Burcot Hall Hospital Ltd

Burcot Hall Hospital

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

Burcot Hall is an independent hospital, based in Bromsgrove, Worcestershire.

The service was registered under the current provider in September 2020 and is an independent hospital that offers a diverse range of cosmetic and weight loss surgical procedures. The service has not yet been inspected.

Whilst primarily offering surgical cosmetic procedures largely privately funded by patients. Since the pandemic, they have had contracts with some NHS acute hospitals. They have been carrying out work to reduce the waiting lists at the acute trusts for, orthopaedic surgeries (both under Local Anaesthesia (LA) and General Anaesthesia (GA), vascular, maxillofacial and plastic surgeries.

The hospital has four surgical theatres and 30 inpatient beds. There is a registered manager in post.

We carried out this unannounced focused inspection because we had received information of concern about the safety and quality of the services. The information of concern related to the following areas:

- Assessing and responding to risk.
- Infection prevention and control.
- Mandatory training
- Staffing provision (medical and nursing)
- Leadership.
- Culture.
- Governance systems.
- At the time of our inspection Burcot Hall Hospital Ltd the registered provider did not employ any staff or provide any regulated services directly. All staff and support services were being provided by another provider. After our inspection a service level agreement was put in place to ensure the accountability lay with Burcot Hall Hospital Ltd.

We did not rate the service at this inspection. This was a focused inspection; based on risk, we only inspected certain key lines of enquiries in the domains; safe and well led.

We found:

- The service did not always make sure all staff completed mandatory training in key skills.
- Staff did not always use control measures to protect patients, themselves and others from infection. However, they kept equipment and the premises visibly clean.
- Not all risks were removed or minimised. Staff completed and updated risk assessments for each patient. Staff identified and acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, records were not always stored securely.
- Leaders did not have all the necessary skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.
- Leaders operated some governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, there were not regular opportunities to meet, discuss and learn from the performance of the service.

Summary of findings

- Leaders and teams did not use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however, they were not always communicated effectively. We could not be assured that the changes, practices and systems would be embedded.

However,

- 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 medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, however, not all lessons learnt were communicated effectively. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inspected but not rated	We found: • The service did not always make sure all staff completed mandatory training in key skills. • Staff did not always use control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. • Not all risks were removed or minimised. Staff completed and updated risk assessments for each patient. Staff identified and acted upon patients at risk of deterioration. • Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, records were not always stored securely. • Leaders did not have all the necessary skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. • Leaders operated some governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, there were not regular opportunities to meet, discuss and learn from the performance of the service. • Leaders and teams did not use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however, they were not always communicated effectively. We could not be assured that the changes, practices and systems would be embedded. However, • The service had enough nursing and support staff with the right qualifications, skills, training

Summary of findings

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 medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, however, not all lessons learnt were communicated effectively. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of findings

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Summary of this inspection

Background to Burcot Hall Hospital

Burcot Hall is an independent hospital, based in Bromsgrove, Worcestershire.

The service was registered under the current provider in September 2020 and is an independent hospital that offers a diverse range of surgical procedures, such as orthopaedics. The service has not yet been inspected.

Whilst primarily offering surgical cosmetic procedures, since the pandemic, they have had contracts with the NHS acute hospitals. They were carrying out work to reduce the waiting lists at the acute trusts for, orthopaedics (both under Local Anaesthesia (LA) and General Anaesthesia (GA), vascular, max fax and plastics.

The hospital has four surgical theatres and 30 inpatient beds. There is a registered manager in post.

How we carried out this inspection

During our inspection we visited the inpatient ward, theatre and recovery areas, we spoke with 15 members of staff, including the hospital director, ward and theatre managers, registered nurses, healthcare assistants, operating department practitioners and medical staff.

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

Areas for improvement

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

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements. This action related to surgical services.

- The service must ensure that effective actions are completed to improve compliance with the World Health Organisations Surgical Safety Checklist. (Regulation 12 (1))
- The service must ensure that all staff have up to date mandatory training and an annual appraisal. (Regulation 18 (1))
- The service must ensure that staff and patients are provided with suitable arrangements to protect from the risk of COVID-19. (Reg 12 (1))
- The service must ensure that there are processes in place to manage the performance of the service effectively. (Regulation 17 (1)).

