feedback. Staff told us of an example where they had implemented learning following an incident which occurred at a different location.

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 incidents reported since the last inspection in November 2021. These were reported and investigated according to local policy.

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

Managers investigated incidents thoroughly. Staff received feedback from investigation of incidents and met to discuss the feedback and look at improvements to patient care. We reviewed a selection of root cause analysis (RCA) reports and found these to be thorough and areas of improvement identified.

Managers debriefed and supported staff after any serious incident or any significant incident. Staff continued to be positive about the debrief process in place following serious incidents, or incidents which were significant to them. This included incidents where patients were transferred from the ward to the local acute hospital for further care and treatment.

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. Staff delivered high quality care and treatment in line with, in date policies, procedures and guidelines which were based on best practice and national guidance and policies. Staff assessed patients' needs and planned and delivered care in line with National Institute for Health and Care Excellence (NICE), the Royal College of Surgeons and the Association of Anaesthetists.

We saw evidence of staff following NICE CG92 in the assessment and treatment of venous thromboembolism (VTE). All patients were risk assessed on admission and appropriate treatment prescribed by medical staff if deemed at risk.

Assessment and treatment for patients with sepsis was in line with the NICE guidance 51(NG 51): sepsis recognition, diagnosis and early management.

Staff had an awareness of the protected rights of patients subject to the Mental Health Act and would follow the Code of Practice. However, due to evidence-based screening tools, patients with a previous history of mental ill health were not routinely admitted to this hospital.

Good

Surgery

At handover meetings, staff routinely referred to the psychological and emotional needs of patients alongside their physical needs. This had been especially important during the pandemic where patients were not able to have their relatives visit them.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. All patients had their nutritional requirements identified during the pre-operative assessment stage of their admission. If patients had any special requirements, this would be discussed with the catering staff to ensure they were prepared to meet the patients' needs when admitted. Staff told us they were able to provide meals for all patients regardless of any dietary requirements or religious and cultural requirements.

Patients told us the food was acceptable and they were offered appropriate amounts of food and drink. However, there were some patients who believed a wider variety of offers would be preferable to them.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We saw evidence of a patient's fluid chart which was completed appropriately following their procedure, including the calculation of their balance at the end of the day.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We observed completed examples of patients' nutritional assessments.

Part of the admission criteria stipulated the acceptable body mass index (BMI) of a patient for admission at this service. Those who were identified to have a low BMI were reviewed by the consultant to consider their suitability to receive their care and treatment at this location. If the decision was identified that they were not suitable to undergo their procedure at the location, they were supported to identify an alternative location where additional support could be provided with nutrition if required.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff provided patients with verbal and written information about the requirements for being nil by mouth (which means nothing to eat or drink) prior to their surgery. This was in line with national guidance and was checked as part of the ward checks and perioperative checks prior to surgery. Following surgery patients had effective management of nausea and vomiting. Patients were prescribed anti-emetic (anti-sickness) medication to enable them to drink and eat.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff assessed patients for pain during routine observation times using a numerical scoring tool. Staff had access to alternative pain assessment tools for patients who were unable to verbally communicate. Staff told us they also wrote down questions for patients who had hearing impairments to gauge the information required. This was then recorded on the observational tool in use.

Pain management audits were now part of the new safe care audits. The audit reviewed prescriptions to ensure adequate pain relief was prescribed and documentation around pain assessments being completed. The most recent audit for June to August 2022 had dropped from 98% to 93%. The reason identified for this was around staff not recording omissions within the medication chart. The pharmacy staff were working with clinical staff to improve this.

Patients received pain relief soon after requesting it. Patients told us and we observed timely administration of analgesia (pain medication) when patients were in pain.

Staff prescribed, administered and recorded pain relief accurately. All patients were prescribed regular and as required analgesia. Pain relief was usually prescribed by the anaesthetist prior to returning to the wards. Staff ensured they regularly monitored patients and their pain levels.

