Nuffield Health

Nuffield Health Leicester 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	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Nuffield Health Leicester Hospital provides a range of private treatments and services. They had specialists in orthopaedic, general surgery, ear nose and throat, cosmetic surgery, paediatric surgery, women's health, physiotherapy and sport injuries. The hospital saw both private, insured and NHS patients. We inspected the surgery core service for adults only.

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

- The service had enough staff to care for patients and keep them safe. Staff understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff managed medicines well. The service managed safety incidents well and mostly learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available 7 days a week.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Not all staff were correctly assessing patients using the National Early Warning Score 2 (NEWS2) scoring system.
- Not all staff were trained on safeguarding adults and children, however, they were close to the target set by the provider.
- Whilst there was a robust audit programme, not all audits were completed, and action plans were not always in place or actioned.
- Leaders did not always feedback information to their teams during meetings. Staff were not always aware of incidents, learning, risks and audits. This meant leaders could not ensure improvements were made.
- The risk register was brief and did not contain all the risks within the service.

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure that all staff are trained on NEWS2. (Regulation 12: Safe Care and Treatment).
- The service should ensure that all staff are aware of the Control of Substances Hazardous to Health Regulations (COSHH) and all items are stored appropriately. (Regulation 15: Premises and equipment).
- The service should ensure that all audits are completed in line with the hospital audit programme, and they have an associated action plan to increase compliance. (Regulation 17: Good Governance).
- The service should ensure they have embedded methods of feedback for staff to ensure that all staff are aware of learning, incidents, audits, and areas where improvements are needed. (Regulation 17: Good Governance).
- The service should ensure that all theatre staff complete the debrief following surgery as per policy. (Regulation 12: Safe care and treatment).

Summary of findings

- The service should consider putting further detail into their meeting minutes to ensure that staff who could not attend were aware of the content of the meeting. (Regulation 17: Good Governance).
- The service should ensure that staff are aware of the risks contained on the risk register and the measures in place to reduce the risks. (Regulation 17: Good Governance).

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	We inspected the surgery core service for adults only. We rated Safe and Effective as Good and Well-led as Requires Improvement. This meant overall the ratings remained at Good.

Summary of findings

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Summary of this inspection

Background to Nuffield Health Leicester Hospital

We carried out this unannounced focused inspection within the surgical service. We checked the quality of the services in response to an incident that occurred at the hospital in March 2023. We looked at certain areas, such as infection control, mandatory training, risk assessments, culture and governance to ensure the service provided was safe, effective and well-led.

During this inspection we inspected the surgical service using our focused inspection methodology. We did not cover all key lines of enquiry; however, we have re-rated some key questions based on the findings from our inspection. Overall, we rated safe and effective as good and well-led as requires improvement in the surgical service. We did not rate the caring or responsive domains. This means that overall, the service remains as good.

How we carried out this inspection

We inspected the service on 13 September 2023. This was an unannounced focused inspection looking at the surgical service. We inspected the ward, pre-operative assessment rooms and the operating theatres including the recovery bays.

The team that inspected the service comprised of 2 CQC inspectors and a specialist advisor with expertise in surgical services.

During our inspection, we spoke with 34 staff members including nursing staff, healthcare assistants, allied health professionals, theatre practitioners, doctors, and managers. We reviewed 7 patient records and spoke to 2 patients.

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.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Not inspected	Not inspected	Requires Improvement	Good
Overall	Good	Good	Not inspected	Not inspected	Requires Improvement	Good

Good

Surgery

Safe	Good
Effective	Good
Well-led	Requires Improvement

Is the service safe?

Good

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included fire safety, moving and handling, infection control, and health and safety.

We saw 92% of staff had completed training in recognising and responding to patients with mental health needs, learning disabilities, autism, and dementia.

Managers monitored mandatory training and alerted staff when they needed to complete any updates. Training was completed electronically. Staff were given time to complete their training. When staff were due to renew their training, they received emails reminding them that their training was due for renewal. Managers also received the training figures for their staff and chased them to increase compliance.

At the time of our inspection there was an overall compliance of 92% for theatre staff, 96% for pre-operative assessment staff and 96% for the ward staff against a target of 90%. However, within these figures, we saw immediate life support training was 84%; this was below the 90% target. Managers had planned a course was being run on 26 September 2023 which would increase the compliance.

We found that whilst training figures were good, the knowledge from these courses was not always embedded. For example, 95% of theatre staff had completed health and safety training but when we asked them about the control of substances hazardous to health (COSHH), they were not aware of the requirements.

Bank staff received and kept up-to-date with their mandatory training. They were paid for their time to complete the training.

Consultants' mandatory training was monitored by the medical advisory committee chair. All consultants had to provide their mandatory training certificates to be granted practising privileges with the hospital. They were also able to attend on site hospital training if required.

Good

Surgery

Safeguarding

Staff understood how to protect patients from abuse. Most staff had training on how to recognise and report abuse and they knew how to apply it; however, they were under the 90% service target for training completion.

Staff received training specific for their role on how to recognise and report abuse. The service had safeguarding processes and procedures in place. At the time of our inspection 89% of staff were trained to level 2 safeguarding adults and 85% were trained to level 2 safeguarding children; this was below the training target of 90%. The safeguarding lead for the service locally was the director of clinical services (DCS) who worked on site; they were trained to level 3. There was also a staff member who worked in the children's and young people service who was trained to safeguarding level 5 who the DCS liaised with if required.

Staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff told us signs of different types of abuse, and the types of concerns they would report or escalate to the safeguarding lead. Staff followed safe procedures for children visiting the adult only ward.

Staff knew how to make a safeguarding referral but not all staff knew who the safeguarding lead was. However, they would inform their manager if they had concerns. There was an up-to-date safeguarding policy. Safeguarding posters were displayed in pre-operative assessment and in ward areas and staff knew where to find the safeguarding policies and procedures.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. They kept equipment and the premises visibly clean. Staff used equipment and control measures to protect patients, themselves, and others from infection. However, action plans following audits were not always completed to increase compliance.

Ward areas were clean, well-organised and had suitable furnishings which were well-maintained. Guidance was available for staff in the form of an infection prevention and control (IPC) policy. The policy detailed all protocols required to maintain a good level of cleanliness, infection control and hygiene. At the time of the inspection, 93% of eligible staff had completed IPC training and 92% had completed practical IPC training. Cleaning records were up-to-date and completed daily. The ward and theatres were cleaned daily by a domestic team. Theatres also had a deep clean completed by an external agency.

Theatre areas were noted to be visibly clean and well-organised. We saw staff cleaning down equipment appropriately following theatre cases. There were separate scrub, anaesthetic, and preparation rooms for each theatre.