Action the service SHOULD take to improve:

Summary of this inspection

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that all records are secured in clinical areas. The service should ensure that all learning and investigations following incidents and never events are communicated with all staff.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Surgery

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Surgery safe?

Inspected but not rated

We found:

- The service did not always make sure all staff completed mandatory training in key skills.
- Staff did not always use control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- Not all risks were removed or minimised. Staff completed and updated risk assessments for each patient. Staff identified and acted upon patients at risk of deterioration.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, records were not always stored securely.
- The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, however, not all lessons learnt were communicated effectively. When things went wrong, staff apologised and gave patients honest information and suitable support.

However,

- 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 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.

Mandatory Training

The service did not always make sure all staff completed mandatory training in key skills.

At the time of our inspection Burcot Hall Hospital Ltd the registered provider did not employ any staff or provide any regulated services directly. All staff and support services were being provided by another provider. After our inspection a service level agreement was put in place to ensure the accountability lay with Burcot Hall Hospital Ltd.

Training for staff working at Burcot Hall had been delivered by the provider who employed the staff.

The mandatory training data provided by the hospital showed that they did not meet the hospital targets for January, February and March 2021, where compliance for the ward was, 48%, 49% and 66% respectively. For theatres it was 52%, 52% and 69%. The compliance rate for April 2021 was 80% for the ward was 80% and 82% for theatres, against a target of 80%.

Inspected but not rated

Surgery

The pandemic and increased workload was given as a reason behind the low compliance rates at the beginning of the year, and the face to face modules could not be carried out.

The mandatory training was comprehensive and met the needs of patients and staff. Areas covered included: equality and diversity, health and safety, fire safety, infection control, and basic life support training.

Training was mostly provided via e-learning courses, with some face-to-face sessions, such as manual handling and basic life support. Staff we spoke with said they had also completed specific training in sepsis; however, this was a one off training module and not part of the mandatory training programme. Staff had not had any updates in sepsis training since 2019.

Managers monitored mandatory training and alerted staff when they needed to update their training. They said that the training programmes were well embedded within the service. Managers confirmed they alerted staff when they needed to update their training via emails, and it would be discussed at staff appraisals.

Basic life support (BLS) was provided for registered nurses and health care assistants (HCA) on the ward and theatres. Compliance for April 2021 showed

- Ward and theatre registered nurses: 51% (11 registered nurses required a BLS update)
- Ward and theatre health care assistants: 25% (27 HCAs required a BLS update).

In the hospital's resuscitation policy, it stated that theatre, anaesthetic operating department practitioners (ODPs) and registered nurses who did permanent nights on the ward should complete immediate life support (ILS). The data showed that 73% of operating department practitioners (ODPs) were trained in ILS. This was below the target of 100% of ODPs being compliant with training.

There were no registered nurses currently rostered for permanent nights.

The training providers for ILS, were unable to carry out training during the pandemic, therefore a number of staff's certificates expired. They have prioritised ODPs to be included in the next training sessions to be held in June 2021, to support the RMO (Resident Medical Officer) and the anaesthetists during an emergency. The managers were in the process of commencing a new training requirement to ensure a proportion of the ward registered nurses, not just those on permanent nights, complete the ILS course, currently no nurses were ILS trained from the hospital.

Cleanliness, infection control and hygiene

Staff did not always use control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Staff worked to prevent, identify and treat surgical site infections. However, there was no available data for surgical site infections post operatively for all patients that received surgery at Burcot Hall. Therefore, the hospital could not learn and improve on any findings.

All patients being admitted to the hospital had to have a documented negative COVID-19 test result. Their temperature was also checked on arrival to the hospital before they could be admitted onto the ward. In November 2020, a patient was admitted and taken to theatre, it was found that after they had the surgical procedure, they were COVID-19 positive. The

staff had not checked the result before admitting the patient into the ward. Since this incident, all staff admitting patients must check the result and document this on a sticker that is placed on the front of the patient medical records. Patients are not permitted on the ward or into theatres until that has been carried out and it shows a negative result. No staff that were in contact with this patient contracted COVID-19, however, they were not told to self-isolate.

