Transform Healthcare Holdings Limited

Burcot Hall Hospital

Inspection report

Stoney Lane
Tardebigge
Bromsgrove
B60 1LY
Tel: 01214457500

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Burcot Hall Hospital is sister hospital to The Pines Hospital and operated by Transform Healthcare Holdings Limited. The 2 locations are known under Transform Hospital Group, however, our report relates only to Burcot Hall Hospital for the purpose of this inspection.

It is in the town of Bromsgrove, Worcestershire and the premises stand imposingly in a rural location. The hospital has been converted to provide waiting areas, consultation rooms, treatment rooms wards and 4 theatres.

The hospital procedures are day case, overnight and some 2 night stay procedures. They have 2 wards consisting of 13 beds on the lower ground floor and 9 beds on the top floor in the event that surgery required an overnight stay or readmission. The hospital provides a range of services including cosmetic surgery, weight loss surgery, orthopaedic and general surgery. We inspected surgery, outpatients and diagnostic imaging as part of a routine schedule of inspections.

We carried out the unannounced inspection on 6 March 2023.

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

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

The main service provided by this hospital was surgery. Where our findings on surgery, for example, management arrangements, also apply to other services, we do not repeat information but cross-refer to the surgery service level.

The hospital has had a new registered manager in post since October 2022.

The main services provided by the hospital are cosmetic surgery and weight loss surgery performed under either general or local anaesthetic and x-ray procedures as part of the surgery pathway to ensure correct placements post procedure.

No services are carried out on patients under the age of 18 years.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

Outpatients

Good

This service was not rated prior to this inspection. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. 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.

Outpatient department is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the body of the surgery report section. During our inspection, there were no consultation clinics running. However, we inspected all areas within

Summary of findings

the outpatient department such as environment, we also spoke with staff and patients and observed a pre-operative and phlebotomy clinic and post-operative wound care clinic

Diagnostic imaging

Good

This service was not rated prior to this inspection. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Staff assessed risks to patients, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available to suit patients' needs.
- 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:

- The service did not always control infection risk well.

Diagnostic Imaging is a small proportion of hospital activity. The main service was surgery. Where arrangements were the same, we have reported findings in the body of the surgery report section.

Summary of findings

We were unable to rate all domains for this service at this time because diagnostic imaging service was not running on the day of our inspection; however, we managed to inspect some aspect of the service provided.

Summary of findings

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Summary of this inspection

Background to Burcot Hall Hospital

Burcot Hall Hospital was previously registered under Transform Hospital Group Limited as the provider on 12 August 2021. The service had no registered manager at this location from 27 June 2022 until taken over by Transform Healthcare Holdings Limited, registered on 1 December 2022 and a new registered manager was appointed. Transform Hospital Group Limited owns and manages 2 hospitals, these hospitals treat patients from a range of private healthcare providers and NHS trusts, as well as from their own member brands.

The hospital provides services to adults over the age of 18 only. These services include outpatient services, diagnostic imaging services and surgery.

Burcot Hall Hospital provides 4 surgical theatres and 31 overnight beds. Whilst primarily offering surgical cosmetic procedures, since the pandemic, they have had contracts with the NHS acute hospitals, carrying out work to reduce the waiting lists at the acute trusts for, orthopaedics (both under Local Anaesthesia (LA) and General Anaesthesia (GA), vascular, max fax and plastics. During our inspection, we were told that the contract with NHS hospitals was no longer in place.

Burcot Hall Hospital provides 1 x-ray room facilities, used only for placement purposes such prosthetics or gastric balloon and not for diagnostics. Burcot Hall Hospital also has an outpatient department with 10 consulting rooms, 2 clinical rooms for minor procedures, a treatment room and a phlebotomy room. A phlebotomy room is a room used to collect blood from patients.

How we carried out this inspection

We carried out an unannounced visit on 6 March 2023 and inspected outpatients, diagnostic imaging, and surgery. During this inspection the diagnostic imaging was not open, however, we inspected all areas and spoke with staff and arranged a telephone call with patients who had recently used the diagnostic imaging services.

For the purposes of this inspection, the main service provided by this hospital was surgery. Where our findings on outpatients and diagnostic imaging for example, management arrangements also apply to other services, we do not repeat the information but cross-refer to the main report surgery service report.

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

During the inspection visit we:

- The reception and waiting areas, consultation rooms, the x-ray room, the treatment room, wards and the operating theatres.
- Spoke with the registered manager, head of operations, governance manager, patient care manager, theatre lead and 2 ward sisters.
- Spoke with 6 other members of staff including 2 nurses, 2 administration staff and 2 doctors.
- Spoke with 4 patients who were using the service.
- Reviewed 10 patient records.

