The Berkshire Independent Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from 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?	Good
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Berkshire Independent Hospital is operated by Ramsay Health Care Operations Ltd. The hospital has 43 beds. Facilities included four operating theatres, X-ray, outpatient and diagnostic facilities.

The hospital provides surgery and outpatients and diagnostic imaging. At this inspection, we inspected the Surgery-core service. This was a focus inspection to follow up on some information of concerns that we had received about the service. The service did not provide care to children.

We carried out an unannounced inspection on 19 March 2019. Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activities at the service.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

Our rating of this hospital/service stayed the same. We rated it as **Good** overall.

We found good practice in relation to surgery-

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff followed infection control procedures to prevent the spread of infection and hand gels were available for patients, staff and visitors.
- The service looked after their equipment well including those in the operating theatres and undertook regular checks of the emergency equipment.
- Staff had received training in safeguarding adults and children and knew how to raise any concerns to safeguard patients.
- Actions were taken to improve service provision in response to feedback, incidents investigations and complaints received.
- The service provided care and treatment that was based on national guidance and monitored its application in practice.
- Incidents were managed well and staff were supported to report incidents. Learning from incidents were shared regularly with the staff through daily huddles and regular meetings.
- There were effective admission processes including exclusion and inclusion criteria which staff adhered to.
- Staff of different roles worked cohesively for the benefits of the patients.
- Staff at all levels spoke passionately about their work, and about the quality of care delivered.
- Staff interacted well and treated patients with care and compassion. Patients were complimentary about the staff and the care they received.

Summary of findings

- There was an effective governance of the service, with clinical governance committees and risks which were linked to the governance framework.
- There were processes in place for the management of risks.

We found areas of practice that require improvement in surgery:

- The service should ensure that medical staff's records contain all necessary pre- employment checks and evidence of training and updates.
- The provider should ensure intravenous fluids are stored safely.
- The provider should ensure intravenous fluids are checked and are in dates.
- There were no clear criteria for the admission of patients in the escalation beds.

Following this inspection, we told the provider should make other improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Name of signatory

Dr Nigel Acheson.

Deputy Chief Inspector of Hospitals

Overall summary

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Surgery was the main activity of the hospital which we inspected. We rated this service as good because it was safe, effective, caring, responsive and well-led.

Summary of findings

Contents

Good

The Berkshire Independent Hospital

Services we looked at Surgery

Summary of this inspection

Background to The Berkshire Independent Hospital

The Berkshire Independent Hospital is operated by Ramsay Health Care Operations Ltd. The hospital opened in 1993. It is a private hospital in Reading Berkshire. The hospital primarily serves the communities of the Berks. It also accepted patient referrals from outside this area.

The hospital has had a registered manager in post since 2018. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage a service. Like registered providers, they are 'registered persons'. Registered persons have a legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated regulations about how a service is managed.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, another CQC inspector, and two specialist advisors a doctor and a nurse with expertise in Surgery.

The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

Why we carried out this inspection

At this inspection, we inspected the Surgery- core service. This was a focus inspection to follow up on some information of concerns that we had received about the service.

How we carried out this inspection

We carried out an unannounced focus inspection of the hospital and we looked at the core service of Surgery.

Information about The Berkshire Independent Hospital

The Berkshire independent Hospital has 43 inpatient and day-case beds. Facilities included three operating theatres, an outpatient, X-ray and diagnostic facilities. The service provides surgery and medical care and does not provide a service for children and young people.

During this inspection we inspected the core service Surgery.

The service is registered to provide the following regulated activities:

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

During the inspection, we visited the ward and the operating theatres. We spoke with 11 staff including registered nurses, health care assistants, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with six patients and their relatives.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12

Summary of this inspection

months before this inspection. The hospital was last inspected in October 2016, which found that the hospital was meeting all standards of quality and safety it was inspected against.

- In the reporting period April 2018 to March 2019. There were 3,717 surgical inpatient and day case episodes of care recorded at the hospital.
- There were 1,268 patients who were insured or self-pay during the same reporting period.
- There were 2,449 NHS funded patients treated during the same period.

There were 100 consultant surgeons and anaesthetists who worked at the service under practicing privileges. There were also two regular resident medical officers (RMOs) who worked on a two- weeks rota.

Track record on safety

No Never events

No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA),

No incidences of hospital acquired Meticillin-sensitive staphylococcus aureus (MSSA)

No incidences of hospital acquired Clostridium difficile (C. Diff)

No incidences of hospital acquired E-Coli

From January 2018 to March 2019, the service had received 12 complaints. These included two clinical and 10 other complaints.

Services provided at the hospital under service level agreement:

- Interpreting services
- Laser protection service
- Maintenance of medical equipment
- Pathology and histology
- RMO provision

What people who use the service say

The people we spoke were complimentary about the care and treatment they were receiving. They told us they had enough information and were involved in the decisions about their care. They said the staff were kind and caring. They felt they were treated with compassion and their privacy and dignity was maintained.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Are services safe?