Following a monitoring and engagement call between the senior management team and CQC staff, we were told the hospital was not providing any COVID-19 testing for any staff, however testing was a requirement as part of NHS contracts. The reason they gave was due to not being provided with tests via the NHS, and Burcot Hall had chosen not to source the tests for their staff. The service told us they mitigated the risk by providing a separate staff entrance to the hospital where they would take members of staff's temperatures and ask them to sign a self-declaration form to say that they had no COVID-19 symptoms, this did not protect patients from the risk of staff having COVID-19 whilst asymptomatic.

Following our monitoring and engagement call, the senior management team told us they would be ordering lateral flow tests (LFT) for staff to take home and carry out twice weekly tests. During our inspection we spoke with 10 members of staff who had been provided with LFT kits. A lateral flow testing policy was produced, that stated once they have completed the test they email human resources (HR) with the result. A form was devised which all staff entering the hospital had to complete. However, we could not see that the form was completed with the LFT result during the inspection. We asked the hospital manager how many staff were compliant and carried out twice weekly tests, they told us they did not hold or review that data, as it was all uploaded directly to human resources. Therefore, they could not give us assurance that staff were protecting themselves and their patients. Since the inspection, the service has been able to provide an overview of the live submission data of completed LFTs. As of 22 April 2021, 39 members of staff had completed twice weekly LFTs.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. The privacy curtains in clinical areas appeared visibly clean and all were dated when to review and change.

We saw in the main waiting area there were no visible signs alerting patients to keep to a two metre distance and chairs/sofas had not been moved apart or signage evident to indicate where patients should safely sit. However, the managers told us that patients' appointments were spaced so that there were limited numbers of patients waiting at any one time, and reception staff would verbally remind patients to adhere to social distancing. The reception staff cleaned the seating after each patient had left the area.

Risk assessments had been carried out for the waiting area, staff changing rooms, the canteen. They were generic risk assessments and were continually being amended. We saw that the male changing room in theatres was very small. Staff told us they could not always keep to social distancing in this area.

Staff followed infection control principles including the use of personal protective equipment (PPE). The hospital had a protocol for the management of patients during the pandemic. It stated what PPE should be worn by staff depending on their role.

We observed staff washing their hands in between patient contact. Staff adhered to the arms bare below the elbow guidance and wore appropriate attire in the clinical areas. Appropriate theatre attire was worn by all clinical staff since the pandemic. Theatre wear (commonly referred to as "scrubs") were laundered off site, which ensured that the attire was washed at the appropriate temperature. Designated theatre shoes were available for staff to wear in the procedure room. This was in line with best practice (Association for Perioperative Practice Theatre Attire (2011)).

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

Surgery

We saw the theatre and wards hand hygiene audit for January, February and March 2021. Compliance rates were:

- Ward: January 2021: 60%
  - February 2021: 100%
  - March 2021: 100%
- Theatres: January: 100%
  - February: 60%
  - March 2021: 60%.

There were identified actions that were communicated to staff and posters visible showing the monthly compliance. Staff who were not adhering to the protocol for effective hand washing were spoken to individually.

Assessing and responding to patient risk

Not all risks were removed or minimised. Staff completed and updated risk assessments for each patient. 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 National Early Warning Score (NEWS2) assessment tool was used. NEWS2 is a tool which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes. The NEWS2 audit was carried out annually and was due in July 2021, therefore we could not see how accurate completion was. However, we looked at 10 sets of patient's medical records and saw that nine out of the 10 had completed NEWS2 with escalations made appropriately to the medical staff where needed.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Patients seen at the hospital generally did not have high risk factors for surgery. Staff we spoke with explained the processes they would take should a patient show any signs or symptoms of sepsis. If they suspected a patient had sepsis, they would contact the RMO who would initiate treatment before arranging for a transfer to the local acute NHS trust. Staff told us they had not had a patient with sepsis recently.

All patients required a negative Covid-19 test in the 72 hours prior to admission. If it was positive, their surgery would be cancelled and not re-booked for three months, to allow for recovery. The patient's temperature was checked before entering the hospital, recorded and the patients then signed a declaration form documenting that they had no symptoms of Covid-19. A sticker was placed on the front of the patient's records declaring a negative COVID-19 test. Staff had to sign this sticker to say that they had seen the test result before they could be admitted to the ward.