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 did not participate in many national clinical audits. However, the corporate clinical team actively reviewed and collated results from national audits to identify any relevant findings which could be used to improve services. Information provided after the inspection showed the service did not participate in many national audits as most of them were not applicable to the services they currently provided. However, the service completed a number of local audits to gather data on their performance locally. The service did participate in the National Joint Registry programme which published data on the outcome or quality of care delivered to patients. As of July 2022, NJR had recorded 339 procedures for patients at this location, the majority of which were hip and knee replacements, although there had been a small number of shoulder and ankle procedures recorded.

Senior members of staff told us they informally compared their performances to those of other services both internal of the corporate provider and external to the corporate provider. They believed they were of similar standing based on a number of items they compared themselves against.

Managers and staff used the results to improve patients' outcomes. The service had previously 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. There had been no further reviews since this, and the actions identified had been implemented.

Outcomes for patients were mainly positive and were mostly in line with national standards. The service submitted information to the Private Healthcare Information Network (PHIN). PHIN is an independent, not for profit organisations which published key performance information on their website to help patients make informed decisions about where to have their care and treatment. PHIN recently published health improvement data sheets covering 1 April 2020 to 31 March 2021, which contained PROMS (patient reported outcome measures) information submitted by the service for primary hip and knee replacements and cataract surgery. On all three measures the service had a higher than England average number of responses to the PROMS questionnaires. The service reported similar or slightly better results for improvement following primary hip replacements (98.2% reported for the service against an England average of 98.3%) and cataract surgery (90.5% reported for the service against an England average of 88%). However, the service reported a lower number of patients who reported they had improved following their primary knee replacement. Information showed 86.4% patients reported an improvement following their surgery against an England average of 95.4%. The service were looking into improving this outcome.

Good

Surgery

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment and shared and made sure staff understood information from the audits. Audits which were included on the local audit programme included (but not limited to) WHO Checklist compliance, Infection Prevention and Control audits, blood transfusion and AfPP (Association for Perioperative Practice) theatre compliance audit. These were completed regularly to ensure compliance was maintained. Staff also told us of the new Safe Care audits which were conducted on a quarterly basis. Included within this audit bundle was VTE, Malnutrition Universal Screening Tool (MUST), Waterlow, Falls Risk Assessments, Theatre Temperature checks, Chaperone, Fasting, NEWS and Pain Management audits.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers made sure staff received any specialist training for their role. The service had organised for all pre-operative assessment staff to undergo bespoke competency training after the last inspection. Staff were now confident and competent in their work which had improved their morale within the service.

Managers gave all new staff a full induction tailored to their role before they started work. Staff who had recently gone through this told us this was detailed and prepared them to undertake their role in the service.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff told us managers were interested in developing their staff further and their appraisals were conducted in a meaningful way to enable them to discuss any developmental opportunities. Information provided after the inspection showed all staff were in date with their appraisal across wards, theatres and pre-operative assessment.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. All medical staff underwent an appraisal as part of their professional body registration requirements. Information of their appraisals was shared with the service as part of their practicing privileges requirements.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We reviewed minutes from department meetings which were detailed and readily available for those who were unable to 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. Staff told us there was a positive attitude towards training and staff were encouraged to develop their skills and knowledge.

Managers identified poor staff performance promptly and supported staff to improve. When concerns were identified in a staff members performance, this was responded to quickly and appropriately and personal action plans were implemented to help with the staff members development.

Multidisciplinary working

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

Good

Surgery

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All members of the multidisciplinary team (MDT) met in the morning to discuss aspects of patient care and treatment at the safety huddle. In addition to this, staff told us the MDT worked together to ensure patients had a positive admission. Staff from all areas commented on how the MDT working relationships had improved since the last inspection.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff told us of a positive experience where they were required to work with other agencies to ensure a patient was discharged safely. Despite this being a rare occurrence, all members of the extended MDT worked effectively to ensure the patient was safe on had all their needs met.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Despite there being a strict admission criterion, staff told us there were rare occasions when patients presented with new mental health challenges which required additional support and follow up. Staff gave examples of where they had arranged for follow up when patients had displayed or discussed mental health challenges. In addition to this, staff had also signposted patients to other agencies and charities which were able to provide additional support.