Our rating of safe stayed the same. We rated it as **Good** because:

- Emergency equipment was maintained safely, as all the necessary checks were completed in line with the provider's policy and procedures.
- All the areas we visited were clean and well maintained. Infection control procedures were followed, and hand gels were available at the reception and in clinical areas for visitors and staff.
- Arrangements were in place as consultants and theatre staff were on call and would attend for any emergency surgical procedures.
- Staff followed their process to safeguard patients from the risks of harm.
- Incidents were investigated and we saw evidence of changes in practice from lessons learnt.

However;

- All Intravenous fluids were not always managed safely and in line with good practice guidelines. Intravenous fluids which had expired were in circulation which may pose safety risks.
- The provider did not have a standard operating procedure for admission of patients in the escalation beds.
- Staff did not consistently follow the procedures and application of the World Health Organisation (WHO) guidelines (5 steps to safer surgery) checklist.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- Care and treatment was provided in line with national guidelines.
- Patients told us that they had adequate information about pain relief and that their pain was managed well.
- Integrated care pathways were used for patients undergoing day surgery procedures. These included assessments of risk such as venous thromboembolism.

Summary of this inspection

- The service had followed their procedures for pre- surgery fasting times in line with best practice. We saw patients were fasted for the least amount of time prior to surgery.

However:

- Some policies and procedures were not regularly reviewed and updated to ensure these were in line with current best practice.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Patients were treated with care and compassion. They were positive about the care and treatment they received.
- Patients were involved in the decisions about their care.
- Patients 'privacy and dignity were maintained always when receiving care. Patients were treated with care and respect.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- The service took concerns seriously and investigated them. The outcome was shared with staff to improve the service provided.
- There were effective admission procedures for patients which included set criteria which staff adhered to.
- Information on how to raise concerns or complaints was available. The service managed complaints well and responded to patients in a timely way.
- Patients received diets and fluids to meet their needs and they were complimentary about the meals and choices offered to them.

Are services well-led?

Good

Our rating of well-led stayed the same. We rated it as **Good** because:

- There was effective governance with clinical governance committee and risks which were linked to the governance framework.
- The hospital had a recognition system for staff and included a long service award.
- Evidence of learning from incidents was effectively managed which included changes in practice.
- The service had a process to review risks and action plans were developed to manage these.
- There was a positive culture where staff felt they were supported and involved in the development of the service.

Detailed findings from this inspection

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 services safe?

Good

We inspected only Surgery core service during this inspection.

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

Mandatory training

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

- The service had a mandatory training programme and all staff were expected to complete health and safety training as part of their induction.
- We saw mandatory training compliance rates were recorded to enable managers to support staff with completion.
- Staff we spoke with told us they were given sepsis screening training and we saw screening documentation within patient's records.
- The data we had received from the service showed theatre staff had compliance with mandatory training was between 91 and 100%.
- We requested the training data for nurses and other health care professionals and this showed compliance rate between 93 and 97%.
- The service had identified there was lower uptakes of E-learning modules and had put in place face to face training for the staff.

Safeguarding

Staff had training on how to recognise and report abuse and they knew how to apply it.

- The service had systems and processes in place to protect patients from abuse and staff were aware of their responsibility in safeguarding patients. Staff were confident on how to seek help and support if they had any concerns about patients' safety.
- There was a safeguarding policy and procedures in place which staff told us they could access. This policy was dated 2016 and was due for review in 2019 in line with their procedure.
- Information on reporting safeguarding concerns to external body responsible for safeguarding was available to the staff.
- The service had a safeguarding lead and staff told us safeguarding was everyone's responsibility.
- The staff had achieved 91-96% compliance with safeguarding adults and children at levels 1 and 2.
- From September 2018 to February 2019, staff compliance with PREVENT duty training across the whole hospital was 97%. PREVENT raises awareness to stop individuals from getting involved or supporting terrorism or extremist activity.

Cleanliness, infection control and hygiene

Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

Good

Surgery

- All the areas we visited were found to be visibly clean and tidy and the service had systems and processes in place to monitor and eliminate the risk of cross infection. Clinical equipment was visibly clean and labelled providing information of cleanliness.
- We saw clean and dirty clinical rooms on the ward were visibly clean and tidy and shared equipment were labelled with 'I am clean sticker'.
- Infection prevention and control and hand hygiene audits were completed monthly. Results were collated and any area of non compliance was identified and action plan developed.
- The hospital had a policy for Meticillin resistant staphylococcus aureus (MRSA) screening and all elective patients undergoing surgery were tested for MRSA.
- We observed staff followed hand washing procedures in accordance with the World Health Organisation (WHO) 'five moments for hand hygiene'.
- Antibacterial hand gel dispensers were available at the entrance to the wards and in the main reception area and in other clinical areas. Staff reminded visitors to clean their hands when they entered the ward areas. We observed hand gels were used in between patients to reduce the spread of infection or cross contamination.
- There was adequate supply of personal protective equipment (PPE) such as gloves and aprons. We observed staff adhered to 'bare below the elbow' policy in clinical areas and used PPE as appropriate.
- In the operating theatre, there were clear procedures for the decontamination of reusable medical devices in line with national guidance which the staff followed.
- Access to the operating theatre was restricted to avoid unauthorised people entering the area. There was a clean and dirty utility area to ensure that the risk of infection transmission was minimised.
- The suction catheters on the emergency trolleys were not sealed and this may pose an infection control risk. We raised this with senior staff members at the time of the inspection for action to be taken.
- The service had reported no cases of hospital acquired Meticillin resistant staphylococcus aureus (MRSA) in the last year.
- The hand hygiene audit for January 2019 which tested compliance with policy, hand washing techniques achieved 100%. Following the audit in December 2018, the service introduced hand wipes for patients to use prior to eating and these were provided on patient's food trays.