The service generally performed well for cleanliness. Monthly audits were completed to assess staffs' compliance with IPC standards and guidance. Compliance was consistently above 90% for all audits from the 3 months before we inspected. Each area had an IPC link nurse. They were responsible for completing the audits. Theatre did not have a link nurse at the time of the inspection. The service had an IPC lead nurse who worked 2 days a week. They coordinated all IPC training and meetings including a monthly link nurse meeting and a quarterly IPC meeting with microbiologist representation. They were responsible for delivering the annual audit programme, surgical site infection surveillance and overall IPC compliance. There was an annual audit which looked at 10 different criteria; this was last completed in June 2022 with an overall compliance of 93.6%. There was no associated action plan with this audit. However, there was an overall IPC action plan which had actions from some of the audits; the IPC lead tracked these monthly. We saw that actions from

ward and theatre audits were put not always into place to make improvements. The IPC lead nurse looked at the completed audits and reminded staff to put the actions onto the overall IPC action plan. Although, we saw there were no actions for August 2023 audits. We fed this back, and the IPC lead nurse told us they would prompt the link nurses to complete these.

Audit results were discussed in monthly clinical governance meetings. However, we found the results were not always disseminated to staff, and they were not aware of actions required to make improvements.

Staff followed infection control principles including the use of personal protective equipment. Hand sanitiser was available in every room and at the entrance to the ward area and theatres. Staff mostly cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Reusable surgical instruments were decontaminated off site at another hospital; there was a 12-hour turnaround time.

Staff worked effectively to prevent, identify, and treat surgical site infections (SSI's). Staff looked at infection data. There were procedures in place to reduce the risk and monitor for signs of SSIs in line with The National Institute for Health and Care Excellence CG 74 Surgical site infections: prevention and treatment. Patients who met the criteria were screened in pre-assessment for Methicillin-Resistant Staphylococcus Aureus (MRSA) before admission. All infections were reviewed by the IPC lead nurse to ensure trends were identified and learning was implemented. The service had recently changed the dressing type they were using as they had found patients were getting them wet and this had increased the incidence of infections. They had since changed their dressings and had seen a reduction in their infections.

The service completed SSI surveillance 30 days post-surgery for all patients who had had a hip or knee replacement. Between April and June 2023, there had been 163 operations and 0 return to theatre or SSI's recorded; this was the same for January to March 2023. Data showed there were 0 suspected infections for hip and knee replacements in 2023. There were 12 suspected SSI's for other specialities. A root cause analysis (RCA) was completed for all patients who returned to theatre (RTT) or had a readmission related to an infection. They had completed 1 RCA in 2023 for a patient who RTT and the outcome was no SSI.

The service was working towards their Aseptic Non-Touch Technique silver accreditation. The accreditation aimed to demonstrate effective clinical governance for aseptic technique, and commitment to infection prevention and patient safety.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, hazardous items were not always stored appropriately.

The design of the environment followed national guidance. The ward area and theatre were suitable for their purpose and mainly clutter free. The theatre corridors were visually kept clean and tidy, and all equipment stored appropriately.

The service had enough suitable equipment to help them to safely care for patients. Patients could reach call bells and staff responded quickly when called. Staff carried out daily safety checks of specialist equipment. We saw all equipment, such as blood pressure monitoring equipment, were tested regularly to ensure their safety and effectiveness. We checked the resuscitation equipment on the ward and in theatre; daily checks were completed in all areas. Theatre staff had access to specialist emergency equipment, such as a difficult airway trolley, and these were checked regularly. Ward staff had access to specialist mattresses and chairs to reduce the risk of pressure damage for those patients who needed them. There was bariatric equipment available when required.

The service had processes in place for the maintenance and checking of electrical equipment in accordance with Managing Medical Devices (January 2021), and other national guidance. All equipment we checked contained evidence of in date electrical safety testing and servicing. Managers told us safety alerts were disseminated to them, and any recalled equipment was removed. We saw safety alerts were discussed in clinical governance meetings and actions were taken where required. However, this was not consistently fed back to the staff on the floor.

There were 2 theatres and 1 recovery area with 3 bays. There was good availability of equipment within the theatres. Staff said there was advanced planning of schedules which meant they could ensure equipment was available. Theatres had a contract with an external company where an engineer attended once a week to fix any equipment required. We checked at least 50 items of single use equipment and most of it was in date. However, we found an out-of-date blood culture bottle, blood collection bottle and wound swab on the ward. We escalated this to a manager who disposed of them immediately and said they would do a full stock check.

We saw staff disposed of clinical waste safely. Within theatres there was a 1-way system from the second floor down to the ground floor. However, we did see within patient bathrooms on the ward there were clinical waste bags within small pedal bins.

The service completed a patient-led assessment of the care environment (PLACE) audit annually. This was last completed in September 2022 and service scored over 95% for all categories apart from dementia and disability which was just below 90%. The fabric of the building and paintwork was the main issue that this highlighted. At the time of our inspection, this had not been addressed. We saw there were areas where the paintwork needed updating and replastering.

The airflow systems in the operating theatres were validated and checked against standards set out in national guidance Health Technical Memorandum 03-01; “Specialised ventilation for Healthcare Buildings” 2021.

We found 3 flammable items which were not stored in a metal cabinet on the ward as per Control of Substances Hazardous to Health (COSHH) regulations 2002. We raised this with the ward sister who immediately locked these away in a metal cabinet. Theatre staff were also not aware of COSHH when asked, although we did not find items inappropriately stored.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, audits were not consistently completed and actions from audits were not always documented or acted upon.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. Nursing staff used nationally recognised tools to assess patient’s risk of developing pressure ulcers, malnutrition, falls, as well as risks associated with moving and handling. Patients identified at risk were placed on care plans and were monitored more frequently by staff to reduce the risk of harm. We reviewed 7 sets of notes and found all risk assessments had been completed and reviewed regularly. A documentation audit was completed quarterly during which 10 sets of patient notes were reviewed. Data from the service showed for July 2023, the records were 90.2% compliant with the service’s required standards. There was an action plan with clear actions and completion dates however it had not been updated since the beginning of September 2023. This meant we were not sure if the actions had been completed or actioned.

Good

Surgery

Risk based pre-operative assessments were carried out in line with national guidance. All pre-operative clinical tests were completed in line with National Institute for Health and Care Excellence (NICE) guidelines.