Seven-day services

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

Consultants attended the ward daily, including weekends. Patients are provided consultant led care. Under the practicing privileges' policy, all consultants were required to attend the ward to review their patients on a daily basis as a minimum. In addition to this, the resident medical officer (RMO) also reviewed patients daily.

Staff could call for support from the RMO who could arrange some diagnostic tests, 24 hours a day, 7 days a week. Operating theatres operated six days each week. There were diagnostic imaging services available on site, however, these were not all available 24 hours each day. X-ray and ultrasound services were available on-site at all times, including via an on-call arrangement outside of normal operating hours. If patients required urgent CT or MRI imaging outside of the normal operating hours, this was arranged with the local acute hospital.

Health promotion

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

The service had relevant information promoting healthy lifestyles. Patients were provided information specific to their needs during their pre-operative assessment appointments.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. In addition to identifying any health promotion needs during the pre-operative assessment appointment, ward staff also looked for opportunities to promote healthier lifestyles and provided patients with information to support their needs.

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, however patients rarely admitted requiring such support.

Good

Surgery

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. We observed good examples of consent forms which had been completed with patients undergoing surgery, as well as staff gaining verbal consent prior to performing any procedures or initiating any therapy.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Staff 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 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. Staff discussed a recent patient where they had concerns around their decision making and the actions, they took to address this.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their safeguarding adults training. Information provided after the inspection showed all areas had good compliance with all safeguarding adults training. All areas recorded 100% compliance with all levels of safeguarding adults training with the exception of the wards who recorded 96.9% for level two safeguarding adults training.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. However, due to the strict criteria for admission at this service, they rarely had any patients who required staff to escalate their concerns in relation to capacity or the necessity to deprive a patient of their liberties.

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. We observed care being provided to patients in a dignified manner. When receiving personal care, staff ensured doors were closed to protect their privacy and dignity. Patients commented on how dignified they had been cared for. The service completed their own internal patient satisfaction survey and results showed 100% of patients felt they were treated with respect and dignity. Additional comments included "all staff treated me with respect and dignity, I felt I was the only patient as my care was individualised" and "absolutely everyone treated patients and each other with dignity and respect. 5-star treatment".

Good

Surgery

Patients said staff treated them well and with kindness. Without exception, all patients we spoke with told us how staff had treated them with kindness and compassion. We observed staff interacting with patients in a kind and meaningful way. Comments provided by patients included “everybody was kind, attentive and helpful” and “I’ve been looked after well”.

Staff followed policy to keep patient care and treatment confidential. All conversations between patients and staff were conducted within rooms with doors closed, and confidentiality was always maintained . This was reflected in the services own local satisfaction survey where 100% of patients were given privacy when discussing their condition and treatment options.

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 any complex needs including (but not limited to) mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff were able to discuss examples of care when they had respected the specific needs of a patient. Cultural and religious needs were well understood, and staff ensured any specific cultural needs would be considered whilst admitted.

In addition to the local satisfaction survey, the service also participated in the friends and family test (FFT) involving NHS patients only. FFT is a single question survey which asks patients whether they would recommend the NHS service to their friends and family there were also feedback cards and comment boxes were available throughout the service. We reviewed the results between January and July 2022 and found the response rate for this service was low and there were occasions (January, May and June 2022) when no results were published because of this reason. For February, March and April 2022 where the response rate was slightly higher, the service recorded 100% for each of these months with patients responding that they would recommend the service to the friends and family.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. We observed staff providing emotional support and advice to patients who required this. Staff commented on how during the pandemic when visitors were not able to visit on the wards, they ensured they spent as much time as possible with patients as they did not want them to feel lonely and isolated. Now visitors were allowed back in, staff encouraged patients who required additional support to have their friends or relatives with them.