Environment and equipment

The service had suitable premises and equipment and looked after them well.

- The resuscitation trolleys were readily accessible and staff were aware of the emergency equipment location. The trolleys had tamper evident tags in place.
- We reviewed the emergency equipment on the ward and operating theatres and found daily checks had been completed in line with the hospital procedure. A senior staff told us a designated staff was allocated daily and they were responsible to check the resuscitation trolley and this provided assurance to the service.
- We noted all sharps bins seen were managed effectively as these were not overfilled and labelled with the dates they were assembled.
- Staff we spoke with reported that they had enough equipment to provide safe care and treatment to patients. Specialist equipment was also available such as bariatric equipment.
- There was an internal process which staff followed when the operating theatre commissioned any new equipment. The staff told us the service routinely liaised with the local NHS Trust to ensure it was in line with their commissioning and the process was correct.
- The theatre staff told us they had the required equipment to provide care and treatment. The surgical instruments were sent out for sterilising with a turned around time of 48 hours and available for the surgical procedures. The service had a facility to fast track sterilising instrument needed urgently but usually we were told this was not necessary, as they had a five days gap between instruments being needed again.
- We noted there was a sharps bin in radiology in one of the patient room which was open. When this was brought to the attention of staff they were unclear why

this was in the room as there was no procedure or bloods taken in this department that would require disposal of sharps. Staff reported that they would remove the sharps bin immediately.

Assessing and responding to patient risk

Staff completed and updated risk assessments for the patients.

- The service was using National Early Warning System (NEWS) to record patients' observations. The NEWS scoring tool is a recognised tool used as a guide which looks at a patient's vital signs such as respiration rate, blood pressure, oxygen saturation level, pulse and pain levels. Any changes in these parameters could indicate early deterioration in a patient's health and requiring prompt actions.
- Staff told us they used the NEWS on all their surgical patients and they had received training in using the tool to assess patients. We saw evidence of this training which had been refreshed following an incident.
- The NEWS charts seen on the ward were fully completed. There was a clear process which the staff followed for deteriorating patients on the ward. Staff told us they would contact the resident medical officer (RMO) for advice and support. The RMO would then escalate to the consultant for further advice and treatment as needed.
- The service had systems and processes in place to support staff on the wards and theatres to assess and respond to patient's risk. We reviewed the adult escalation policy which required all ill or deteriorating patients to be screened for sepsis, using bedside observations, clinical skill and blood tests.
- The service had a service level agreement for acute patient transfer to a local NHS trust. The service defined an acute transfer as a transfer to a higher acuity unit for specialist care. The admitting consultant was responsible for arrangement and agreement of the acute transfer to another hospital.
- The provider had a service level agreement with an a local service for the provision of assessment and transfer services of the deteriorating patients.
- We saw the provider followed the Sepsis Six pathways for patients identified with severe sepsis. This included timely bloods, and antibiotic therapy. A sepsis box had recently been implemented which contained all the necessary equipment for timely intervention and treatment of sepsis.
- The service had a pre- operative assessment process which was followed. Patients who had been referred to the hospital for elective surgery were contacted to attend the service. The pre-operative assessment was a way of assessing patients' fitness for surgery.
- The hospital had set criteria which patients had to meet. The pre-operative assessment service was managed and delivered so that patients were fit to undergo surgery on the date of their operation, avoiding last minute cancellations.
- We reviewed the care pathways for adult assessments. Clinical risk assessments included the American Society of Anaesthesiologist (ASA) score. This is a system used to assess patients' fitness for surgery such as healthy patients and those with health deficiency at the pre-operative stage. Patients with severe health concerns would be excluded following discussions with the surgeon and anaesthetists.
- Patients records showed venous thromboembolism (VTE) risk assessments, pressure ulcers and risks of falls were completed by the nursing staff. Care plans were developed as required to manage these risks.
- The service used the World Health Organisation (WHO) guidelines (5 steps to safer surgery) checklist. The surgical safety checklist is guidance to promote safety of patients undergoing surgery. This sets out what should be done during every surgical procedure to reduce the risk of errors. The checklist must be read out loud, and must include all sections of the checklist including the 'sign in' before anaesthesia is commenced, the 'time out' before starting surgery, and the 'sign out' before any member of the team leave the operating theatre.
- We observed the use of the WHO checklist in theatre as part of observations of patients' care. We found there were inconsistencies in the application of the WHO checklist which included a lack of engagement from the team. This could pose risks to patients' safety.
- The service undertook a WHO safety audit in theatres in February 2019. They had scored 100% for all components except for all theatre members present for

debriefing which was 80%. The service developed an action plan where a list safety officer (LSO) was identified for every list - The name of the LSO was written on the theatre board outside theatre and the LSO wore a red hat to ensure that everybody in the team was aware who the designated LSO was for the list. We observed this was in practice during the inspection.

