Practice Plus Group Hospitals Limited

Practice Plus Group Surgical Centre, Gillingham

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?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

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

However:

- Staff were not always trained in key skills or on how to protect patients from abuse.
- Medicines were not always managed well.
- Records were not always filed appropriately.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service stayed the same. We rated it as good. See the summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to Practice Plus Group Surgical Centre, Gillingham

Practice Plus Surgical group is a provider of surgical healthcare for both NHS and private patients. The centre offers general surgery, endoscopy services, ophthalmic procedures and orthopaedic surgery to adult patients.

The service is regulated to provide diagnostic and screening procedures, surgical procedures and the treatment of disease, disorder and injury. The current registered manager has been in post with the service since March 2020.

Between September 2021 and August 2022, the service carried out 5900 procedures, 3000 of these were endoscopy procedures.

The service was previously inspected in August 2016. It was rated as good in each domain.

How we carried out this inspection

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity. We inspected this service using our comprehensive inspection methodology. Two inspectors, with support from an offsite inspection manager, carried out the inspection on 6 and 7 September 2022.

During the inspection we reviewed a range of documents related to running the service including staff members recruitment packs, an independent website browser platform and servicing records of equipment. We spoke with 12 members of staff including the registered manager and five patients who had used the service. We also reviewed six sets of patient records and four staff records.

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.

Outstanding practice

We found the following outstanding practice:

- The service was an early adopter pilot site for nurse led wet AMD procedures.
- The service was working to see 2 week NHS pathway patients within 72 hours by training additional nurse practitioners and moving away from a theatre to outpatient environment.

Areas for improvement

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

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure the proper and safe management of medicines; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12(2)(g)
- The service must improve its low mandatory training completion rates Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18(2)(a)
- The service must make sure that all staff have been provided with a level of safeguarding training, relevant to their role. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13(1)

Action the service SHOULD take to improve:

- The service should consider reviewing its record management processes.
- The service should ensure it improves the completion of local audits in line with the schedule set out by the service to monitor and improve patient care.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

Are Surgery safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service did not always provide mandatory training in key skills to all staff or make sure everyone completed it.

Staff had not always received or kept up-to-date with their mandatory training. Only 77 percent of the health care support staff and 60 percent of allied health professionals had completed their mandatory training.

Only 22 percent of the nine allied health professionals and 62 percent of the 29 registered general nurses had completed intermediate life support training. The service had recognised the low compliance of mandatory training and this sat as a risk upon the risk register. Senior managers planned the rota to ensure a member of staff trained in advanced life support was on duty however this did mean that staff may be required to undertake basic resuscitation. All operating department practitioners had completed level three safeguarding training along with 81% of the 21 registered nurses.

Training was provided on recognising and responding to patients with learning disabilities, autism and dementia however the completion rate for these courses was low. Of the 17 health care assistants 53 percent had completed autism awareness training, 71 percent of the 21 registered general nurses and 11 percent of the allied health professionals had completed a learning disability awareness course. The governance lead for the service was also the training and education lead and monitored training levels within the service. An action plan was in place to address the areas of non-compliance which included additional monthly resuscitation training courses. This was reviewed monthly at a head of department meeting.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Not all staff had completed training on how to recognise and report abuse.

Good

Surgery

Staff received training specific for their role on how to recognise and report abuse however compliance levels of the training courses were low for some disciplines of staff. Of the nine allied health professionals only 56 percent had completed their annual training in safeguarding adults' level three and of the 17 health care support staff only 71 percent had completed safeguarding training level two courses. This was not in line with national legislation and was a concern because if staff were not provided the appropriate training, they may not be able to recognise or know how to respond to concerns of harm or abuse.

Medical staff received training specific for their role on how to recognise and report abuse. Of the seven consultants, 86 percent had completed training in safeguarding adults' level three and children level two.