Staff supported patients who became distressed and helped them maintain their privacy and dignity and demonstrated empathy when having difficult conversations. Staff were able to sign post patients to organisations for additional support if this was required. Feedback received through the local satisfaction survey included comments on how staff had provided them with “excellent support” during their stay and how they were able to “provide the required reassurance”.

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.

Good

Surgery

Staff made sure patients and those close to them understood their care and treatment. Staff took the time to ensure patients understood the information they were provided during the admissions. We observed patients being given the time to ask questions if they were unsure about the information provided. Feedback from the local satisfaction survey included comments in relation to how staff "exceptionally explained the process in detail".

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff ensured they adapted how they explained details to patients so that they were able to understand. Where patients had other requirements around communication, staff took this into consideration.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients gave positive feedback about the service. The service used a variety of resources to capture the feedback from patients. This included the friends and family test (FFT) for NHS patients who used the service, local patient satisfaction surveys, social media sites and online reviews services. All methods for capturing feedback demonstrated mainly positive feedback with words such as 'excellent' 'lovely' 'wonderful' and 'exceptional' used to describe their experiences. Managers at the service told us their online review service had recently reached a four-star (out of five) rating which was comparable to other local providers. Patients were also encouraged to provide any feedback they had to staff during their admissions to ensure they had a positive experience.

Are Surgery 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. All admissions to the service were elective admissions and planned in advance. The service used a corporate admissions criterion to ensure only those patients whose needs could be met by the service were admitted. The service worked with the local system and the local acute trust to ensure the needs of the local population were being met. This had most recently included supporting the local acute trust with their elective recovery programme post pandemic.

At the time of our inspection, the service was providing more care and treatment to NHS funded patients (approximately 60%) than privately funded patients (approximately 40%). The service was supporting their local acute hospital by undertaking elective procedures such as orthopaedic and general surgery procedures. They were also providing the facilities for the local acute trust to complete cardiac procedures.

Facilities and premises were appropriate for the services being delivered. The service provided level zero (ward-based care) and the services available were appropriate for this.

The service had processes in place to escalate any patients who required additional support or specialist intervention. This included but was not limited to patients with complex needs and patients who deteriorated and required additional support to help recover.

Good

Surgery

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 with complex needs received the necessary care to meet all their needs. Staff told us the strict criteria meant they rarely had patients with mental health needs or learning disabilities, however they occasionally admitted patients who were living with dementia. When they had patients with additional needs, they ensured they took the necessary steps to meet their needs. Staff discussed how they had provided a patient's relative with a bed so they could stay with them if this was required and had started to collect items for distraction therapy. The wards had a dementia champion who was taking the lead on ensuring individual needs of a patient living with dementia could be met if admitted to the service.

The wards were not currently designed to meet the needs of patients living with dementia. However, staff told us there were plans to make the ward more dementia friendly and items had been purchased which were essential to meet the needs of patients living with dementia.

On the rare occasions patients living with dementia were admitted into the service, staff supported them by using 'This is me' documents and patient passports if available.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us about examples where communication aids for those who were blind had previously been used.

The service had access to information leaflets available in languages spoken by the patients and local community. However, most leaflets observed within the hospital were in English which staff told us was the main language which their patients spoke. Staff told us they would easily be able to access patient leaflets in alternative languages when required.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff ensured interpreters were booked in advance for patients where required, this also included British Sign Language interpreters for deaf or hearing-impaired patients. On the rare occasion an interpreter was not available, or a new patient attended pre-operative assessment with no prior knowledge of interpretation requirements, staff had access to telephone interpretation services or online interpretation services. Staff were strict on ensuring the correct processes were followed for providing interpretation services and would not use family members for this purpose.

Patients were given a choice of food and drink to meet their cultural and religious preferences. In addition to providing patients with a choice of food and drink to meet their cultural and religious needs, staff showed us a room which was being converted into a multi-faith room. Staff also told us they had access to a variety of faith leaders should patients require a visit from one.