Risk assessments to assess a patient's risk of developing blood clots or venous thrombo-embolism (VTE) whilst in hospital and after surgery were always completed in line with NICE guidance (NG89) March 2018. We looked at 7 sets of records and found the VTE assessment was completed in pre-operative assessment and signed by the consultant on admission. All patients who required VTE prophylaxis had this prescribed and in all 7 records, this was given. The VTE risk assessment was also checked the day after surgery in all 7 records; this was in line with best practice. We saw within the clinical governance meeting minutes for July 2023 that an incident had been raised as patient reported a painful calf; staff acted appropriately, and guidelines were followed for the management of a potential VTE. Data showed there were 3 confirmed VTE's within the last 12 months.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The National Early Warning Score (NEWS2) was used for adults. Clinical observations, such as blood pressure, heart rate, and respirations were recorded and contributed to a total score. Any patients with a NEWS2 of 4 or more would trigger a review from the doctor. During our review of the NEWS2 charts, we found these were mostly calculated and escalated correctly. However, we found in 2 out of the 7 charts we checked, the NEWS2 total from when the patients were in recovery was incorrect which could have meant a deteriorating patient was not identified as quickly. However, patients staff undertook continuous monitoring of the patients which mitigated this risk. All NEWS2s were correct from the ward meaning that patients were monitored safely.

There was a policy for how to manage a deteriorating patient within the service. There was a team who were assigned to attend any clinical emergency which was led by the Resident Medical Officer (RMO); this was decided daily at the hospital huddle. Staff were supported by the RMO if a patient's health deteriorated. If the patient could not be managed within the service, as there was no higher-level care, they would be transferred by ambulance to the local NHS trust. The hospital had a transfer agreement in place with the local acute NHS trust should a patient required a higher level of care. The RMO told us the nursing team escalated concerns with deteriorating patients promptly and appropriately. If a patient became unwell, the RMO would escalate the concerns to the consultant. The service had a previous serious incident where concerns had not been escalated to the consultant in a timely manner; the RMO told us they had learned from this and always ensured that any change in medical condition was escalated promptly.

The service used the '5 steps to safer surgery', World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency (NPSA) guidelines. We looked at 7 sets of notes on the ward and 4 sets of notes in theatre and these were all completed. We observed the WHO checklist being undertaken in theatre on 6 occasions during our inspection and they were completed well. Following the inspection, the service completed a 5 steps to safer surgery audit on 3 theatre lists; they were 100% compliant. The theatre staff should complete a WHO audit quarterly to establish if the 5 steps to safer surgery were being completed in line with the recommendations. The WHO audit, which prior to our inspection, had not been completed since January 2023 showed a compliance of 87.2%. There was no associated action plan with the audit; we were not assured that actions had been taken to address the poor compliance. National Safety Standards for Invasive Procedures (NatSSIPS) were available in the theatre department. NatSSIPS provide a framework to produce Local Safety Standards for Invasive Procedures (LocSSIPS). We saw the service had a LocSSIP for the WHO Surgical Site Safety Checklist. The stated all teams should perform a brief and debrief for each theatre list. We saw 3 team briefing sheets; all of them had completed a brief prior to surgery, however, only 2 teams had completed the debrief following surgery. This was not audited by the department therefore we were unable to ascertain compliance to the LocSSIP.

Good

Surgery

Staff shared key information to keep patients safe when handing over their care to others. We were told handovers included all necessary key information to keep patients safe; these were attended by the nurses and the RMO. We observed the daily staff 'huddle' at 9:45am. All heads of department and the senior leadership team attended the huddle.

The service had a service level agreement for the provision of blood and blood products. Staff had access to blood in the event of an emergency, with 4 units of universal blood stored in theatres. Blood products were ordered in advance for patients if it was required. The blood fridge and stock were checked daily to ensure it was safe for patient use. Theatres recently did a practice scenario where they phoned the local trust, who supply their blood products, to request blood and it did not arrive in a timely manner. They were looking into different options to improve this such as a blood bike or supply from another hospital within the trust; they plan to repeat this practice scenario to ensure improvements have been made.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Managers told us they had good staffing levels and were able to manage their staffing rota well. The service did not use a safer nursing care tool to measure patient acuity as patients were of similar dependency.

The ward had a ratio of 1 nurse to 5 patients, 2 healthcare assistants on in the daytime and always had 2 registered nurses overnight. The ward used bank staff when needed; they rarely used agency staff. Managers made sure all bank and agency staff had a full induction and understood the service.

The theatres were staffed in accordance with the Association for Perioperative Practice (AfPP) guidelines. There were enough staff on duty during the patient's surgical procedure, which included surgeons, anaesthetists, and operating department practitioners. The theatre manager completed the rota on a weekly basis. Theatres used between 400 and 900 hours of agency staff per month, depending on sickness and leave. There were 2 agency staff members in recovery on the day of inspection, both had received an induction and were employed as part of a long-term contract and had been with the service over 1 year.

Managers adjusted staffing levels according to the needs of patients and flexed their staffing accordingly. Planned activity for the hospital was reviewed by managers in a capacity meeting on a bi-weekly basis so substantive and bank staff could be adjusted according to activity.

The service had low sickness and vacancies. There was a vacancy for a ward manager, although an interim ward manager was in place. Vacancies were mostly filled with bank and long-term agency staff. Managers told us they were finding it hard to recruit into specialised scrub nurse positions such as ear, nose and throat and general surgery scrub.

Managers limited their use of bank and agency staff and requested staff familiar with the service. When they had new agency starters, they made sure staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Good

Surgery

Patient care was consultant-led. The service had enough medical staff to keep patients safe. Consultants were available for advice and to review admitted patients. They provided 24-hour on call cover for their patients post-operatively and were required to be within a 30-minute drive of the hospital when off site. If the named consultant was unavailable at any time, they arranged appropriate alternative named cover by another consultant in the same specialty.

All consultants who worked at the hospital did so under practising privileges (PP's). This is a process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital. The hospital had a medical advisory committee (MAC) whose responsibilities included ensuring new consultants were granted PP's if deemed competent and safe to practice. Meeting minutes showed that this was discussed at MAC meetings in January and June 2023. However, data presented at the MAC meeting showed that only 82% of consultants had valid Disclosure and Barring Services (DBS) checks completed and there was no action to increase compliance. We discussed this with the DCS who said that all consultants required their DBS to be renewed every 3 years. All consultants were sent 3 reminders and if they did not produce the DBS, then their PP's were suspended until their DBS was complete.

The service had a RMO who was on site 24 hours a day 7 days a week who were employed through an external agency. There were 2 RMO's for this service who rotated between working 1 week on and 1 week off. The RMO was responsible for the patients when the consultants were off site and informing them of any changes to their patients' condition. Both RMO's had been with the service since October 2022. If there was sickness, their agency would provide cover for the hospital. Managers made sure the RMO had a full induction to the hospital before they started work. The RMO was contacted overnight only in an emergency.