Staff we spoke with during the inspection knew how to make a safeguarding referral and who to inform if they had concerns. The director of nursing was the designated safeguarding lead for the service and could offer support to staff whom may have concerns about harm or abuse

Staff followed safe procedures for children visiting the ward. This included the rescheduling of appointments, and pre-operative information sent to patients advising them not to attend with children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The housekeeping lead for the service reported to the operations lead and regular walk arounds were undertaken to ensure that all areas were suitably clean.

The service performed well for cleanliness and bi-monthly cleaning audits were undertaken. The cleaning audit for the 6 September 2022 achieved 99 percent.

Staff followed infection control principles including the use of personal protective equipment (PPE) and hand hygiene audits were undertaken on a monthly basis. In July 2022 the audit score was 82 percent and actions of reminding staff about hand decontamination had been undertaken. At the time of the inspection we saw members of staff observing the five moments of hand hygiene in practice.

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

Staff worked effectively to prevent, identify and treat surgical site infections. This included screening all patients for methicillin-resistant Staphylococcus aureus (MRSA) and Meticillin-Sensitive Staphylococcus. aureus (MSSA) at their pre-operative appointments and testing both patients and staff for COVID-19.

Staff used records to identify how well the service prevented infections. MRSA audits were undertaken monthly to monitor the number of positive cases and a monthly infection prevention and control committee reported on all infections including E Coli and pseudomonas. In July 2022 three cases of pseudomonas were identified although it was not clear from the meeting minutes what actions had been taken in response to this.

Environment and equipment

Good

Surgery

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

Patients could reach call bells and staff responded quickly when called.

The design of the environment followed national guidance and included dedicated endoscopic rooms where patients that had received bowel preparation could visit the toilet privately without leaving their cubicle.

Ventilation of theatre suites were assessed annually in line with national guidance. The service was fully compliant at its last annual inspection in November 2021. Manufacturing and servicing arrangements were in place with providers of all equipment and annual safety checks undertaken.

Decontamination and sterilisation were completed at the service with a dedicated facility on the top floor. This was in line with national guidance and dedicated staff worked in the area sterilising the equipment.

Staff carried out daily safety checks of specialist equipment including anaesthetic equipment.

Staff disposed of clinical and general waste safely twice weekly which was coordinated by a waste manager.

An external facilities engineer was based on the site meaning that any identified issues with estates could be resolved quickly.

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately based on this tool. Staff we spoke with knew what to do if a patient deteriorated whilst in their care.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly before, during and after the operation.

Staff knew about and dealt with any specific risk issues including falls, sepsis and venous thromboembolism (VTE) risk assessments which were undertaken which was in line with national guidance. Any patient suspected of suffering from sepsis had a blood sample taken and was reviewed by the consultant caring for them to ensure they received the correct care, including receiving antibiotics as quickly as possible.

An agreement was in place with a local NHS trust who would receive any patients that did not recover as planned. The patient was transferred via ambulance with a transfer form following prior telephone discussions between the onsite anaesthetist and the receiving hospital.

A '100 hour' telephone call by a clinician is made to each patient prior to their appointment to ensure the patient is clinically well and has not developed, for example, a chest infection or diarrhoea and vomiting. This meant the patients attending for procedures were as well as they could be and suitable to undergo anaesthetic and surgical procedures.

A 24-hour post-surgery telephone call was also made by a clinician to review the patient and ensure no complications had arisen following the surgical procedure. This meant that any developing infections and reactions such as sepsis could be identified and action taken to reduce the impact.

Emergency resuscitation trolleys were available in each area of the service, these were checked daily and then audited monthly to ensure that equipment was available, in date and ready for use.

The service has a Local Safety Standards for Invasive Procedure (LocSSIPs) in place which was due for review in March 2023 and set out responsibilities and accountabilities, standard operating procedures and evaluation methods. Examples of local standards in place included site marking and procedure verification and implant verification.

The service followed the World Health Organisation safety checklist procedures for each surgical procedure. During the inspection we saw that these were appropriately undertaken and fully documented. A safety huddle took place at the beginning of each theatre list and any important messages were shared with staff.