Staff had access to communication aids to help patients become partners in their care and treatment should they require them for patients.

Access and flow

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

Good

Surgery

Activity at the service was reported to be reduced since the last inspection in November 2021. However, managers told us this was beginning to increase again. Between December 2021 to July 2022, there were 2,990 operations performed at the service. Endoscopy procedures were the main procedures completed for NHS funded patients with orthopaedic procedures (including replacement of prosthetic knee joints) also being a common procedure for NHS patients. Primary hip replacements were the most common reason for surgery for privately funded patients.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service had continued to support the local acute trust throughout the pandemic and had accepted a number of long waits from them to support with the elective recovery plan. At the time of our inspection, there were 2,838 NHS funded patients waiting for their elective surgery at the service. The majority of patients were within the 18-week waiting period (43% of the total number of patients waiting). There were currently no patients on the waiting list who had been waiting over 100 weeks. Managers told us there was a focus on prioritising the patients currently who will be breaching 78 weeks by the end of March 2023. There were currently 570 patients who would be in this position who they will be listing for surgery over the coming months.

There were no patients waiting who were privately funding their surgery. Staff told us they organised patients who were privately funding their surgeries for the time they requested.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff told us the average length of stay for patients was around three days.

Managers worked to keep the number of cancelled operations to a minimum. However, between December 2021 to July 2022, there were 912 operations cancelled. Information showed the largest proportion of surgeries were cancelled by the patient (59% of the total number) with personal reasons being cited as the main reason for this. Clinical issues were also identified as a significant reason for cancelling operations (13% of the total number). COVID-19 related concerns continued to impact the service with 23% of surgeries cancelled attributed to COVID-19 (including staff and patient related COVID-19 issues).

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. Information provided showed there were 14 patients (1.5%) of patients cancelled on the day of the surgery due to clinical reasons. All patients were rescheduled for the earliest (and most convenient) opportunity.

Managers monitored and took action to minimise missed appointments and ensured that patients who did not attend appointments were contacted. Between December 2021 to July 2022, there were a total of 16 patients who were categorised as ‘did not attend’ the service. This included patients who did not attend for their operation.

The service moved patients only when there was a clear medical reason or in their best interest. There was a service level agreement (SLA) in place with the local acute hospital for management of patients who were at risk of deteriorating or required additional support which could not be provided at the service. Between December 2021 to July 2022, there were nine patients who were transferred to the local acute hospital under this SLA.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff ensured the patient had suitable discharge arrangements in place as early as the pre-operative assessment appointment. If there were any concerns identified in relation to a patient discharging after the procedure, their suitability for undergoing the procedure would be reviewed at this stage.

Good

Surgery

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients told us they felt comfortable raising any issues with the staff caring for them at the time. One patient told us they had vocalised some concerns when they were originally admitted; however, at the time of the inspection, all patients we spoke with were happy with the care and treatment they were provided.

The service clearly displayed information about how to raise a concern in patient areas. Posters were visible around the hospitals providing complaints information.

Staff understood the policy on complaints and knew how to handle them. The service followed the corporate complaints' policy which provided clear structure on the management of complaints. Staff always tried to ensure any complaints could be resolved locally in the first instance prior to any escalation of formal complaints.

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 we spoke with were knowledgeable about the complaints they had received and the investigation process they used. All managers we spoke with told us they had received low numbers of complaints since the last inspection. Information we received showed between December 2021 to July 2022, there were 76 complaints received by the service, with April 2022 recording the most in one month (17 complaints). Some of the complaints had multiple themes within them. The main themes were:

- Consultant related complaints.
- Communication.
- Clinical care and treatment.

No complaints had been referred to either the Parliamentary and Health Service Ombudsmen (if related to NHS funded care) or the Independent Healthcare Sector Complaints Adjudication Service (if related to privately funded care).

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. Complaints information was a standing agenda item on ward and departmental meetings. Information about complaints and any actions taken was discussed during these meetings and there were notes taken for staff to read who were not able to attend.

Are Surgery well-led?