- The provider did not have a standard operating procedure for patients who were admitted to the escalation beds. The provider told us they were reviewing this as they did not have a standard operating procedure for this area.

Nursing and support staffing

The service had enough staff with the right skills, training and experience to keep people safe and to provide care and treatment.

- The service had a number of staff who had worked there for a number of years and some who had returned after taking a break. The duty roster and feedback from the staff and patients confirmed there were adequate staff with the right skills to meet the patients' needs.
- Feedback we received from the patients were positive and they told us there were enough staff and they did not have to wait when they required help and support.
- Staff worked flexibly to meet the service demand and we were told this was effectively managed to meet the elective surgery list and caring for the patients.
- There were always core staffing levels and the service used bank or agency staff to cover any unplanned absence and leave. Staff told us they used the same agency staff if possible to maintain continuity of care.
- Staff told us the duty roster was reviewed and took into account staff's skill mix to meet the acuity of patients and the elective surgical list. There were adequate skilled staff to meet the needs of patients. A senior staff told us they always had a minimum of two trained staff on duty even when at weekends when they have had only one patient. The duty roster showed they were meeting their planned staff allocation. For example, we saw staff worked flexible hours to cover the elective surgery list on the day of the inspection.

Medical staffing

The service had adequate medical cover to keep people safe and to provide the right care and treatment.

- The service had approximately 100 consultants who had been granted practicing privileges to work at the hospital.
- We reviewed records of consultant's annual employment checks that included ensuring they had an active professional registration, completed mandatory training and had participated in an annual appraisal were held on an electronic spreadsheet. We noted that there was a process of checking this spreadsheet daily and any documents that were going out of date were identified as the cell changed colour. The individual was contacted when any updated document was needed. We were told that failure to provide the necessary documents the consultants practicing privilege(PP) would be withdrawn. No PP had been removed to date.
- There were two orthopaedic consultants and an anaesthetist consultant employed by the service.
- The service had two regular resident medical officers(RMOs) who provided 24-hours cover, seven days a week and they rotated on a weekly basis. Staff told us this worked well for them. The hospital had a contract with an agency to supply these RMO. Any RMO leave, sickness or absences were covered by the agency ensuring they had the required training and competence for the role.
- All patients were admitted under a consultant who was responsible for their care. A senior staff told us the consultants lived locally and could attend the service within 30 minutes in an emergency.
- The staff paper files had recently been updated to standardise these, the majority of files we reviewed were up to date. Most of the files had a photo and record of compliance with mandatory training. All files seen had an application form, CV, 2 references, GMC, DBS, appraisal, professional documents and certificates.
- We found that the majority of the consultants' records we reviewed contained no proof of identification. We brought this to the attention of senior managers during

the inspection who explained why this was the case but acknowledged that this information was required to be held on file. The senior managers agreed to take action on this matter.

Records

Staff kept detailed records of patients' care and treatment.

- Patients' care records were in paper formats and we saw these were stored safely and securely to minimise the risks of unauthorised access to personal information. The computers were password protected and we observed that these were locked when not in use. This was in line with the Data Protection Act 1998.
- We reviewed 12 sets of medical and nursing paper records and saw these were fully completed. The records contained details of pre-operative assessments including past medical history, risk of blood clots. We saw treatment plans were developed and a summary of their progress and any specific issues were recorded.
- Medical notes were completed by consultants working under practising privileges and these notes were retained by the hospital. This ensured that the staff had the necessary information to provide care and support to patients.
- The service undertook an audit of patients' records between January and March 2019 where 10 patients who were undergoing elective surgery records were selected. The audit results varied between an average of 50 and 90% compliance. An action plan was in place with defined steps needed in order to achieve compliance. A re- audit was planned for April 2019.

Medicines

The service followed best practice when prescribing, giving, recording medicines. Intravenous fluids were not always managed safely.

- The service had a medicines policy that detailed the safe management of medicines including controlled drugs (CDs).
- All medicines were stored safely including those which were kept in the medicines fridge. Staff monitored the minimum and maximum temperature of the fridge and records were maintained.
- We observed that the medicines were kept securely and access to medicines was restricted to authorised staff.
- The service had an in-house pharmacy and this was staffed Monday to Friday. A pharmacist was available to offer advice and support to the staff. The resident medical officer (RMO) had access to the pharmacy out of hours and at weekends and the pharmacist was available on call as needed.
- There was a procedure for access to pharmacy out of hours that required two staff such as the RMO and the nurse in charge who each had a key. This was to reduce the risk of misappropriation of medicines.
- The pharmacy team carried out medicines reconciliation for inpatients. This ensured that patients medicines were reviewed on admission and they continue to receive their medicines as needed.
- Emergency medicines were available on the resuscitation trolleys including those for the treatment of anaphylactic shock. Anaphylaxis is an adverse allergic reaction which can be life threatening and requires immediate treatment.
- There was piped oxygen in patient's rooms and these were set up ready for post-operative patients. Staff confirmed that oxygen therapy was prescribed as needed.
- Medical gases were stored safely and in an upright position in line with best practice.
- We reviewed nine medicines charts and found that patients' allergy status was recorded to ensure their safety when prescribing additional medicines.
- Staff told us the Resident Medical Officer (RMO) would refer to antibiotics' prescribing protocols and consultation with the surgeons prior to prescribing any antibiotics for patients.
- The service did not always manage intravenous fluids safely such as those which contained higher concentration of potassium which should be kept separately in line with good practice guidelines.
- We found five bags of intravenous fluids of 20% Glucose which had expired in October 2018 and we brought this to the attention of the senior nurse in charge. Immediate action was taken to remove them from circulation.