Summary of this inspection

- Reviewed 5 staff records.
- Reviewed a range of policies, procedures and other documents relating to the running of the service.

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

Areas for improvement

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

Action the service SHOULD take to improve:

- The service should ensure that all equipment in the x-ray room is kept cleaned at all times. (Regulation 15)
- The service should ensure that the cleaning schedule for the x-ray room is kept up to date. (Regulation 12)
- The service should ensure that information on how to raise a complaint should be displayed in all patient area. (Regulation 16)
- The service should ensure venous thromboembolism (VTE) risk assessments are completed on all patients and documentation completed in full. (Regulation 12)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Is the service safe?

Good

Mandatory training

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

All staff received and kept up to date with their mandatory training. The service provided mandatory training in key skills to all staff and made sure everyone completed it. Each member of staff completed an induction and mandatory training according to their specific role.

Managers monitored mandatory training and alerted staff when they needed to update their training. During the hospital's transition to a new provider, there was a temporary loss of access to the training system. The service leads retained oversight of training needs and those were prioritised for completion when they regained access. Despite this, most staff were compliant with training requirements at the time of our inspection between 90% and 100%, or had training dates planned.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training included: infection control, safeguarding vulnerable adults and children, basic life support and manual handling. All qualified staff were trained in immediate life support.

Staff completed training in mental health and learning disabilities. Nursing staff were provided with sepsis and deteriorating patient training in case of any change in a patient's condition either before, during or following surgery.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. All staff were trained to level 2, including female genital mutilation and anti-radicalisation and some senior staff were trained at level 3. The ward staff were 92% compliant and the theatre staff were 85% compliant at the time of the inspection. This was despite the suspension of the training system, which was now accessible, and staff were prioritised to undertake training and increase compliance.

Good

Surgery

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Information was available for all staff in order to report concerns immediately.

All staff we spoke with knew how to make a safeguarding referral and who to inform if they had concerns. All local safeguarding contacts were available for staff in reception, the staff area and the wards. The service had a safeguarding lead and another member of staff was undertaking advanced training to be the lead in their absence.

Staff followed safe procedures for children visiting the clinic with relatives.

The service promoted safety through their recruitment processes and on-going employment checks. During our inspection all staff had a Disclosure and Barring Service check relevant to the role they were employed for.

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.

Wards and theatres were clean and had suitable furnishings which were clean and well-maintained.

The service performed well for cleanliness. The cleaning was outsourced, and all staff had access to their online portal. Cleaning records were maintained and kept on site. The service had cleaning procedures in addition to this, which they adhered to, such as cleaning equipment after patient use. We saw the service completed regular infection prevention and control audits of the environment. Which showed compliance in all areas.

The surgical site infection data for January and February 2023 had not been verified by the infection prevention and control multi disciplinary team at the time of the inspection, however, it was planned to be verified at the next meeting.

We saw hand hygiene audits were completed monthly and showed 100% compliance. We observed staff during the inspection and saw they were always bare below the elbow, washed hands regularly and used hand sanitiser appropriately.

The service had amended the use of face masks in public areas in line with the local incidence of COVID-19.

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.

The service had suitable facilities to meet the needs of patients. There were toilet facilities available for all patients to use, including patients who may have accessibility issues. The reception area and consulting rooms were spacious, and the theatres were maintained to a good standard.

All equipment and consumable items were stored appropriately. Ward and theatre environment audits were carried out biannually and service leads picked up on any additional environmental issues on an ad hoc basis. Any issues identified in the period between audits were addressed at the time.

We found cleaning products stored in line with the Control of Substances Hazardous to Health Regulations.

Annual electrical safety testing and servicing was conducted and all items which required testing and servicing had evidence of in-date tests and services. Fire safety equipment also had evidence of in-date servicing. There was also an annual health and safety inspection by an external provider.

The service had resuscitation trolleys on each floor and an emergency grab bag in the clinic area on the ground floor. Defibrillators were available on each floor and oxygen cylinders stored on the walls. These were checked daily, and we saw evidence of these checks between December 2022 and March 2023. The service had enough suitable equipment to help them to safely care for the patients currently using the service. We reviewed a selection of consumable items including dressings, syringes and needles and found them all to be in date with a system to ensure that staff are aware of any upcoming dates in advance.

Staff disposed of clinical waste safely. We observed staff correctly segregated clinical and domestic waste. Waste bins provided for the department were enclosed and foot operated. Sharps bins were correctly assembled and below the fill line. The management and disposal of sharps and waste was completed in accordance with policy. The service-maintained records on all waste collections to ensure compliance with the legislation which covers waste disposal.