Good

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

Leadership

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

Good

Surgery

The service had a clear management structure in place which defined lines of responsibility and accountability. The executive director (ED), who was also the registered manager, was supported by the director of clinical services and director of operations. There was also a network of heads of department (HODs) who supported the director of clinical services and director of operations. Since the previous inspection, there had been a change in personnel in the positions of director of clinical services and director of operations. All staff we spoke with, without exception, spoke positively about the new members of the senior management team.

All members of the senior leadership team (SLT) were viewed by staff as visible and approachable. Staff were all complimentary about the SLT and the positive impact they had on the service. They were genuine in their approach to ensuring they were accessible to staff if they had concerns and felt they were always listened to. The 'you said, we did' boards were a reflection of this.

All leaders had the skills and abilities to run the service. The new director of clinical services and director of operations both had extensive backgrounds within their roles and responsibilities and all staff believed they had the skills and abilities to lead the service. The HODs also demonstrated the required skills and abilities to lead their departments. The ward manager and pre-operative assessment lead were both new in post since our previous inspection and were considered to be well suited and experienced for these roles. Staff were supported in all areas by their local leaders to develop their skills and further their careers.

During the previous inspection, there were concerns over the changes which had occurred to the senior leadership team, especially in relation to the ED role. However, the new ED was viewed as a positive appointment who had already brought some stabilisation to the service. During this inspection, we were aware some forthcoming changes in the senior leadership team. Staff told us about their concerns in relation to this announcement, however they believed the changes that had been implemented were embedded and the previous concerns would not reoccur.

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 and high-quality care and treatment. Leaders and staff understood and knew how to apply them and monitor progress.

The service had an overarching corporate vision which they implemented. This was to 'provide the high quality, safe and compassionate care our patients need and expect'. A set of values underpinned this which staff were aware of.

The service had devised their own objectives for which they wanted to achieve locally which was aligned with the corporate strategy. This included:

- To provide open, transparent, accessible, high quality care providing the best possible patient outcomes.
- To be a supportive, open, transparent respectful team. Allowing staff to develop and be able to speak up and help scope the service provided.
- To provide care within the agreed standards of accreditations across all clinical areas. To ensure services are delivering the most up-to-date evidence-based care to our patients.
- To maintain safety whilst ensuring we deliver an efficient profitable service to meet the needs of the local population.

Staff spoke of an immediate priority for this hospital in relation to the increase in activity over the coming months whilst ensuring patient safety remained at the centre of this.

Good

Surgery

Culture

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

The change in the culture of the service was palpable during the inspection. Staff were vocal about the positive changes in the culture at the service since the last inspection in November 2021. Staff were engaged and staffing had improved in relation to the positive changes within the service. Staff now felt respected, supported and extremely valued by the senior leadership team and the heads of department. Staff were supported to develop their skills and look for career opportunities. Staff in theatres were especially vocal about the support they had received to develop their career. There was an open-door policy amongst most of the managers and staff were not afraid to approach with concerns if they had them. They continued to feel supported by their peers in their immediate areas. Staff well-being was an important aspect and managers ensure all staff had the opportunity to seek support. In addition to this, the SLT had provided staff with rewards to acknowledge their hard work as well.

Where behaviours had been identified as going against the values and standards of the service, this was immediately dealt with, which staff identified as a positive action and supported the change in the overall culture.

All staff we spoke with told us the service was patient centred and they were committed to ensuring patients had a safe and positive experience whilst admitted. This was expected to continue without challenge as the service prepared to increase activity. All staff were committed to ensuring the patients remained at the heart of all they did.

The service was committed to promoting equality and diversity. A member of staff had recently volunteered to become a lead for promoting equality and inclusivity within the service.

A staff survey was conducted in March 2022. The results showed there had been an improvement in a number of measures which supported the positive change in culture at the service. The largest change in the survey was around the satisfaction with the leadership at the service. This measure had increased by 21% from the survey which was conducted in March 2021.