Good

Surgery

Incidents

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately.

- The service had declared that they had no 'Never events' in the reporting period of April 2018 to January 2019. Never events are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.
- The provider reported only one serious incident relating to Surgery which related to a patient's death. A root cause analysis (RCA) was carried out which identified concern relating to the escalation process. Staff spoke to us about how lessons learnt were shared and care practices reviewed.
- The staff told us there was an open culture and learning from incidents was discussed regularly.
- There were clear processes in place for investigating any incidents that may affect the health and welfare of patients.
- Staff understood duty of candour (DoC) a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of their responsibility to inform patients when anything went wrong. They said that the consultants would initiate this and the clinical lead for the service would be part of the investigations. Staff were aware of the Duty of Candour.
- Staff told us following an incident, the provider had put in place on-going support for the patient/ their family and staff. This included additional or refresher training for escalating deteriorating patients.
- A senior manager told us they took a team approach to undertake investigations including for example the director of clinical services, the manager of the area and an independent manager. The report was reviewed by the managing director and the final report was sent to head office for review before being shared.
- RCA training was provided by the corporate team and all investigators were expected to have completed this. A senior manager told us there was a refresher session planned for RCA, this will be half a day and all investigators were expected to attend.

Safety Thermometer (or equivalent)

The service used safety monitoring results well.

- There was a process for assessing falls, infection rates, catheter related urine infection and thromboembolism were monitored. Patients' records showed records showed that action plans were developed to address shortfalls identified. The service did not display safety information on the wards for patients and visitors.

Are surgery services 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 of its effectiveness.

- The service provided care and treatment based on national guidance in line with best practice and national guidance, such as the National Institute of Health and Care Excellence (NICE) and Royal College of Surgeons (RCOS).
- Surgery was carried out in line with evidence based care and professional guidance. The service followed The Royal College of Surgeons' Standards for consultant led surgical care and the recommendations from the Association of Anaesthetists of Great Britain and Ireland (AAGBI).
- Patients had investigations and blood tests done as part of their pre- operatively assessment based on NICE guidelines to ensure they were fit for surgery.
- The service measured clinical indicators such as venous thromboembolism assessment compliance, national

early warning score documentation, infection control, consents and adherence to the WHO checklist. These were discussed at their Clinical Governance Committees and governance meetings.

- Integrated pathways were in use for patients undergoing day surgery procedures including documentation to assess risk such as venous thromboembolism (blood clots).
- Processes were in place regarding fasting times and intravenous fluids in line with best practice and we saw patients were fasted for the least amount of time prior to surgery.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Patients were offered meal choices to meet their dietary needs.

- Patients for surgery were given fasting information in accordance with the Royal College of Anaesthesia guidelines. This meant they did not fast for extensive periods of time. Patients told us that they received some information during the pre- admission assessment stage and again prior to admission for their elective surgery.
- Staff told us they had reviewed the fasting times and the service had introduced some new guidelines regarding the pre- operative fasting times. Patients were given a small amount of fluids pre- operatively until a pre-determined time prior to their surgery. This meant patients were able to have fluids and did not fast for long periods.
- Patients' records we reviewed contained a nationally recognised nutritional assessment tool. The service used the malnutrition universal screening (MUST) tool. MUST is a screening tool to identify adults who may be at risk of malnutrition, under nourished or obese.
- Patients were provided with food and fluids to meet their needs and choices were offered. Patients were complimentary about the meals and access to hot and cold drinks at all times.

Pain relief

Staff assessed and monitored patients regularly and received regular pain medicines to keep them comfortable.

- Patients told us that they had adequate information about pain relief and they received 'very good' management of their pain. A patient commented 'the staff are always asking if the pain is all right'.
- Patients' records showed they had received regular pain tablets as prescribed which had a positive impact on their welfare and well- being.
- Staff told us pain control was discussed when patients attended their pre-operative assessment and a choice of pain control methods was available.
- Patients' records showed that anticipatory pain relief was prescribed and pain was assessed in recovery and on the wards.
- Patient controlled analgesia (PCA) was available for patients. Epidural pain relief (via the spine) and nerve route 'blocks' for specific surgical cases were also available.
- Pain assessment was part of the NEWS score cards. We saw that appropriate pain score was also used to assess patients' pain. This ensured that pain management was monitored and patients received pain control medicines in a timely way.
- The service had a pain specialist doctor and patients were referred to them as required. The anaesthetist was overall responsible for the post- operative pain management of patients.