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, allied health and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, allied health professionals and healthcare support staff needed for each shift in accordance with national guidance. Rotas were planned based on theatre lists and then amended if required as changes occurred. The director of nursing for the trust monitored the rotas and ensured that the correct skill mix including advanced life support trained members of staff were on duty.

Two registered general nurses and one healthcare support staff member was allocated to each theatre list daily. However, the ward and theatre managers could adjust staffing levels daily according to the needs of patients. For example, if a patient was known to suffer from dementia and needed additional support then extra staff could be brought in.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Senior managers and executives monitored the usage of agency staff. Managers met weekly for a rota meeting to ensure that staffing was planned and covered adequately, so that agency use was for short notice absence where possible.

Managers made sure all bank and agency staff had a full induction and understood the service. This included a local induction and also access to the reporting systems such as incident and safeguarding reporting. Agency staff were allocated a senior lead whilst on shift who could support with the management of controlled drugs and any other help which may be required.

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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

Good

Surgery

The service had enough medical staff to keep patients safe. One employed anaesthetist was in place within the service and consultants worked under a variety of contracts including self-employed and bank contracts. Agency staff were also used within the service. These staff were given an informal interview prior to working within the service and due diligence such as suitability for the role, qualifications and training formed part of the agency contract with the service. Practicing privilege contracts were reviewed annually by a company-wide human resource and recruitment team.

All medical staff recruited to the service underwent a recruitment probationary period of six months and evidence based outcomes were gathered by 360 reviews from theatres, outpatients and doctors. In addition, theatre activity and outpatient profiles were reviewed to ensure the suitability of referrals to both outpatients and theatres meaning the service could assure itself the medical staff were operating safely within the service.

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. Errors in the administration of records meant that records were not always filled appropriately.

Patient notes were comprehensive and all staff could access them easily. At the time of the inspection we reviewed six patient records. The records were thorough and contained clear care plans for each patient. However, they did not always contain information about patient allergies and medical notes were not always legible.

Records were stored securely within the company wide medical records store. Locally records were scanned onto an electronic system before being archived for a three month period. However, between June and August 2022, 18 incidents relating to records had been recorded. Examples included misfiled blood forms, clinical reports in the wrong patient notes and an imaging referral form found in the wrong patient records. The service had identified this and the issue sat as a high risk upon the risk register with a review date planned for November 2022. This was a concern because an information governance breach such as this could lead to a patient receiving the wrong treatment or diagnosis.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely such as checking the patient details and double checking controlled drugs. We observed this in practice during the inspection and found that checks were consistently followed.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. This included medicines provided following surgery such as antibiotics.

Information provided by the service following the inspection demonstrated that controlled drug medicine checks were carried out in line with statutory guidance.

Staff did not always store and manage all medicines and prescribing documents safely. Three items of ward stock medications were out of date and gaps in fridges temperature checks were noted in the checklist between July and September. In August 2022 ward fridge checks (or a narrative to explain the lack of fridge temperature check) were not recorded on 13 occasions.

may be carried out more or less often depending on the circumstances". No controlled drug incidents had been reported between January and August 2022.

Incidents

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

Staff spoken with at the time of the inspection knew what incidents to report and how to report them. This was in line with service incident reporting policy. Incidents were reported electronically.

The service had no never events in the last twelve months. In total, 48 incidents and near misses had been reported between June and September 2022. These were broken down into areas such procedure, communication, infection control and clinical assessment which enabled the service to determine themes and trends.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. An electronic prompt was installed on the incident reporting system which meant that the investigation could not be progressed until this had been inputted as completed. Senior leaders within the service were responsible for ensuring formal duty of candour was undertaken. No instances where duty of candour was formally required had occurred within the last twelve month period.

Staff received feedback from investigations of incidents, both internal and external to the service. Feedback was individually delivered and collectively shared at whole team meetings which were held quarterly within the service. This was used as an opportunity to share learning and prevent incidents from occurring.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations including face to face meetings with managers regardless of whether their complaint was generated formally or as a concern. Patients were also informed of the investigation findings and the incident outcome. A copy of the root cause analysis investigation was also given to the patient.