The service had an open and honest culture where staff, patients and their families could raise concerns without fear of this negatively impacting them. The service continued to have a Freedom to Speak Up Guardian in place. Since our previous inspection, there had been a reduction in staff needing to seek support from them.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a corporate governance framework in place which the location had implemented locally. This had recently been launched and provided structure and transparency around how the governance of the service was designed to drive continuous improvement and safe and effective care. The framework also identified clear lines of accountability at all levels.

Good

Surgery

Clinical governance meetings occurred on a monthly basis. We reviewed minutes of the meetings and saw incidents, complaints, audit outcomes and mandatory training compliance were amongst the topic regularly discussed. Where actions were identified for staff to complete, these were formally recorded, and actions were reviewed as part of subsequent meetings to ensure these were monitored and closed when completed. Sub-committees for infection prevention and control and health and safety fed into the main clinical governance meeting.

Ward and department areas conducted their own meetings where information from the clinical governance meeting and other sub-committee meetings was cascaded down. These also gave staff the opportunity to raise concerns or risks which required escalating up at the next opportunity. We reviewed minutes of these meetings which were well attended.

The medical advisory committee (MAC) was chaired by a clinical chair under the new corporate governance system. 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. The MAC had recently undergone a change in representation and new consultants were elected to join. This was in line with the corporate policy in relation to the MAC membership.

The practicing privileges policy was updated shortly after the last inspection. This was shared with all consultants who held practicing privileges at this location to reaffirm the expectations of them when undertaking private work at the hospital. The policy largely appeared to be similar to the previous version, which was in place, which included the individual arrangements around expectation of follow up for patients which was individually agreed with the consultant and the ED and clinical chair. However, the ED had conducted a review of all 200 consultants on practicing privileges in relation to the distance they were form the hospital. A local measure was put in place to ensure the consultants were within 30 minutes of the service when they had patients receiving care and treatment.

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 decontaminating surgical equipment, laboratory investigations and escalation of care if a patient became unwell. These were annually reviewed and where changes required, these were negotiated.

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.

Heads of departments managed their departmental risk registers and regularly reviewed them. Departmental risk registers fed into the hospitals overarching register. The overarching risk register had undergone some changes since the last inspection. There had been risks which had been removed due to there no longer being a risk to the service. However, new risks had rightly been added to reflect the new risks which the service now identified. One new risk which was evident was around the impact of the previous inspection and the risk that the service had not improved which would continue to impact confidence in the service. The largest risk on the overarching register was in relation to staff absence due to on-going COVID-19 sickness. This was graded medium based on the concerns and the mitigation in place. Staffing as a whole had been removed from the overarching risk register due to the successful recruitment which had occurred since the last inspection.

Good

Surgery

The service used a process called 'Stop the Line' to help with potential risks on a more immediate basis. All staff members were involved in this and could stop the line at any point when they encountered a situation where harm may be caused. Staff gave examples of where these had been conducted. From this, a collective problems-solving process called a 'Swarm' occurs.

Swarms gave those involved an opportunity to explore the issues identified and identify ways to resolve it in a timely manner. Swarms were always completed when there had been a 'stop the line' situation, however they could be held when any situation was identified and called by any member of staff. Staff told us examples of Swarms they had been involved in and we saw documents which recorded recent Swarms. One example shared with CQC was in relation to the upgrade in phone lines and wireless internet service which had stopped the staff from being able to call '2222' in the event of an emergency with a patient. Immediate actions were taken to ensure patient safety with some longer-term actions identified which would require longer to implement.

The corporate team sent out 'flash alerts' which staff at the service used for shared learning purposes. The flash alerts covered a range of incidents which had occurred. Examples of these we observed including an incident where scrub solution was drawn up and injected instead of local anaesthetic and a never event where a retained swab had occurred. Some of these had led to Swarms being performed to ensure the service was not at risk of similar incidents occurring.