Patient outcomes

The service participated in clinical audit, benchmarking and quality improvement initiative.

- The service participated in national Patient Reported Outcome Measures(PROM) for Hip and Knee replacement, cataracts surgery and the Public Health England Surgical Site Surveillance Service.
- Patients undergoing hip replacements, knee replacements and cataract extractions were sent information about the patients' reported outcome measures (PROMs) survey. Patients who elected to take part completed this on line and were reminded three to six months following their operation to update the PROMs survey.

- The latest PROM report indicated that the service was not an outlier for hips and knee replacement and this was similar to other services.
- The hospital used the National Joint Registry to record outcomes for patients that underwent surgery such as hip, knee replacements.
- Readmission rates for this core service were low compared with other services within the group. Staff told us that patients did not always return to the service as they were sometimes admitted to the local NHS trust.
- The service contributed to the Private Healthcare Information Network (PHIN). Data was submitted in accordance with legal requirements which were regulated by the Competition Markets Authority (CMA).

Competent staff

The service made sure staff were competent for their roles.

- Staff had completed training in the identification of deteriorating patients and used national early warning score (NEWS) tool to assess and escalate any changes in a patient's condition.
- The theatres had a regular monthly training day, usually the third Friday of the month as they were less surgery performed on this day as many of the consultants participated in training or governance days at their NHS trust on this day. Staff told us and we saw evidence that this training included a range of topics included training on new equipment and learning from incidents.
- In the operating theatres, staff had competency folders and staff were expected to sign and confirmed they had attended training on any new equipment and were competent to use it.
- Nursing staff registrations were checked against the Nursing and Midwifery Council (NMC) registers. Staff told us nurses would not be allowed to practice until they could provide up to date registration evidence.
- There was a training programme which offered staff a variety of training courses to maintain their skills such as sepsis, pain management, blood transfusion and NEWS.

Multidisciplinary working

Staff of different professions and roles worked together as a team to benefit patients.

- There was effective multi-disciplinary working to support the patients. Staff told us they worked as a cohesive team. This was evident on the wards and in the operating theatres.
- The allied healthcare team such as physiotherapist, pharmacy team, nursing and medical staff worked well together which benefitted patients.
- Staff told us they had good support from the business service staff ensuring patients records were available and ready for admission.

Seven-day services

- The service had physiotherapists who were available six days a week and formed an integral part in the assessment and rehabilitation of patients.
- Theatre staff worked an on- call rota out of hours and were available for emergency and during the weekend if there was no elective surgery.
- The pharmacist was on site Monday to Friday and was available for advice and support out of hours.
- The service had a service level agreement with a local NHS Trust for access to blood in an emergency.
- The radiology service operated from 07.30 until 20.30 or until the last outpatient patient had been seen. This meant that the service was readily available to meet the needs of both day case and inpatients.
- Consultants were available out of hours seven days a week to support clinical decision making and there was always an RMO on site.

Health promotion

- Patients leaflets were available and displayed at the service including healthy eating and smoking cessation. All patients were asked about smoking and alcohol consumption as part of their pre- assessment.
- Patients said staff gave them advice on healthy eating, weight loss, wound care and infection prevention

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Surgery

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

- The service had policy and procedures for consents which were aligned to Mental Capacity Act 2005 (MCA) which the staff had access to. Staff told us capacity assessments started at the pre- admission assessment stage to ensure patients met their admission criteria.
- Staff understood the consent to care and best interest process. Staff could identify other situations when capacity assessments would be necessary.
- Care records showed that consent for surgical procedures were clearly recorded and patients told us the consent process was explained to them when they first saw the consultant.
- Staff told us that training in consent and mental capacity was available and formed part of safeguarding training.

Are surgery services caring?

Good

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

Compassionate care

Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.

- We observed staff treating patients with compassion, kindness and respect. Staff introduced themselves to the patients before starting any care interventions and sought their consents.
- Patients told us they were treated with care and respect. They told us the staff were 'very caring and kind' and they received care and support that met their needs.
- There were friends and family test (FFT) feedback cards which were available at the reception areas and staff encouraged patients to complete these
- We reviewed the last FFT feedback result for February 2019. These consisted of 12 NHS day case and 28 NHS inpatient who had received care at the service. This showed 100% had said they were 'extremely likely' to use the service

Emotional support

Staff provided emotional support to patients to minimise their distress.

- Patients we spoke with told us they felt well prepared as they had received support from staff at their pre-admission assessments and on admission.
- A patient told us that 'it was normal to feel anxious' however; they had received reassurance from the staff.
- Staff told us that relatives were supported to remain with patients to provide provided support f they chose.
- We observed numerous instances where patients were supported to allay their anxiety in a kind and considerate way.
- Patients for elective surgery were supported and given information to ensure they had the information they needed regarding their care.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment

- Patients told us they felt fully involved in their care and staff took time to explain things clearly and kept them informed of the procedures for their surgery.
- Patients said they knew what was happening with their surgery and what their treatment plans were and how long they were expected to stay in hospital.
- Patients were supported to have family and friends to support them and staff said they were always welcome.
- The self- paying patients were given clear information about the cost of treatment to support them in their decision about care and treatment.

Are surgery services responsive?