Managers debriefed and supported staff after any serious incident which included access to wellbeing support for staff.

Are Surgery effective?

Good

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Good

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. This was governed by a central team within the organisation and fed back to the service. Any changes to practice were reviewed by the senior leadership team and cascaded locally via email, face to face discussion and quarterly team meeting. Any immediate changes such as patient safety alerts were shared with staff by heads of departments.

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Biscuits and hot and cold drinks were available following surgical procedures. Patients identified at their pre-assessment appointment as having nutritional needs such as diabetes were offered low sugar options such as oat cakes. If more substantial nutrition was required, this could be pre-ordered.

Staff fully and accurately completed patients' fluid charts where fluid had been administered to patients intravenously during their operation.

Patients waiting to have surgery were not left nil by mouth for long periods and starve to theatre times were recorded within the patient records. We reviewed six patient records and found this had been appropriately recorded and had not exceeded the recommended length of time set out in national guidance.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients did not remain in the service for long periods of time however were assessed for pain throughout their pathway by asking for a pain score. Sign language and picture cards could also be used for patients unable to express their level of pain verbally.

Patients received pain relief which was prescribed, administered and recorded correctly soon after requesting it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits including DVT and enhanced recovery pathway audits.

Outcomes for patients were positive, consistent and met expectations, such as national standards for varicose vein and hernia surgery set out in the patient reported outcome measures.

The service had a lower than expected risk of readmission for elective care than the England average, and had a national infection rate of 0.3 percent compared to the 1.4 percent national average.

Managers and staff carried out a programme of repeated local audits to check improvement over time. However, the service had recognised that the audit compliance had not been adhered to in line with the audit schedule. The controlled drug audit had not been completed in March and June 2022 as planned, and the nurse led processes for the management of medicines and controlled drugs had "lapsed". In response to this the service was in the process of recruiting a pharmacy technician and a second pharmacist had been employed to cover the Gillingham and Ilford sites of the service. This increased provision is planned to include all medicines audits, training and guidance, process review, improvement and implementation of medicines. Work has also been commenced with a central team to improve audit compliance, and immediate actions identified and controlled drug audits have been completed in September 2022 after the inspection took place.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. This included outcome data as part of the Joint Advisory Group (JAG) accreditation. Success of intubation rate, median fentanyl rates and greater than recommended sedation doses. In addition, posterior capsular rupture rates were monitored following ophthalmic procedures.

The service was accredited by the JAG on GI Endoscopy. The advisory group had reviewed and revalidated the service in 2021.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work which included a supernumerary period and a dedicated 'buddy'.

Managers supported staff to develop through yearly, constructive appraisals of their work. This included annual appraisals with the medical director for all medical staff and heads of departments for all clinical and non-clinical staff. No audit compliance data was received from the service.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Service provision was stopped for a day each quarter to enable all staff to attend and participate in the meeting.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. This including specialist training specific to their role such as intravenous cannulation and macular degeneration awareness.

Professional registration checks were completed by a central human resource team annually. Managers were notified if registrations were approaching three months of expiring. Important pre-employment (Schedule three) recruitment checks designed to ensure that unsuitable people are not employed to work with vulnerable adults and children were also conducted by a central team. Four staff recruitment files were reviewed at the time of the inspection and all contained appropriate details including enhanced data barring checks in line with the regulatory requirements.

Three yearly data barring checks were carried out for each staff member by the central human resource team.

Good

Surgery

Professional revalidation was monitored by the head of department and medical appraisals completed by a central appraisal team.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. The Macular Society, NHS trusts and across other locations within the organisation that were able to deliver larger more complex surgeries.

Seven-day services

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

Consultants reviewed each patient prior to discharge.

Staff could always call for support from doctors and other disciplines during the hour of operation for the service. This was typically 7am to 6pm Monday to Saturday.