The service had completed 9am safety huddles for some time. These were deemed extremely beneficial to ensuring any risks to patients or the service were identified early and thus acted upon. The service had implemented a new 3pm clinical huddle which all clinical heads of department attended to ensure the safety patients (and staff) continued throughout the remainder of the day and into the evening.

Performance of the service was discussed during various meetings including but not limited to local clinical governance meetings and the MAC meetings. The service had implemented the relatively new safe care audits. These enabled the service to keep a closer oversight on some key risk factors within the service and to ensure action was taken immediately on the results. Results were also discussed at corporate clinical governance meetings if the results identified any key improvements or concerns.

The service underwent an assurance visit by the Clinical Commissioning Group (CCG) now formerly known as commissioning function of the Integrated Care System (ICS) in May 2022. This visit was to gain assurance around the improvements which the service had made since the inspection in November 2021. The outcome from the visit was largely positive and commended the service on the work they had done. There was one aspect which the service was required to take action on, and this was confirmed as actioned immediately after the visit.

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

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

Good

Surgery

The service collected reliable data and analysed it internally to enable improvements to be made. At present a lot of records were paper based however, there were plans in place to upgrade to electronic systems which would support the rigorous data collection and simplify this. For the activities which staff used electronic systems for, these were secured and monitored. We observed that they had secure log ins for each computer, and these timed out if they were not used in a set time.

The service ensured data and notifications were submitted to external bodies as required. The CQC had received statutory notifications from the service when incidents had occurred which met the regulations for reporting. In addition to this, the service submitted data to organisations such as PHIN (for performance data) and UK Health Security Agency (for surgical site infections).

Engagement

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

All staff encouraged patients to provide feedback on their experience at the service. This was through the various feedback options available to them. The service regularly reviewed the feedback they were given and had acted on feedback received. When positive feedback was given, the service celebrated this and informed the corporate provider about this. One example of where this occurred was when the ward staff received an 'Oscar award' from a patient who was thankful for the care and treatment provided during their admission. The Oscar was similar to the statue issued within the film industry and was sent to the ward staff in recognition of the 'outstanding' care and treatment they provided a patient.

Staff forums had been introduced at the service. These were well received and well attended. No formal minutes were taken of these meetings, however themes from the feedback given was taken to enable the senior leadership team (SLT) to target where action was required. In response to the themes raised, the SLT had introduced 'you said, we did' boards around the hospital to update staff on actions taken. One suggestion from the staff forums which was being implemented was employee of the month recognition awards.

The SLT had provided staff with a crepe van to celebrate International Nurses and Operating Department Practitioner days. This was well received by all staff within the service.

The service worked closely with the ICS and the local acute trust to improve the services for patients at the hospital.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Following our previous inspection in November 2021, we identified several concerns which required improvement. During this inspection, we identified the service had made substantial steps to improve. All staff were engaged and committed to improving the service and shared the vision of the managers. Compliance with risk assessments, staffing and the overall improvement in the culture of the service was some of the most noticeable improvements observed during this inspection. The pre-operative assessment department had also undergone improvement since the last inspection, with all staff completing competencies within the area.

Good

Surgery

The implementation of the onsite pharmacy meant that patients received a safer and more effective service, especially when it came to discharge medication. The pharmacy team were able to turn around TTOs (to take out) in 25 minutes which had seen a reduction in complaints from patients about the wait for medication. The pharmacy service would soon be participating in quality improvement programmes (QIPs) in relation to TTOs and medication explanation to patients when discharging.

The service had achieved their AfPP (Association for Perioperative Practice) accreditation, demonstrating they had achieved high standards of perioperative care. The service was preparing to undergo their JAG (Joint Advisory Group) accreditation for endoscopy services.

The service was aiming to improve the service and become a centre of excellence for orthopaedics. Part of this aspiration included proving day case knee replacement surgery.

The service had worked hard to improve their patient satisfaction and staff engagement score. At the time of our inspection, the service had recently received a 4.1 on the online satisfaction system which was comparable to other independent hospitals within the region.

The service won an award earlier this year from the National Joint Registry (NJR) for compliance.