Good

Surgery

Good

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

Service delivery to meet the needs of local people

- As an independent hospital, most of the patients using the service were insured, self-funded and self-referred patients. Therefore, service development was informed by which services these patients chose to use.

Meeting people's individual needs

The service took account of patients' individual needs when providing services.

- There were a variety of facilities at the service to support patients with diverse needs. This included a hearing loop in the reception and ward for the hard of hearing to facilitate communication with those patients.
- Staff had access to a translation service for patients whose first language was not English. Patients had access to face to face translation service, deaf sign language interpreter as needed to meet their needs.
- Staff also gave an example of how they supported a patient to bring their hearing dog during their outpatient appointment and during the patient's inpatient stay.
- Clinics and pre-assessment were flexible to meet the individual needs of patients including staying open late or opening early to meet demands.
- Patients we spoke with were complimentary about the meals and the choices offered to them A patient told us 'you can have anything even if it's not on the menu'.
- To ensure consultants were aware of their lists, they were sent text messages at 48 hours prior to it as a reminder including an update on the number of patients they have. This reduced the risk of them arriving late, or being unaware of booked cases.
- Staff followed the hospital's discharge policy and procedures which included aftercare, post -operative instructions and a 24 hour follow up call after discharge.

Access and flow

People could access the service when they needed it.

- Between September 2018 to February 2019, there were 54 cancellations.Of these 27 were related to pre-assessment tests. There were 25 cancellations for admitted care and the provider told us these were due to patients being unfit for surgery at the time of admission.
- The service reviewed their theatre activities daily and weekly. Theatre utilisation was currently at 60% and a senior manager told us would like to increase this to the national level of 87%.
- At the pre-admission assessment process, the discharge plan was also initiated with the involvement of allied health professionals as needed. Patients' progress was discussed with the multi- disciplinary team which included physiotherapy and at follow up appointments.
- The waiting times from referral to treatment was on average two weeks and the service took into consideration patients' choices and availability. We were told the service monitored waiting times, although they said this was not an issue for them and had not had any complaints about the length of time patients had waited for either an outpatient appointment or inpatient care or treatment.
- Staff followed their discharge pathway, a summary of the treatment or procedure was included in the discharge letter to their GPs. The service also monitored the rates for patients who did not attend (DNA) for elective surgery. Between September 2018 and February 2019, the service had four DNAs. We saw that they followed these up, contacted the patients and the reasons for DNAs were clearly recorded.
- The service had a system in place where they contacted the patients 48 hrs prior to their planned surgery. All DNAs were either rescheduled, if telephone contact failed, the patient was sent a letter and they were referred back to their GPs.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Good

Surgery

- From January 2018 to March 2019, the service had received 12 complaints. These included two clinical and 10 other complaints.
- The service had policies and procedures to support the management of concerns and complaints and staff were confident in using these.
- There was a standard process such as on receipt of a complaint an acknowledgement letter was sent within 24 hours. The complaint was passed to their internal department to investigate and provide a draft response within 10 days. This was then sent to the managing director for review, response sent to the complainant within 20 days. This process was monitored and we saw that all complaint letters were acknowledged within 24 hours or the next working day. The majority of complaints were responded to within 20 days, if the complaint was complexed or required further time to ensure a full investigation was undertaken the complainant was kept informed of delays and the expected date when a response would be sent to them,
- The service had a process of tracking complaints and their outcomes which included dates and responsible individuals input, outcomes and learning. Complaint themes were identified from this on a quarterly basis and staff told d us information was used to effect learning and improve the service.
- Information was available to patients on how to raise a concern or complaint. Complaints could be escalated to external bodies such as Independent Health Sector Complaints Adjudication Service (ISCAS). The provider had confirmed there was no outstanding complaints with (ISCAS) at the time of the inspection.

Are surgery services well-led?

Good

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

Leadership

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

- The senior management team at hospital included the hospital director and head of clinical services, finance and operation managers who were responsible for the day to day management and development of the service. They were supported by the clinical team managers, physiotherapist, and pharmacy managers who all reported to them.
- There were ward and theatre managers who were responsible for the day to day management of the service.
- The ward manager and senior nurses told us they had positive relationships with the senior management team and the consultants who were all supportive.
- The staff felt that managers communicated well with them and kept them informed about the management and service any changes.

Vision and strategy

The service had a vision for what it wanted to achieve and workable plans to turn it into action, which it developed with staff.

- Staff told us they were involved in the development of the service which had been reviewed recently. This was aligned to the '6Cs' which translated as care, courage, compassion, commitment, communication and competence.
- This was displayed at the service and staff we spoke with were aware of the service visions. A staff member told us their team's vision was to 'provide the best and highest standard of care'.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values

- There was a staff engagement forum which included representatives from each department at the service. Staff told us they were looking at the results of the staff survey to identify areas of improvement. They gave us an example to improve communication, a staff suggestion box was introduced in the staff's restaurant and a newsletter was starting in March.