A handover took place between RMO's at the start/end of each week. Handover included a structured discussion of each patient and details of any work outstanding. They also attended daily nurse handovers. The RMO said they felt supported by the nursing and medical staff and could contact a patients' named consultant or anaesthetist if they needed further support or advice.

Records

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

Records were stored securely. The hospital used a paper-based system for recording patient care and treatment. We saw these were stored securely to protect confidential patient information.

Patient notes were comprehensive, and all staff could access them easily. We reviewed 7 sets of patient records and found they were legible, up-to-date, and contained all relevant information regarding patients' care and treatment. Managers completed a quarterly audit of 10 sets of patient records. This was completed in July 2023 and was 90.2% compliant; there was an action plan which detailed improvements needed.

Clear pathway documents were used throughout the patient pathway. Risk assessments were completed from the start of the patient's pathway in pre-operative assessment through to admission. These assessments were carried out in line with NICE guidance. We reviewed a sample of these and found they were completed thoroughly.

When patients were transferred to a new team, there were no delays in accessing their records. Patient notes were transferred with the patient between the ward and theatres. There were processes in place for sharing and transferring information between teams and organisations. For example, when a patient was discharged.

Staff completed and recorded intentional care rounding. It was a structured process where staff performed regular checks with individual patients at set intervals. For example, the staff would go into the patient every 1 to 2 hours and check they had drinks, they were in a comfortable position, and they were not in any pain. We saw these were completed in the notes we reviewed.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines. However, audits did not have clear actions for improvement.

Staff followed systems and processes to prescribe and administer medicines safely. Doctors prescribed medicines on a paper-based chart. This was stored within patients' nursing record. Documentation of medicines administration including routes of administration and specific times of administration were clear on all medicine records reviewed. The pharmacist checked this daily and challenged doctors when prescriptions were not correct. For example, if paracetamol was prescribed intravenously to a patient who weighed below 50kg, the pharmacist would alert the doctor to change to prescription to ensure that it was based on the patient's weight.

Allergy statuses of patients were routinely recorded on all medicine records seen.

VTE risk assessment outcomes and prescribing were completed on admission.

The principles of antimicrobial stewardship were implemented which included review dates for re-assessing prescribed antibiotic treatment.

Pharmacy staff reviewed each patients' medicines each day they were on site and provided advice to patients and carers about their medicines. Pharmacy staff provided support to staff and patients. This ensured medicines safety.

Staff completed medicines records accurately and kept them up-to-date. We looked at 7 medicine records and found they were all complete.

Staff stored and managed all medicines and prescribing documents safely. We found all medicines were locked away in the appropriate cupboards. Medicines, including controlled drugs (CD), were stored safely and securely on the wards and in theatres. We observed no medication was left unattended. Staff carried out twice daily checks on the CD's and weekly medication stocks to ensure medicines were reconciled appropriately. All medication checked was in date and the controlled drug balances were correct. Emergency medicines were stored in secure containers on the resuscitation trolley; these were all in date.

The service ensured medicines requiring refrigeration were stored at the recommended temperature. The refrigerators and the room temperature in theatre and the ward were monitored digitally by an external company. If it was to go out of range, the company would call pharmacy within working hours and the ward out-of-hours. Pharmacy had a continuous tracker online of these temperatures. If the temperature was to go out of range this would register an incident on the system; these were checked regularly by the champions within the ward and theatre areas. A report was completed monthly by the pharmacy.

The pharmacy department was open Monday to Friday from 9am to 5pm. It was led by the lead pharmacist. If medication was required out of hours, the RMO and a registered nurse would enter pharmacy together; the RMO had a code for access. They both signed a register to confirm what medication was removed, which pharmacy staff reconciled the following day.

The pharmacy prepared any medication in advance for discharge where able. The ward held several pre-packed medicines for out of hours and weekend discharges. These were mostly analgesia or antibiotics. Each of these medications given on discharge were recorded, checked, and signed for by 2 nurses.

Patients were given advice at the pre-operative assessment regarding stopping certain medications which may interfere with their procedure; we saw documentation in patients notes regarding these conversations.

Regular audits were carried out to ensure medicines were reconciled, prescribed, administered, and stored in line with national guidance and hospital policy. The pharmacist completed quarterly controlled drugs audits. The results for the ward were overall good. However, the last 3 audits between January and July 2023 all had the same action which was "the CD register in good order but not consistent with legislation". It was not clear what was being done to improve compliance with this. This issue had been documented since January 2023 with no increase in compliance.

The medicines audit had not been completed in theatre 1 since April 2023. The audit found issues including staff CD competencies not completed, staff had not read or signed the relevant standard operating procedures and the CD register was not in good order nor consistent with legislation. There were issues documented but no actions to drive improvements and the action plan had not been updated since April 2023. We looked at a sample of CD records and found them to be completed well. Suboptimal CD documentation in theatre was added to the risk register in August 2023. Controls showed that all staff applicable had undertaken CD competencies, but additional CD audits had not been completed and were outstanding on the risk register.

Both the ward and theatre had a medicines security audit completed in September 2023. They scored 96% and 91% respectively. Where non-compliance was found, these issues were documented but actions were not documented for how they were going to improve compliance.

The hospital had systems to ensure staff knew about safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents but did not always report near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The hospital used an electronic reporting system to report all incidents. Reported incidents were reviewed by DCS initially and investigated by the managers. Any immediate learning points were raised at the daily hospital safety huddle. Managers within theatre did not consistently share key learning and feedback from incidents with theatre staff. However, the manager had plans to start a daily huddle for all staff on shift to mitigate this.

Managers investigated incidents thoroughly. Incidents were discussed monthly at clinical quality and safety meetings and the senior management meetings. We were told about an incident where the wrong patient was brought to theatre and anaesthetised before the staff realised, they had collected the wrong patient. The staff immediately had a meeting about it and completed an investigation. They found there was room for error in their current processes. They implemented changes, including a step-by-step walk-through guide, within the pre-theatre checks to ensure this did not happen again.

Good

Surgery

Staff reported serious incidents clearly and in line with trust policy. However, the manager felt they did not report near misses. This meant there was a chance some incidents could have been avoided if staff had highlighted a near miss; this was something the manager wanted to educate the staff on. It was highlighted within the August 2023 director of clinical services report that reporting of incidents was low and they wanted to improve the reporting culture. It had been discussed on 8 September 2023 with ward staff in their team meeting.

The service had started to implement the patient safety incident response framework (PSIRF) which was an NHS approach to the management of incidents which promotes learning and improving patient safety. They had recently used the PSIRF to analyse a recent safety incident which they found the different approach helped with finding solutions and created learning points.