Health promotion

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

Staff assessed each patient's health when admitted including mobility, medication and past medical history and provided support for any individual needs to live a healthier lifestyle by referring patients to smoking cessation services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. This was a two stage process. Initially, consent was gained at the time of the pre-operative appointment and once again on the day of the surgery. Five retrospective patient records were reviewed at the time of the inspection. Consent had been gained and recorded in all five cases. In addition, we observed consent being appropriately sought on three occasions from patients on the day of their surgery at the time of the inspection. This was in line with national legislation and guidance and meant the patient was fully informed and consented to treatment based on all the information available.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. An assessing capacity and deprivation of liberty safeguard policy was in place and easily accessible to all staff. This set out what to do when a patient could not give consent and included liaising with the patient's general practitioner and making a best interest decision about whether to continue, postpone or stop the planned procedure.

86 percent of all staff had completed training on mental health awareness, the mental capacity act and deprivation of liberty safeguards. In addition, the service had six mental health first aiders who were able to support staff and patients with any issues relating to their mental health and wellbeing.

Good

Surgery

Are Surgery caring?

Good

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

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection we observed staff interacting with patients and talking to them individually and holistically about their lives, families and not just about the procedure they had attended the service for.

Patients said and we saw that staff treated them well and with kindness, they were discreet and followed the service policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs and additional needs such as dementia.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients attending for ophthalmic procedures were required not to bend down so that pressure does not build up in the eye. One member of staff we observed made sure that a patient's family member was at home to support with anything which would require bending down such as putting socks on

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. During the inspection we observed a member of staff talking to a patient and supporting them when they were frightened. The staff took time to answer and address any questions and concerns and offered reassurance to the patient.

Staff could tell us how they would support patients who became distressed in an open environment and help them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. A private area was available for staff and patients which meant that patients could have open discussions with staff privately.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Good

Surgery

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. This included carers and relatives of patients with additional complex needs. Information was provided to patients at the point of discharge on what to expect, what to look out for and how to get help if they were worried about anything following their procedure.

Staff talked with patients, families and carers in a way they could understand, using communication aids including British sign language where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. A feedback champion was in place within the service and patients could give feedback in a variety of ways including written and electronic.

Patients gave positive feedback about the service. Between 1 and 31 July 2022, 126 patients provided feedback about the service. Of these, 98.4 percent rated their overall experience as good.

Are Surgery responsive?

Good

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

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. Work had been undertaken with commissioners to identify which services were in greatest need in addition to collaborate with NHS trusts to understand what capacity was available. From this, the service identified and increased its sessions for endoscopic and general surgical cases.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The pre and post-operative area was split between male and female which meant that patient sex was not mixed in line with national guidance.

Facilities and premises were appropriate for the services being delivered. Multiple disabled toilets were available, services were delivered across the ground floor meaning that patients with mobility issues could easily access and navigate the service.

Public transport links including bus routes ran near to the service and ample car parking was available with dropped kerbs and clear signage into the building. This meant that patients unfamiliar with the service, and those with additional needs such as visual difficulties could easily and safely access the building.

The service had systems to help care for patients in need of additional support or specialist intervention. This included chaperoning, one to one nursing and allowing carers into the patient areas to support them through the pathway. Stickers on the front of patient notes were used to identify patients with additional needs such as those at risk of falls and risk assessments for patients with dementia were undertaken at pre assessment clinics to ensure that patients had the level of support available which they required.

Managers monitored and took action to minimise missed appointments. Audits of missed appointments and cancellation rates were undertaken monthly and reported in an executive summary document. In August 2022, 10 patient operations were cancelled. The service analysed the reasons for cancellation and broke them down into clinical and none clinical reasons. Three patients cancelled for non-clinical reasons including not following bowel preparation suitably and changing their mind about having the procedure. This meant that any themes could be identified and actioned. Text messaging and pre-operative telephone calls prior to surgery were undertaken to reduce missed appointments.