Some patients underwent general anaesthesia although, where required, local anaesthesia could be administered. We were told that all patients admitted to theatre were assessed according to the American Society of Anaesthetists (ASA) guidelines and were either grade 1 (normal healthy patient for example, non-smoker, minimal alcohol intake) or 2 (mild systemic disease without substantial functional limitations, such as well-controlled diabetes, increased blood pressure, social drinker, pregnancy, obesity with a BMI between 30 and 40). Very exceptionally a patient with ASA 3 (systemic illness with substantial functional limitation, such as poorly controlled diabetes, reduced cardiac function) would be admitted and pre-operative clinical investigation conducted to assure patient safety prior to the procedure. No ASA 4 patients were admitted and there were no spinal or epidural anaesthesia undertaken. However, we could not see any documented evidence of ASA scores in the patient's medical records. The managers told us that it would be documented on the patients booking form at the start of the admission process; however, this was not clear on the booking forms we requested to review. After our inspection the provider advised this would also be on the anaesthetic record, however examples were not provided.

Inspected but not rated

Surgery

The responsibility for all patients who have been intubated with an endotracheal (ET) tube lies with the anaesthetist, the policy at Burcot Hall was that patients must be extubated in theatre. Managers told us this was complied with. However, during the inspection we observed a patient, still sedated with an ET tube in place being wheeled out of theatre into recovery. We discussed this with the managers who spoke with the anaesthetist, who said they had assumed they were able to do this procedure in recovery. This showed that the communication of the hospitals protocol was not effective.

Theatre staff followed the World Health Organisations (WHO) Surgical Safety Checklist. The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events and increase teamwork and communication in surgery. We saw in the patient medical records that this document was always completed. However, on observation of two procedures in theatres, we saw that staff did not all listen and pause and go through each step before commencing surgery. The form was ticked and signed once the operation had already commenced but without active participation in the process. We saw the audit for March 2021, that showed 70% compliance overall. In response to our feedback the hospital told us they had completed an action plan to improve compliance. This included:

- Implementation of a WHO champion. Each theatre would have an identified WHO champion for each session. The nominated person would be highlighted on the “theatre white board”. The WHO Champion would be empowered to address and/or escalate areas of poor practice within the theatre. All escalated concerns would be addressed by the theatre lead.
- Covert Observational Audit. A weekly covert observational audit would be carried out. A nominated individual would be identified to conduct the covert observation. The observational audit would be presented at the theatre huddle so that lessons continued to be shared. A summary of the observational audit would be reported to the MAC (medical advisory committee) quarterly, although only one MAC meeting had been held.
- Theatre Huddle. WHO principles would be raised at each morning huddle. Lessons from the observational audit would be shared each morning to ensure all staff receive the feedback.
- The WHO policy would be the selected policy of the week at least once a quarter to ensure that it remained a high priority. The WHO policy would be shared with all clinicians who have Practising Privileges.

Staff were not aware of all risks and issues. For example, COVID 19 testing for staff and patients being extubated in the recovery unit, and not in theatre.

Safety performance was monitored and reported via the incident reporting and complaints processes.

Staff shared key information to keep patients safe when handing over their care to others.

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

Patients were advised on how to seek support if their condition deteriorated after discharge from the hospital.

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.

At the time of our inspection Burcot Hall Hospital Ltd the registered provider did not employ any staff or provide any regulated services directly. All nursing staff and support services were being provided by another provider. After our inspection a service level agreement was put in place to ensure the accountability lay with Burcot Hall Hospital Ltd.

Inspected but not rated

Surgery

The service had enough nursing and support staff to keep patients safe. The ward sister and theatre lead could adjust staffing levels daily according to the needs of patients.

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. A daily review of planned staff versus actual staffing was undertaken by the ward sister and theatre lead to ensure safe staffing levels for the day ahead. The staffing level status was reported at the daily huddle, which was attended by the hospitals operational team and at the corporate huddle, which was attended by the head of hospital operations.

Ward staffing levels were based on a 5:1 ratio. For every five patients there would be one registered nurse allocated. Theatre staffing levels were based on the AfPP (The Association for Perioperative Practice). For every patient the minimum staffing level would be, one ODP, two scrub practitioners, one HCA and one recovery practitioner.

The ward manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers from the staffing rotas we reviewed for January, February and March 2021.