Staff understood the duty of candour (DoC). They were open and transparent and gave patients and families a full explanation if and when things went wrong. The duty of candour is 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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw evidence the DoC was carried out following the incident described above.

Staff received some feedback from investigation of incidents, both internal and external to the service. Staff were aware of some incidents but were unable to tell us of changes that had been made in theatres, pre-assessment or the ward following some incidents. We saw team meetings happened infrequently in all areas and we were told that feedback from incidents was informal. We saw the ward had a team meeting in May and September 2023 where incidents were discussed although no learning was documented; this meant if a staff member was unable to attend the meeting and was reading the minutes, they would not be aware of the learning.

The service had no never events within the last 12 months. Managers shared learning with their staff about never events that happened elsewhere. In clinical governance meetings the managers discussed incidents that happened at other Nuffield Health hospitals and made changes to their practice if required. For example, they were told about another hospital who had implanted the wrong cataract implant. The team discussed this and made sure their processes were robust to ensure this did not happen within their service.

Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good

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

Evidence-based care and treatment

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

Good

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies seen contained current national guidelines and were in line with evidence-based practice. Policies were stored on an online system which all staff had access to. All new policies were highlighted to staff on a twice weekly briefing note. Local policies were reviewed annually and were managed by the clinical governance team.

The service used evidence-based guidance and quality standards to inform the delivery of care and treatment. For example, the pre-operative assessment nurses assessed patients in accordance with National Institute for Health and Care Excellence (NICE) guidance NG45 Routine pre-operative tests for elective surgery and CG 74 Surgical site infections: prevention and treatment. NICE guidance was sent out monthly from the central team to the hospital. Managers discussed up-to-date guidelines within their clinical quality and safety meeting and implemented actions as required.

Staff followed guidance regarding the records and management of medical implants, such as hip implants. Patients signed a consent form agreeing they were satisfied for their details to be stored on the central database. Relevant paperwork was completed at the time of insertion of an implant and was documented on the National Joint Register (NJR) by theatre staff. The service also participated in the breast registry.

Staff used surgical pathways which were in line with national guidance. This included integrated care pathways specific for a day case procedure. Consultations, assessments, care planning and treatment were carried out in line with recognised professional guidelines. Our review of patient records, guidelines and clinical pathways, and discussions with staff confirmed care was delivered in line with national guidance and standards.

The service also ran an enhanced recovery programme for patients undergoing hip or knee replacement surgery. This included an information session pre-operatively in a group and post operative rehabilitation sessions with the physiotherapy team.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patients' nutrition and hydration needs. This was in line with national guidance. Staff fully and accurately completed patients' fluid and nutrition charts where needed. MUST assessments were completed in the records we reviewed. These were routinely updated as required. Staff used fluid balance charts to monitor patients' fluid intake and output.

Patients waiting to have surgery were not left 'nil by mouth' for long periods. They were kept 'nil by mouth' in accordance with national safety guidance. This was to reduce the risk of aspiration during general anaesthesia. Patients having elective surgery were given clear instructions about fasting before admission. Information was given verbally at the pre-operative assessment and in writing. Admissions were generally staggered, so patients were fasted for the minimum amount of time.

Patients recovering from surgery had jugs of water within reach. These were regularly refilled. Staff completed care rounds for each patient where they checked if they had or needed a drink.

Patients who experienced nausea or vomiting were prescribed antiemetic medicine (used to minimise vomiting and nausea). Patients were given antiemetic's intravenously (into a vein) in the recovery area if they complained of nausea post-operatively. We saw antiemetic medicines prescribed in the prescription charts we reviewed.

We spoke to 2 patients who both said the food and drink was good and there was a choice available.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The NEWS2 chart was used which prompted staff to assess, record and manage pain effectively. This scored the pain from 0 to 10. We reviewed 7 sets of patient notes which showed pain was assessed within the NEWS2 pain scale and hourly on care rounds; high pain scores were acted on promptly.

Staff prescribed, administered, and recorded pain relief accurately. Patients received pain relief soon after requesting it. We spoke to a patient who said they had managed their pain very well.

Patients were provided with a leaflet which gave advice on expected symptoms post-surgery and how to treat any pain they might have.

The pharmacist discussed pain management with all patients and how to use their analgesia effectively. The physiotherapists ran an enhanced recovery programme for patients undergoing hip or knee replacement surgery. This included an information session pre-operatively in a group. They discussed pain within this session and what pain relief should be used. They discussed being proactive about their recovery by keeping on top of pain relief; one patient fed back after the session they found this very useful.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They mostly used the findings to make improvements and achieved good outcomes for patients. However, actions were not always created to make improvements following audits.

The service participated in relevant national clinical audits, which they generally performed well in. Managers used the results to improve services further. The service had an effective system to regularly assess and monitor the quality of its services to ensure patient outcomes were monitored and measured. Outcomes for patients were positive, consistent and were in line with national standards. Clinical audits and risk assessments were carried out to facilitate this. The hospital participated in some national audits to monitor patient outcomes including the elective surgery Patient Reported Outcome Measures (PROMs) programme and the NJR.

The NJR data for August 2017 to August 2022 showed for hip replacements, the hospital was as expected for 90-day mortality and revision ratio. This was in line with other similar services. The NJR submission data from 1 April 2021 to 31 March 2022 showed the hospital submitted data for more than 600 patients. The data showed that 99% of patients had consented to have their personal data stored on the NJR; this was above the national expectation of 90%. However, they were worse than expected for the time taken to enter the data. The national expectation was 30 days, and the service took 57 days.

Good

Surgery

PROMS data was collected for patients who underwent hip and knee replacements and cataract surgery. They had an average of 37% participation rate; the Nuffield Health average was 40%. For patients who had undergone a hip replacement, they had found 100% improvement and there was 95% improvement for patients who had undergone a knee replacement. There were no responses for cataract PROMS. The service held a meeting in August to discuss this. They found due to the pre-operative assessments (POA) being done over the phone, the patients were not getting their pre-operative questionnaires before their eyes were dilated. They changed the process for POA nurses to ask the patient the PROMS questions within their appointment; they were going to re-evaluate the results in October 2023. Increasing PROMS participation was a focus for August 2023 within the director of clinical services board report.

The service did not benchmark themselves against other hospitals, but they were able to see performance for all hospitals within their group for certain outcome measures such as PROMS, patient satisfaction, and length of stay. They shared learning where required. For example, one hospital had a low length of stay for their joint patients and the director of clinical services shared learning with other peers to show what they were doing differently for their patients to reduce the length of stay.