In addition, the service had adjusted its booking process so that instead of all patients attending at 7am each patient was given an individual arrival time. This meant the resequencing of the list could be done without cancelling and rearranging all patients and also that patients were not kept waiting.

Managers ensured that patients who did not attend appointments were contacted on the day of the appointment and following two cancelled appointments patients were referred back to their general practitioner (GP) by letter so that they did not get lost within the system. Gastroenterology patients were individually assessed prior to being referred to their GP.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff had access to communication aids to help patients become partners in their care and treatment including a hearing loop and braille literature which could be requested in advance of the patient's surgery. One staff member was trained and championed British sign language within the service and picture communication books were available to help communicate with non-verbal patients.

The service had information leaflets available in languages spoken by the patients and local community and managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Interpreters used were face to face in the theatre and telephone based for pre and post-operative assessments.

Patients were given a choice of food and drink to meet their cultural and religious preferences following their surgery. For patients undergoing ophthalmic procedures they were offered tea and biscuits whilst those undergoing larger surgery's such as colonoscopies were offered toast and sandwiches.

Appropriate arrangements were put into place to take account of the individual needs of people being discharged who have complex health and social care needs requiring special considerations. At the pre-operative assessment social and health needs are established and care plans put in place such as arranging transport and arranging for family members or carers to accompany patients on their return home, this meant that people were not left at home unable to access medications, sanitation, healthcare and nutrition.

Good

Surgery

Wheelchairs were available for patients so that they did not need to walk to and from theatre if they were unable to and staff reviewed mobility issues of patients as part of the theatre briefing.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. Weekly breach reports were created which included inherited18 week and 96 week breaches that the service had received from the NHS. Each patient was contacted and a root cause analysis review was completed for any 96 week breach. Weekly rota meetings reviewed each breach.

Clinical triaging of all breaches was undertaken to ensure patients had not deteriorated whilst waiting for treatment. Gastroenterology patients were reviewed weekly and low priority cases were also reviewed.

Managers and staff worked to make sure patients did not stay longer than they needed to. Discharge planning was started as soon as the patient arrived. Managers monitored the number of delayed discharges on a daily basis and took action to prevent them. An electronic system monitored each case via live tracking to ensure patients were progressing smoothly and as planned. A live dashboard also monitored how long the patient was at each point of their journey. If a patient was in theatre for longer than planned this was escalated as a concern to senior managers.

Managers worked to keep the number of cancelled appointments operations to a minimum. Each procedure was confirmed with the patient in a pre-operative call, job plans were in place for each consultant and other disciplines were then planned around this to match capacity.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance of rebooking the appointment within a 28 day period meaning that the patient was not left waiting indefinitely.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Posters were displayed and the website for the service had information on how to raise a concern.

Staff understood the policy on complaints and knew how to handle them and managers investigated complaints and identified themes from them. Complaints were discussed at weekly managers meetings and feedback from complaints shared with staff via team meetings, by email and face to face individually.

Are Surgery well-led?

Good

Surgery

Good

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

Leadership

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

Leaders had the skills, knowledge and experience that they needed to effectively run the service.

The leadership team 'paired up' with other leaders in the same role across the wider organisation. This included the hospital director and meant that at each level of leadership there was peer support available. This meant they could support one another in addressing key challenges they each faced. Each senior leader had completed or was undertaking a senior leadership development course. First line managers were supported to complete an accredited leadership course and the service were in the process of establishing an apprentice scheme as part of its staff retention initiative. This meant there was a route for development and succession for staff in the service.

Leaders were visible and approachable. The senior leadership team worked across site and operated an open door policy to all staff

Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them. These included Staff retention, national shortages in ophthalmologists and increased waiting times following the COVID-19 pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service strategy was to increase capacity by reviewing its what it delivered and how it could increase this such as longer hours and evening working. A network improvement plan was managed by the senior leadership team and was reviewed at monthly leadership meetings and with head of departments. These considered ideas which would be of wider impact to the community and reviewed action plans.