The service had six full time equivalent (FTE) vacancies for OPDs, six FTE registered nurse vacancies on the ward and three FTE vacancies for HCAs. Two of the OPD and two registered nursing posts had been recruited to, however they had not started employment.

The service had reducing sickness rates in theatres. The hours lost due to sickness, out of 10,066 hours were:

- Theatres: January 2021: 293
  - February 2021: 188
  - March 2021: 165
- Ward: January 2021: 511
  - February 2021: 523
  - March 2021: 521.

These figures took into account hours lost for all sickness, including long term sickness, carers leave and COVID-19 related absences, such as vulnerable staff shielding. These shifts were covered by bank staff.

The service had reducing rates of bank and agency nurses. This was due to a recruitment drive and new staff were commencing each month. However, at the time of inspection, bank and agency staff were still used regularly.

Managers limited their use of bank and agency staff where possible and requested staff familiar with the service. The bank and agency staff we spoke with during the inspection had all worked for the hospital for six months or longer.

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

Inspected but not rated

Surgery

At the time of our inspection Burcot Hall Hospital Ltd the registered provider did not employ any staff or provide any regulated services directly. All medical and support staff were being provided by another provider. After our inspection a service level agreement was put in place to ensure the accountability lay with Burcot Hospital Hall Ltd.

The service had enough medical staff to keep patients safe. The organisation offered independent practising privileges to consultants and anaesthetists to ensure that safe and effective anaesthetic and surgical services were provided to patients. A practising privilege is the 'licence' agreed between individual medical professionals and a private healthcare provider. At the time of our inspection there was a lack of oversight of these from the leadership team. We saw from the one medical advisory committee meeting that practising privileges were discussed briefly; however, not all medical staff were discussed.

It was mandatory for all admitting surgeons to visit their patients at least once per day, or more frequently if the patient was receiving a higher level of care. If the named surgeon was unavailable at any time while they had patients admitted to the hospital, they arranged appropriate alternative named cover by another surgeon in the same speciality.

Each surgeon remained on-call for their own patients for the immediate post-operative period, unless they had made alternative arrangements with a colleague. Any alternative arrangements were communicated to the ward team. In addition, there was a resident medical officer (RMO) on site 24 hours a day seven days a week, who provided first line assessment for any patient who was already an inpatient and for any patient who may attend out of hours for review, following discharge.

One anaesthetist was on call every night and provided an urgent response in the event of any requirement for a patient to return to theatre. Some specific cases had an enhanced-on call anaesthetist cover from an intensive treatment unit consortium.

The hospital had a service level agreement with an agency to supply RMOs who worked rotating periods to cover the service 24 hours a day, seven days a week. The agency provided appropriate training for the RMOs. The hospital informed us that training modules completed by the RMO included for example: safeguarding children and adults (level 2), equality and diversity, manual handling, privacy and dignity and infection prevention.

There was always an RMO on the premises who carried out routine work during daytime hours and who was on-call out of hours. The hospital monitored the RMOs on-call for those working 24-hour shifts. There was an RMO 'call out' proforma which monitored the number, type and duration of any RMO contact during silent hours and weekends. This was completed each time the RMO was called and used to review and identify reasons for the call, time and duration of call out and which member of staff requested it. This enabled the hospital to identify any trends, to monitor and therefore address any issues to reduce any unnecessary call outs.

The service always had a consultant on call during evenings and weekends. Patient care was consultant-led. Surgeons were available for advice and/or review admitted patients. They provided 24-hour on-call for patients post-operatively and were required to be within a 30-minute drive of the hospital when off site.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. However, records were not always stored securely.

Inspected but not rated

Surgery

Records were not always stored securely. We observed that confidential records were kept in a lockable trolley by the nurses' station on the wards, that we were told only staff had access to. However, we observed these cabinets were not locked which meant there was a risk that these records could be viewed by unauthorised persons.

We saw computer terminals were locked when not in use. This reduced the risk of unauthorised people accessing patient information.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 10 sets of patient records and found they were generally legible, up-to-date and contained all relevant information regarding patients' care and treatment. Appropriate pre-operative assessment information was recorded. This included a full explanation of the procedure, likely outcome and the patient's medical and social history. This was in line with national guidance (Royal College of Surgeons Professional Standards for Cosmetic Surgery (April 2016)).