Managers and staff carried out a programme of repeated internal audits to check improvement over time. The programme ensured different aspects of care and treatment within the service were checked during each audit. Audits included medical records, infection prevention and control, WHO safety surgical checklists and medication audits. Audit results were discussed at governance meetings, where all clinical leads were present. However, managers did not always share or make sure staff understood information from the audits. Staff were not aware of audit results or able to give examples of changes that had been implemented following audits. We saw audit results were discussed with the ward team in September 2023 team meeting and December 2022 but not in May 2023. In September minutes there were no actions documented to make improvements from the audits. For example, the pain audit was 88.9% but there was no explanation as to what had caused the lower score and what improvements needed to be made. We were not assured staff were learning and making improvements from audits. Team meetings did not occur regularly in pre-operative assessment or theatres and there was no formal feedback from the management to the staff regarding the results and changes that had been made.

From January to September 2023, there were 3 unplanned returns to theatre. For the same reporting period, the hospital had 8 unplanned transfers to the local NHS trust and 3 unplanned readmissions to the ward. All incidents of unplanned transfers were reported and investigated for any trends by the senior management team. We saw an unplanned readmission and unplanned transfer out were discussed at the September 2023 clinical governance meeting.

The service had a low surgical site infection rate with only 12 recorded surgical site infections within the last 12 months.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. We looked at 5 staff files and saw employment checks, references, Disclosure and Barring System checks and professional body checks had been completed. Managers gave all staff a full induction and competency booklet to complete when they started work. Clinical staff had a supernumerary period until they felt competent in their role and worked alongside a more senior staff member. Staff completed a variety of mandatory and role specific training through an e-learning system and face-to-face training. Managers made sure staff received any specialist training for their role. For example, the pre-operative assessment nurse had attended a pre-operative assessment training course. Competencies were required for each role and included drug administration and scrub competencies.

Training had been provided for NEWS2 as part of an emergency practice scenario, but managers were not sure who had attended; we were not assured all staff were appropriately trained on NEWS2. The service had planned for another NEWS2 scenario in October 2023.

All staff told us they received an induction to the service including a supernumerary period.

Due to a lack of consistency within the management team, not all staff had received an up-to-date appraisal. Sixteen out of 19 staff from the ward received an appraisal between 2022 and 2023. The service was awaiting the appointment of the new ward manager prior to completing further appraisals. Theatre staff had not commenced their appraisals for 2023 to 2024. The DCS told us they were formulating a plan to complete the theatre staff appraisals.

Staff had 1 to 1's with their managers and reviewed their objectives every 3 months. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they had been given development opportunities by the hospital.

Senior managers made sure consultants working under practising privileges were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Practising privileges were reviewed annually. The review included all aspects of the consultant's performance such as appraisal, revalidation, scope of practice and indemnity insurance.

The service undertook practice emergency scenarios on both the ward and theatres. These were run by resuscitation officers. For example, sepsis was due to be practised in September 2023.

RMO's had their competencies assessed, and mandatory training provided by their external agency provider. They worked in line with guidelines. They had a yearly appraisal completed by their agency. We spoke to an RMO who said they were up to date with their appraisal.

Consultant competency was reviewed by the medical advisory committee chair every 2 years which included a review of their appraisals and outcome data, this included infection rates. There were speciality leads within the medical advisory committee who were able to comment on competency.

At times, consultants brought their own staff to work alongside them in theatres such as a scrub nurse. They were required to provide information to the hospital including their professional PIN number, references and disclosure and barring service checks; these had to be checked prior to the staff member working on site.

Multidisciplinary working

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

We observed effective multidisciplinary working, and communication between staff in theatres and the ward. All staff told us they had good working relationships with consultants and the RMO. We saw good interactions between all members of the team. The RMO, pharmacist and physiotherapists were present on the ward daily. Staff said they were approachable and worked well as a team. Patient records confirmed there was routine input from nursing and medical staff and allied healthcare professionals, such as physiotherapists.

Good

Surgery

We saw evidence of effective team communication across the service. The hospital held a daily 'huddle' meeting. This took place at 9:45am every morning. It was attended by the senior management team and a representative from each department, including theatres, ward, pharmacy, and outpatients. We observed a brief overview of hospital activity, staffing, utilisation, staff on call for emergencies and potential risk to the service were discussed. Information was then cascaded to teams within the department.

Information about the treatment a patient had received during their admission was communicated to the referring GP by letter, once the patient had been discharged.

Seven-day services

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

The hospital only undertook elective surgery, and operations were planned. The exception to this was if a patient was required to return to theatre due to complications following a procedure.

Theatre sessions were held between 8am and 9pm, Monday to Saturday. We were told that theatre lists were mostly scheduled effectively which ensured the surgeon had finished operating on the last patient within their time slot allocated. There was an on-call rota for theatre staff for out of hour's requirements.

Staff could call for support from doctors 24 hours a day, 7 days a week; consultants were always on-call for patients under their care. Consultants led daily ward rounds on all wards, including weekends. Patients werereviewed by consultants depending on the care pathway. If the consultant was not available, they arranged cover by another consultant. We were told this was communicated to ward staff.

The RMO and staff had a list of contacts for all consultants and anaesthetists for each patient. Staff told us medical staff could be easily contacted when needed. Anaesthetists were available as part of an on-call rota if a patient needed to return to theatre. There was a 24-hour RMO cover in the hospital to provide clinical support to patients, consultants and staff.

A senior nurse was always available for advice and support during working hours. Furthermore, the management operated a 24-hour 7 day a week on-call rota system. Staff could access senior management for advice or support as needed.

The pharmacy was open from 9am to 5pm, Monday to Friday. If a patient required medicines out of hours, the RMO and registered nurse went to the pharmacy department and checked out the medicines.

Health promotion

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

Staff assessed each patient's health and provided support and advice to help patients lead healthier lives. Patients attended a pre-operative assessment appointment where their fitness for surgery was checked. Staff asked patients a series of questions about their lifestyle such as smoking and drinking. Patients were given advice about smoking cessation when required.

Good

Surgery

A wide range of leaflets were available for patients regarding their care and health. Patients received leaflets on patient safety which included how to reduce the risk of developing a VTE, falls prevention and recognition of sepsis. There were also a range of leaflets to promote a healthier lifestyle such as 'Iron in your diet', 'taking control of sugar' and 'understanding cholesterol'.

A range of leaflets from Dementia UK were available, including advice on eating and drinking to help people living with dementia be healthier.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions.