- We observed staff were respectful to patients and their peers. The staff told us they worked well together and we found they worked cohesively as a team offering support to one another.
- Staff told us morale was good and they felt there was an open culture where they were supported to raise any concerns with the ward manager and senior leaders. They described their senior management as 'very approachable' and felt they were listened to.
- All staff were clear about their roles and responsibilities, patient-focused, and worked well together. They told us they received support from their managers in undertaking their roles and responsibilities.
- The service operated a staff recognition scheme and included private health care, long service awards.

Governance

The service systematically improved service quality and safeguarded high standards of care.

- The governance structure consisted of the hospital director, operation manager, finance manager, matron and head of departments such as wards, theatres, physiotherapy and radiology. Reviewing of incidents was a standard agenda item on the monthly clinical governance committee meeting and we saw evidence of this from meeting minutes.
- Most of the consultants also worked at the local NHS trust and attended meetings at the trust where cases including NHS patients being treated at the hospital were discussed.
- We saw minutes of meetings which showed all serious incidents and deaths relating to patients were discussed at morbidly and mortality meetings. These discussions facilitated some shared learning.
- We observed the clinical nursing leaders were visible and were involved in the day to day management of the service and providing support to the staff.
- The service had a number of health and safety committees that looked into patients' risks. The health and safety committee met bi – monthly. The infection prevention and control committee met quarterly and this fed into the clinical governance meetings which reported to the MAC.
- The hospital had introduced a new process of reviewing practicing privileges (PP) every two years. The medical advisory committee (MAC) was responsible for this review as they met four times a year. All new PP applications completed a standard application and were the applicants were provided with a pack.
- Minutes pf the MAC meeting from February 2019 showed the meeting structure, review of PP and presentations included speaking up for safety and communications training to prevent unintended harm to patients.
- There were quarterly contract monitoring meetings with the clinical commissioning group (CCG) that not only looked at financial position but also quality of the service provision. They are clinically-led statutory bodies responsible for the planning and commissioning of health care services for their local area. The CCG looked at activities, quality and financial elements of the service provided. This was an important pathway as NHS patients were allocated to the service to reduce the NHS surgery waiting times which benefitted patients.

Managing risks, issues and performance

The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

- Incidents and complaints were presented at the quarterly clinical governance committee and the medical advisory committee (MAC) meetings.
- Complaints were also discussed at their weekly service meetings and at the head of department (HOD) meetings. A summary was included in the annual quality reports and learning form these were shared with staff.
- Minutes of Heads of Department (HODS) meetings showed risks and strategies, staffing was discussed and included duty of candour (DoC) and that any potential DoC issue was flagged at huddles.
- There were daily safety huddles and this included a resuscitation briefing which was attended by the resident medical officer and other clinical staff. This ensured that any patients' risks were communicated and staff were aware of actions needed.
- Staff had access to a range of policies, procedures and guidance which were available on the service's

electronic system and in paper formats. However, we noted that several paper policies and procedures had not been reviewed and were out of date. This posed risk of staff working with policies and guidance which may not reflect current practices.

- Managers told us the policies were reviewed at their head office and cascaded to the local service. It was unclear how corporate policies and procedures were adapted to reflect local practices. A senior staff told us they were working through the policies and updating the files to ensure the paper copies were up to date.
- The service had a generic risk register that contained 23 risks. We saw that the risk register was discussed at their monthly governance meeting and this was up to date. The risks were reviewed and action plan were in place to mitigate the risks. One of the risk related to the loading of trolleys from the theatres. The service had developed an action plan to resolve this issue.

Managing information

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

- The service had a variety of information for the staff which focussed on improving the service delivery. The staff board contained information on the five key lines of enquiries aligned with the Care Quality Commission (CQC).
- All designated staff had access to patients' medical records which included assessments, tests results, current medicines, referral letters, consent forms, clinic notes, pre- and post -operative records.
- Following care and treatment letters were sent out to patients'' GPs detailing procedures undertaken and any follow ups they may require. A copy of the discharge letter was also given to the patient.

Engagement

The service engaged well with patients and staff to plan and manage appropriate services.

- People using the service were encouraged to provide feedback on the quality of care and service they received.
- Patients satisfaction surveys were undertaken to gather feedback on the service. We reviewed the response rates for day case and in patients for the months of November2018 to February 2019. These varied from 7 t0 36% in November 2018 to 25 to 50% responses in February 2019.
- We saw the friend and family test for the past three consecutive months which showed patients were positive about the care and treatment they received at the service.
- There was a staff engagement forum which included representatives from each department at the service. Staff told us they were looking at the results of the staff survey to identify areas for improvement. They gave us an example of action that had been taken to date; this included introduction of a staff suggestion box and a newsletter was starting in March 2019 with the aim to improve communication.

Learning, continuous improvement and innovation

The service was committed to improving services by learning from when things went well or wrong and promoting training.

- The service had supported the development of one of our physiotherapists to become an Advanced Practitioner. The Advanced Practitioner provided an enhanced musculoskeletal triage service including new patient assessment and post-surgical follow-up.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should store all intravenous fluids safely and check the use by dates, discarding all out of date fluids from circulation.
- The provider should develop policies and procedures and standard operating procedure for the admission of patients in the enhanced recovery unit.
- The consultants' personnel records should include proof of identification.
- Policies and procedures should be reviewed and updated to reflect current practices.