Incidents

The service generally managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents, however, not all lessons learnt were communicated effectively. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff reported serious incidents in line with the hospital's policy. An incident form was used to record all incidents or accidents that occurred within the service. Staff we spoke with said they were familiar with this.

The service had one never event recorded. Never events are defined as serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

The never event occurred in 2020. It was a wrong site surgery.

Suitable action was taken following this never event and an action plan was put in place. Duty of Candour was displayed, additional training was provided for the reception and administrative teams in relation to NHS procedure codes, governance around the importance of data accuracy and increased training given on the IT booking system, which was new at the time of the incident.

Managers told us they shared learning about never events with their staff and across the hospital. However, during inspection, some staff could not tell us about the never event. Despite the never event, the WHO surgical safety checklist was not always performed effectively, showing that staff were not reducing the possible risks to patients following this incident.

Staff received feedback from investigation of incidents, both internal and external to the service. The senior management team received the investigation into the surgeon from the local NHS acute trust, they were employed by.

Managers debriefed and supported staff after any serious incident.

Are Surgery well-led?

Inspected but not rated

Surgery

Inspected but not rated

We found:

- Leaders did not have all the necessary skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced.
- Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, there were not regular opportunities to meet, discuss and learn from the performance of the service.
- Leaders and teams did not use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however, they were not always communicated effectively. We could not be assured that the changes, practices and systems would be embedded.

However,

- Leaders were visible and approachable in the service for patients and staff.

Leadership

Leaders did not have all the necessary skills and abilities to run the service. They did not always understand and manage the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

At the time of our inspection Burcot Hall Hospital Ltd the registered provider did not employ any staff or provide any regulated services directly. The employment of the registered manager and all governance processes were delivered by another provider.

After our inspection a service level agreement was put in place to ensure the accountability for all staff and processes lay with Burcot Hospital Hall Ltd.

Following the implementation of a service level agreement, the hospital had a management and committee structure with the defining lines of responsibility, prior to this, it was not clearly aligned to Burcot Hall Hospital Ltd. The registered manager who was also the hospital director, held the accountability for the service at the location. The hospital director was supported by various staff including a ward and theatre manager, head of hospital operations, governance manager, facilities team leader, reception and administrative manager and a pharmacist. There were two ward sisters and a theatre lead.

The hospital director and senior management team did not always manage and understand the registration process for their service and the implications for the delivery of a regulated service. There was a lack of clear systems and accountability by the registered provider regarding the management of the service.

There was a lack of responsibility by the hospital management team regarding the safety of their staff and patients by not providing COVID 19 testing which was part of a contractual agreement by commissioners.

Inspected but not rated

Surgery

Staff we spoke with were generally positive about the senior management team. They told us they were visible, and they felt well supported, valued and respected.

Governance

Leaders operated governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities. However, there were not regular opportunities to meet, discuss and learn from the performance of the service.

During the inspection we found the hospital's governance system was not operated by the registered provider. It was still managed and supported by Burcot Hall's previous provider.

The committee structure had been developed in September 2020. It was in place to support the monitoring and reporting requirements required to support the governance framework, and to provide assurance to the board.

The hospital's committee structure was headed by a governance board chaired by the organisation's chief executive officer. Burcot Hall Hospitals' main committee was the medical advisory committee (MAC), which reported to the clinical governance and compliance committee. There were incident review meetings and an infection prevention and control committee, which reported to the Medical Advisory Committee MAC.

We were told by the hospital director that each committee would consider, monitor and review data to allow each chair to make informed recommendations and assurances to the governance and compliance committees. This was in accordance with the recommendations set out by the Independent Healthcare Providers Network (IHPN), and in response to the Patterson inquiry.

Senior staff had meetings with the chair of the Medical Advisory Committee (MAC) and with the hospital director at the hospital managers meeting to review the performance of the surgical services. However, since September 2020, there had only been one MAC meeting, we saw from the minutes that the never event was not discussed. The next MAC meeting was due to be held in June 2021. Medical staff told us they felt they were not held regularly enough. Contracting agreements had meant the type of procedures undertaken had changed during the pandemic; however, the scope of these had not been agreed through the MAC. The outcome of quality reviews and incidents was not communicated to all staff. Therefore, there were not effective medical governance oversight systems in place.