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. There was a consent policy. Staff made sure patients consented to treatment based on all the information available. Patients were given information about their proposed treatment both verbally and written, to enable them to make an informed decision about their procedure. Each patient file contained a consent form which showed staff had discussed the risks and benefits of treatment with patients prior to any procedures being undertaken. Staff clearly recorded consent in the patients' records. There was also a checklist within the pathway to ensure the consent form was checked prior to surgery going ahead; this was completed in all notes we checked. We looked at 7 sets of patient notes and saw consent was recorded in all these records. All patients were given a copy of their completed consent form on discharge from the ward.

Staff were given the appropriate skills and knowledge to seek verbal and written informed consent before providing care and treatment to their patients. Staff were aware of the legal requirements of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS). Data showed 97% of staff had completed consent to examination or treatment training and DoLS training.

We were told patients who were booked for cosmetic surgery were given a 2-week cooling off period before undergoing the procedure in case they wanted to change their mind. This was in line with national guidance.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. They would involve the patients representative and other healthcare professionals. Staff told us most patients admitted had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process, where it was determined whether they could be admitted for treatment at the hospital.

Staff had training on the Mental Capacity Act 2005; 97% of staff were compliant with this training.

Is the service well-led?

Requires Improvement

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

Good

Surgery

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. However, within the last 12 months, there was a high turnover of managers and a lack of stability within the leadership team.

There was a clear management structure with clear lines of responsibility and accountability. However, there was a lack of stability within the leadership team. This was highlighted as a risk on the risk register with mitigations in place until the substantive positions were filled. The senior leadership team (SLT) consisted of the health systems director (HSD), who had overall responsibility for the hospital, the roving director of clinical services (DCS) and the sales and services manager. There was a recently appointed HSD who was due to retire, a roving DCS, an interim theatre manager and an interim ward manager who was the manager in radiology and gaining experience within the ward setting; there were interviews for the ward manager post in October 2023. The interim DCS was a roving DCS who worked for Nuffield Health and went to the hospital where they were needed; they had been at Nuffield Health Leicester Hospital since May 2023. The SLT met informally on a weekly basis and had a formal board meeting monthly. Each head of department reported to one of the senior managers. The DCS met with the clinical head of departments monthly.

Staff told us leaders were well respected, visible, approachable, and supportive. Departmental managers worked clinically and provided cover for sickness when required. Ward and theatre staff worked together effectively. However, we were told at times key messages got lost as the managers had changed regularly and wanted things done differently and this was confusing.

The theatre manager was in an interim position and had 1 full time and 1 part time team leader. On the day of inspection, there was no theatre manager or team leaders within theatres. We discussed this with the theatre manager after the inspection who said it was a rarity that a team leader or manager was not there. On the day of the inspection, the HSD, DCS and theatre manager were on leave; the hospital was clinically managed by the radiology manager. Following the inspection, we discussed this with the DCS who stated this was circumstantial due to all the interim positions; leave had been granted prior to the staff members moving into the leadership roles. We were told it was not usual practice for the HSD and DCS to be off at the same time.

The consultants we spoke with felt the hospital was well run, and the managers were responsive despite the lack of stability within the management teams.

Vision and Strategy

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

The service worked in conjunction with another Nuffield Health hospital as their HSD worked across both sites. They had a shared strategy and vision. The service had a clear vision and values which were focused on patient safety and the quality of the services provided. The hospital's vision was to improve the population's health by building a healthier nation. They did this through providing activities that contributed to this such as joint health, gym memberships and some programmes which were free of charge. For example, patients who were undergoing joint replacements, through the enhanced recovery programme had access to the local gym and some appropriate gym classes, free of charge, to aid in their recovery.

Good

Surgery

The service had an operational strategy which was based around the CQC key lines of enquiry. Their strategy within the surgical service was to ensure all patients were as fit and healthy as possible for their surgery. They had found since the NHS waiting lists length had increased, patients had more co-morbidities when they eventually had their operation. They had recently employed a physician to assist with assessing and optimising patients for surgery.

The service's values were an acronym of "Care" which meant 'Connected', 'Aspirational', 'Responsive' and 'Ethical'. Staff worked together as one team to deliver the best experience to their patients; inspire individual and collective health and wellbeing; listen, communicate and act in an open, straightforward way; and demonstrate their commitment to individuals, communities, society and environment.

All staff we spoke with were aware and understood the values, they felt these were embedded within their daily practice. However, not all staff or managers were clear about the service's vision.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff we met with were welcoming and friendly. There was a positive, open, and caring culture. Staff told us management were approachable and there was a no blame culture at the hospital.

Staff were proud to work at the service and believed they worked as part of a team which was valued. Quotes from staff were "lovely team and everyone works well together" and "I love working here". Staff told us the managers within the service were very supportive. We were told there had been a lot of change with the managers and further change was imminent in October 2023. The DCS and theatre manager were interim at the time of the inspection. Staff told us they were very supportive but at times, due to immense change within the last 12 months with the management teams, it had been difficult. However, staff felt settled within their own teams and staff were described as static and stable.

There were cooperative, supportive, and appreciative relationships among staff. They worked collaboratively, shared responsibility and resolved conflict quickly and constructively.

To show their appreciation for the staff, managers had arranged staff away days and all staff were given 2 wellness days. There was also a longtime service shield where the member of staff could pick a treat as a reward for their long service.

The service had a freedom to speak up guardian who felt empowered by their role.

Governance

There was an effective governance structure, but leaders did not always ensure that staff were kept informed or improvements were made where required. Whilst staff at all levels were clear about their roles and accountabilities, they did not have regular opportunities to meet, discuss and learn from the performance of the service.

There were governance structures, processes, and systems of accountability in place to support the delivery of good quality services. The hospital's governance framework was supported by a medical advisory committee (MAC) meeting and a clinical quality and safety meeting. They held risk forum meetings which fed into these meetings such as clinical heads of department monthly meeting, infection prevention and control, medical devices and medicines management. We reviewed 3 sets of clinical quality and safety meeting minutes and saw they were well attended by managers and

heads of department. Standard agenda items for discussion included clinical incidents, complaints, audits and risks. There was evidence of actions taken to address compliance within the surgical service. The managers told us because it was a small hospital, issues were often dealt with immediately rather than waiting for the next clinical quality and safety meeting.

The MAC were responsible for providing assurance and advice to the senior management team on medical and operational matters. The MAC were due to meet quarterly and should be attended by a representative consultant from each speciality, as well as members of the senior management team. However, the MAC had only met twice in 2023. The consultants were responsible for feeding back to the consultants within their specialty; we spoke to 7 consultants and only 1 had received feedback. This meant that consultants were not always updated on any changes within the hospital.