Sustainability of services was aligned to local plans within the wider health economy and included within the budgeting of the service. Elective and cancer treatment work formed part of sustainability work as did elective satellite hubs as this was essentially what the service was currently running.

Culture

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

Good

Surgery

Staff generally felt supported, respected and valued. Annual informal meetings were held with staff to discuss wellbeing and an annual staff survey was undertaken to assess staff satisfaction. In the staff survey carried out in May 2022, 78% of staff completed the survey and of them 98% said they felt the service treated patients and each other as they would like to be treated.

The culture within the service encouraged openness and honesty at all levels including people who used the services. Leaders met with patients that had raised both formal and informal complaints, staff understood and knew how to apply duty of candour when things went wrong and leaders facilitated time out sessions at team meetings for staff to collectively discuss and learn from scenarios where outcomes were not as they should be. This demonstrated a culture centred on the needs of the patient receiving care.

Equality and diversity were promoted within the service for both patients and staff. An equality, diversity and inclusion committee were in place and had contributed to the equality, diversity and inclusion strategy for the wider organisation. This was led by the medical director. Male and female signage had been removed from the patient toilets in the ward areas to support transgender patients attending the service.

Reverse mentoring was also in place within the service and training, recruitment, complaints and disciplinary processes were all compared with the Workforce Race Equality Standard (WRES).

Governance

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

The service had a governance structure in place with a clear route of escalation both internally and with partner organisations. Service level agreements with third party organisations were clear, in date and set out expected standards of accountabilities and responsibilities. Internally regular weekly meetings were held between senior leaders and heads of departments. These feed into monthly senior management meetings within the service which in turn fed into organisational senior management meetings. Monthly directors' reports featured information about operational risks and concerns, incidents, complaints, staffing and demand.

Quality and governance meetings for all staff were held every other month and meant staff were kept informed of important updates and changes within the service, and also had opportunity to escalate any issues or challenges they had experienced.

Management of risk, issues and performance

Leaders and teams used systems to manage performance. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Systems were used within the service to manage performance effectively. An incident reporting system linked into the risk register. From this a monthly quality and governance report was generated and monitored by the governance and management teams within the service. Electronic dashboards provided information on patient pathway performance and identified blockers within the system in real time.

Good

Surgery

Managers understood the greatest risks to their service and had a process for escalation to executive level on risks scored as high. Anyone within the service could identify a risk and the profile was monitored by a central risk management team. Incident reports, near misses, top themes and actions were discussed at the twice monthly quality and governance meetings.

The service had a business continuity place which included actions to take in an unexpected event or incident. Risks in each department were noted as well as the length of time each department could function on reduced function. For example, a loss of power in theatres.

Staff contributed to decision-making by giving feedback on improvements, a staff feedback box was located in the staff room and meant that staff could anonymously make suggestions of improvement. An example of improvements made following staff feedback was the location of a water cooler in the staff where previously it had been located elsewhere. This contributed to staff wellbeing and overall staff satisfaction. Action plans were created against staff suggestions where possible and these were then broken down further into departmental action plans. Access to staff training was added into the staff budget for department leads to allocate to suit the needs of that department rather than a service wide training budget.

Actions the service had taken following an infection of pseudomonas were not always clear. The service had recorded three occurrences of the infection within the last twelve months however had not listed this as a risk upon its register nor provided information to demonstrate what actions the service had taken in response to these cases.

Information Management

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

Performance measures such as key performance indicators and productivity metrics were used by the service. These included the number of cancelled procedures, NHS waiting times and NHS referral data. This meant the service was able to monitor the quality of the service provided. For example, by identifying blockages and hold-ups within the pathways.

Dedicated information technology and business systems teams were in place and monitored data and information technology. They were working to upgrade the IT systems to fully electronic by quarter four of 2022/2023. Qn IT helpdesk was available to offer support to staff needing advice and guidance.

Data notifications such as safeguarding referrals and interruptions to service provision were submitted to external organisations as required.