At the time of our visit the provider did not have a system in place to ensure medical staff had suitable checks needed to grant practicing privileges which enable medical staff to practice at Burcot Hall Hospital. After our visit a service level agreement was put in place ensuring another provider would complete these checks.

There was a corporate practising privileges policy, however this was not specific to the provider. Practicing privileges is a term used when doctors have been granted the right to practice at an independent hospital. The policy included the granting of practising privileges, and roles and responsibilities. The MAC had some oversight of practising privileges arrangements for clinicians. We saw evidence in the only MAC meeting minutes of a brief discussion about renewing or granting of practising privileges. The majority of clinicians also worked at NHS trusts.

To maintain practising privileges, medical staff have to provide evidence of an annual appraisal, indemnity cover, and an up-to-date disclosure and barring service check along with evidence of completed training.

Inspected but not rated

Surgery

The provider who was conducting checks on behalf of Burcot Hall Hospital Ltd had recently introduced a bi-annual review of clinicians independent practising privileges enabling the hospital to consider the suitability of each clinician and the clinician to review their scope of practice within the hospital. However, this was not completed for all medical staff from other private healthcare organisations carrying out clinical work at the hospital.

Not all staff we spoke with had received an appraisal. Staff were not supported to deliver effective care and treatment through the supervision and appraisal processes. We saw that 76% of ward nursing staff had received an appraisal in April 2021, this had declined from 78% in January 2021. In April 2021 data showed that only 60% of theatre nurses, ODPs and health care assistants had received an appraisal, which had slightly increased form 49% in January 2021. Senior staff told us this was due to the increased workload and pressures given by the pandemic.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact, however, they were not always communicated effectively.We could not be assured that the changes, practices and systems would be embedded.

There were some processes for identifying, recording and managing risks. There was a hospital wide risk register with departmental risks recorded. This was a combined document; however it was possible to filter this by area.

We were told that known risks and mitigation were discussed each month by the governance manager and hospital manager and at the hospital management team meeting, before being presented to the clinical governance and compliance committee and the medical advisory committee (MAC). However, we saw no evidence of the risk register on the MAC meeting agenda and only one meeting had been held in seven months so oversight appeared to be limited.

Staff did not always have access to information relating to risk management, information governance and how to raise concerns. However, staff were knowledgeable about the service's incident reporting process. Any team member was able to provide an outline report that was escalated to the incident review team (IRT) for oversight and management of investigations and dissemination of lessons learned. The IRT reported to the MAC and the clinical governance and compliance committee.

The hospitals risk register was rated and prioritised against a set of clinical indicators to ensure those which presented a higher risk to patient care were prioritised. At the time of our inspection there were two high risks for the hospital. These were relating to equipment and the range of new clinical procedures that were taking place at the hospital to support external NHS trusts. Risks were not displayed on staff boards and staff were not aware of the main risks within the service and hospital.

The fire alarm system was checked weekly and all other fire safety equipment was checked annually.

From the one MAC meeting held, minutes evidenced brief discussions around the monitoring of the hospital services performance. We saw discussions around some data that included:

- Incidents (one discussed).
- Infections (no data was discussed; however, they were asked what information they wanted in relation to infection control for future committee meetings).
- Theatre efficiency/utilisation.

- Complaints.

There was no analysis provided alongside the data to guide the committee members. The data/ performance was not benchmarked against the hospitals previous months. The hospital did not benchmark themselves against any other organisations.

Safety performance was monitored via the organisation's incident reporting system, complaints process and internal and external risk assessments. The hospital had a local audit calendar and results were used to highlight any areas where standards were not being met. We found that actions were not managed effectively as many areas, issues and concerns highlighted during our inspection had already been identified in the audits results; for example, the WHO surgical safety checklist. While the hospital was responsive to our findings, we could not be assured that the changes, practices and systems would be embedded.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures Nursing care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The registered person had failed to ensure that all staff had received up to date mandatory training and an annual appraisal.**

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury Nursing care	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose **The registered person had failed to ensure effective actions were completed to improve compliance with the World Health Organisations Surgical Safety Checklist.** **The registered person had failed to ensure that staff and patients were provided with suitable arrangements to protect from the risk of COVID-19**

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures Nursing care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person had failed to ensure that there were processes in place to manage the performance of the service effectively.**