The meeting structure within the hospital was used to monitor performance and provide assurance of safe practice. There were a range of other systems which supported the delivery of safe and high-quality care. These included daily senior management huddles and at least twice daily walk arounds by the director of clinical services. Staff at all levels were clear about their roles and understood what they were accountable for and to whom. We were told although there had been a large amount of change within the management teams within the last 12 months, there had still mostly been accountability, stability, and structure.

Heads of department attended a monthly meeting with the DCS. They received an update on the hospital, audits, complaints, learning, risks and they all gave an update on their areas. We looked at 4 sets of meetings minutes and saw issues were rectified and actions were closed. However, the heads of department did not always feed information back from these meetings to their own teams. We saw that team meetings happened within the ward area, but these were not regular and pre-operative assessment and theatres did not have team meetings. The ward team meetings did not contain all the updates from the risk forums and governance meetings. We found staff were not aware of audit results, learning and risks; we were not assured that there was always effective communication from the managers to the staff.

There was a quality management online system where all audits, complaints, incidents, and risks were stored. This meant managers had clear visibility of the service. They could see the audit results, what was outstanding and actions in place to improve compliance. This system was also monitored regionally. Managers told us they had found that the audit results were better than expected and they found that the same person had been completed the audits each time. They had since split the audits across the senior team for different people to complete the audits and pick up different trends. We saw that not all audits which were due had been completed. For example, the WHO audit was outstanding at the time of the inspection. We found systems were in place to assess, monitor and improve the quality of care within the surgical service but staff were not always aware of them. We found whilst audits were mostly completed, actions were not always taken to address the discrepancies within the audits. Audits were discussed in clinical governance meetings with all heads of department. We looked at April 2023 minutes and staff discussed audit results, but minutes showed that no actions plan from departments were shared. This meant changes were not always made to make improvements.

There was a director of quality for the region and the DCS met with them bi-weekly. They also had a monthly DCS meeting where they shared learning across the country. The service had a peer review completed by another DCS from a different hospital. This was done annually. The hospital created an action plan from the comments made to improve compliance.

Arrangements with third-party providers were managed effectively. We were told contracts were in place which detailed the scope of the work provided. Senior staff told us they worked collaboratively with third-party providers to ensure services met the needs of the patients. For example, they had a service level agreement with the local trust to provide

blood products in an emergency. They had run an emergency practice scenario to ensure blood products could be delivered within an acceptable timeframe. They found this did not happen, and they were in discussions with the third-party provider to make improvements; they had not added this to their risk register whilst they put mitigations into place.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They mostly identified and escalated relevant risks and issues. However, the actions were often brief and lacked information about how they reduced their impact. Risks were not always communicated with staff.

There was a process for identifying, recording, and managing risks. The service had a risk register which was kept on their online governance system and monitored by the senior leadership team. It was discussed within the monthly clinical quality and safety meetings. The risk register was also updated at the board meeting monthly. We saw the risk register contained risks and control measures. However, we found the risk descriptions were brief and there was limited detail regarding the control measures in place. For example, the risk description was "Senior clinical staffing" and the impact that there was a risk of some head of department responsibilities and functions not being done leading to process issues. They had controls in place to reduce the risk which included an acting theatre manager, senior staff nurse in pre-operative assessment and the director of clinical services managing governance and an acting ward manager. However, there was no further detail such as mention of the recruitment in place and any support for these staff as interim managers. We were sent an updated risk register following our inspection which included recruitment and brief support information. The DCS stated they felt that the senior staffing was their biggest risk due to the instability. We also found risks which were not on the risk register such as the potential delay in receiving blood products in an emergency.

Staff were not aware of the main risks within the service. Managers did not always communicate these to the staff. We saw the risk register was discussed in the clinical governance meetings and risks were added and removed as risk were highlighted or mitigated. However, these were not always discussed with the staff on the wards and in theatres. We saw in September 2023 the ward manager had a team meeting with the staff and said that there were no new risks. However, the risk register had 7 new risks added on 4 August 2023, 3 of which were relevant to the ward.

The hospital planned for emergencies and staff understood their role if one should occur. Up-to-date policies, such as transfer to a higher level of care, were accessible and detailed what action staff should take in the event of a major incident. A fire coordinator was allocated at the daily huddle, along with the emergency response staff.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure. Data or notifications were submitted to external organisations as required.

The service had arrangements and policies to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards.

Information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way. The service used paper records. The service used booklets which contained clear pathways to follow. This meant all patients records were within the same pathway. For example, the pre-operative assessment, ward care and theatre records were all within the booklet. This meant all healthcare professionals could follow the patient pathway clearly.

Good

Surgery

There were information technology systems used to monitor the quality of care. There was an online governance and risk management system for incidents, risks, audits and complaints recording.

There were systems in place to ensure data and notifications were submitted to external bodies as required. Staff were aware of the need to report to the Information Commissioners Office for data breaches, CQC in relation to incidents in line with Care Quality Commission Registration Regulations 2009, and UK Health Security Agency. The hospital submitted data to the Private Healthcare Information Network. They also collected PROMs data for certain surgical procedures, such as hip and knee replacements.

Staff were aware of how to use and store confidential information. During our inspection, we found computers were locked when not in use. This prevented unauthorised access to information. The service had a data protection policy and 98% of staff had completed training in information governance.

Engagement

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

The service gathered and acted on people's views and experiences to shape and improve the services. Staff routinely monitored feedback from patients to analyse trends and themes in both positive and negative feedback. The service did a 'voice of the customer' survey and the friends and family test monthly. The survey was discussed at the clinical quality and safety group and the monthly clinical heads of department meetings and improvements were made. For example, some patients had said that their discharge was rushed. The managers educated staff to think of the patient need and that not all patients need to be discharged by 10am and can be flexible to suit the needs of the patient. The DCS had noted a trend that the feedback had declined therefore was going to set up a group to look at the survey and create actions to make improvements.

The staff completed a survey every 2 months. These were reviewed by the heads of department and themes were collated and actions were put into place.

The service gave staff free gym memberships and were given 2 wellbeing days a year. We were told the management did small gestures that made staff feel valued. For example, they were each given an easter egg and an ice cream during the hot weather.

The company ran "We Care" awards monthly where staff could nominate their colleagues for an award. The central team decided who won and the winner received a £50 voucher.

The health systems director ran a staff forum every quarter. This had a charity update and a company update and then a local update for the teams. There was also a hospital newsletter which was circulated bi-monthly.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them.

The service had a silver award for 'one together' infection prevention and control and had applied for a gold award.

Good

Surgery

The service was keen to improve its sustainability and positive climate action. This included education by the infection prevention team regarding the use of plastic gloves and couch roll to decrease usage, collecting blister packs and recycling them and a local recycling scheme. Staff also took part in pen recycling in aid of brain tumour research and out of date supplies being given to charity.