Engagement

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

The service gathered people's views and experiences to help shape and improve the services it delivered. This included a family and friends survey which showed that between January and July 2022, 96 to 100 percent of patients would recommend the service.

Good

Surgery

Prior to the COVID-19 pandemic the service had actively engaged with patients through a patient forum. This consisted of an active group of patients that had undergone surgery within the service. At the time of the inspection the forums had not yet recommenced however managers told us this was something they were hoping to restart.

Engagement with the clinical commissioning groups, safeguarding engagement meetings and specialty inclusion ophthalmic groups enabled positive collaborative relationships with external partners, as well as shared understanding of the challenges within the system for the benefit of the patients. Close engagement with the clinical commissioning group had led to an increase in the provision of services offered to NHS patients in support of the NHS recovery plan following the pandemic.

In July 2022 the service ran a continual professional development event for local opticians and had worked with ophthalmic groups to set up a trial for macular degeneration treatment. This meant the service was engaging with the wider population to share up to date practice and education on the condition with other services.

An annual staff survey was completed by the service. The survey completed in May 2022 had a return rate of 79 percent.

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. Leaders encouraged innovation and participation in research.

The service was taking part in a wet AMD trial - this was an innovative practice which supported the national shortage in ophthalmologists by training advanced practitioners to deliver the treatment. It also supported patient's recovery as they no longer needed to attend theatre as well as service planning as the treatment could be delivered in a clinical setting rather than a theatre environment. From this the service was working to utilise the freed up clinical space to see NHS two week wait patients within 72 hours meaning that patient outcomes were likely to be better.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not always store and manage all medicines and prescribing documents safely. Three items of ward stock medications were out of date and gaps in fridges temperature checks were noted in the checklist between July and September. In August 2022 ward fridge checks (or a narrative to explain the lack of fridge temperature check) were not recorded on 13 occasions. In addition, staff did not always complete medicines records accurately nor keep them up-to-date. Controlled drug checks inside the theatres were completed only when controlled drugs were used. Checks had been completed on 1 June 2022 and then not until the 2 August 2022 another gap occurred between 9 and 23 August where no check had been carried out. This was not in line with The Royal Pharmaceutical Society professional guidance on the administration of medicines or the services' own safe and secure handling of medicine policy which stated that a stock check was completed prior to each operating list starting. Guidance set out by the National Institute for Health and Care Excellence NG46 Controlled drugs: safe use and management "*the frequency of stock checks, which should be based on the frequency of use and controlled drug related incidents, and risk assessment; for most organisations stock checks should be at least once a week, but they may be carried out more or less often depending on the circumstances".* No controlled drug incidents had been reported between January and August 2022.

Regulated activity	Regulation
Surgical procedures	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Requirement notices

Staff received training specific for their role on how to recognise and report abuse however compliance levels of the training courses were low for some disciplines of staff. Of the nine allied health professionals only 56 percent had completed their annual training in safeguarding adults' level three and of the 17 health care support staff only 71 percent had completed safeguarding training level two courses. This was not in line with national legislation and was a concern because if staff were not provided the appropriate training, they may not be able to recognise or know how to respond to concerns of harm or abuse.

Regulated activity	Regulation
Surgical procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff had not always received or kept up-to-date with their mandatory training. Only 77 percent of the health care support staff and 60 percent of allied health professionals had completed their mandatory training. Only 22 percent of the nine allied health professionals and 62 percent of the 29 registered general nurses had completed intermediate life support training. The service had recognised the low compliance of mandatory training and this sat as a risk upon the risk register. Senior managers planned the rota to ensure a member of staff trained in advanced life support was on duty however this did mean that staff may be required to undertake basic resuscitation. Training was provided on recognising and responding to patients with learning disabilities, autism and dementia however the completion rate for these courses was low. Of the 17 health care assistants 53 percent had completed autism awareness training, 71 percent of the 21 registered general nurses and 11 percent of the allied health professionals had completed a learning disability awareness course