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. The service made sure patients knew who to contact to discuss complications or concerns.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service used the national early warning system (NEWS) track and trigger flow chart. It is based on a simple scoring system in which a score is allocated to physiological measurements (for example blood pressure and pulse). The scoring system enables staff to identify patients who were becoming increasingly unwell and provide them with increased support. All clinical staff had received training should any escalation be required.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. All patients who had consultations were required to undergo risk assessments and a past medical history review. The pre-operative risk assessment had been reviewed as audits showed that some patients had not provided adequate past medical history. Therefore, the questions had been adapted to carry out more detailed assessments, which included emotional and psychological history. All patients had a baseline set of observations recorded to ensure they were of suitable health to undergo the procedure and we saw an admissions policy was in place and strictly adhered to.

Staff knew about and dealt with any specific risk issues. Staff provided patients with aftercare information following their procedure, which was supported by an aftercare advice leaflet. On this information leaflet was a list of numbers for patients to use if they had concerns. Prior to any surgical procedure patients received information to explain the signs and symptoms for sepsis and venous thromboembolism (VTE). Sepsis is a life-threatening reaction to an infection and VTE are blood clots which form within vessels of the body.

The service carried out a VTE audit in December 2022 which showed 47% compliance. As a result of the audit score, a full review of the VTE process was undertaken, led by the group pharmacist and ward manager and there was an action plan created to improve compliance.

Good

Surgery

New VTE paperwork was implemented in February 2023, this included VTE policy; VTE risk assessment; drug chart and accompanying patient information. A planned action from the Medical Advisory Committees was to schedule an audit within 6 months to review the outcome of the implementation of the new VTE process. An interim audit was performed on 15th March 2023, the result of which was 80%, demonstrating large improvement from the previous audit completed in January 2023. Failure to sign and failure to prescribe thrombo-embolus deterrent stockings on the medication chart contributed to the 20% non-compliance. The improvement work was ongoing at the time of our inspection with a further audit planned for 15th April 2023. However, we reviewed 10 sets of records during the inspection and all VTE risk assessments were completed fully.

The service had access to external specialist mental health support (if staff were concerned about a patient's mental health) during their episode of care.

Staff within the service used the World Health Organisation (WHO) checklist when performing procedures. The WHO checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre. For patients being treated with local anaesthetic, staff followed a checklist to check allergies, including latex allergy, likelihood of fainting, and any known diagnosis of HIV or Hepatitis B. We witnessed pre and post procedure checks and were provided with an audit document that showed the WHO checklist was audited. The service provided the most recent WHO audit dated 1st November 2022 and was 97% compliant. An action plan was created, and all tasks were completed by 29th November 2022. Any staff that were not compliant at the time of the audit were provided with refresher training immediately and during the morning theatre huddles the leads were regularly reminding staff to complete the WHO checklist correctly. We reviewed 10 sets of patient records which all had correctly completed WHO checklists and we observed 3 surgical procedures where the checklist was completed for each one.

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, agency and locum staff a full induction.

Managers reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction. At the time of the hospital transition, there was a significant loss of staff. However, the service had reducing rates of bank and agency nurses and requested staff familiar with the service. This was an improving picture as recruitment had been successful and ongoing and all surgeons and anaesthetists were employed under practicing privileges.

The service had enough staff to keep patients safe. Burcot Hall Hospital followed a safe staffing policy which was 1 operating department practitioner/anaesthetic practitioner, 2 scrub nurse, 1 healthcare assistant, 1 recovery nurse for theatre. This model was followed for every theatre list regardless of volume of patients. In the event that a shift was unfilled, attempts were made to utilise cross-skilled staff (for example the theatre manager who is an experienced scrub nurse) from other areas of the hospital. If it was felt that safe staffing could not be provided within this model then patient procedures were postponed.

The wards ran on a ratio of 1 nurse to 6 patients. Staff were also utilised across both hospital sites such as, where staffing gaps were identified and patient numbers could not be reduced (for example staff sickness for the night shift when patients had already had their procedure), staff could be relocated from the providers hospital in Manchester to Burcot Hall Hospital, or vice versa.

Good

Surgery

The service had a vacancy rate of 7 whole time equivalent (WTE) for wards and 9 WTE for theatre, which was an improving picture as patient demand continues to grow and recruitment was ongoing. Recruitment at Burcot Hall Hospital had been problematic for some time. Staff told us this was due to the location of the hospital (not close to rail or bus networks) and previous reputation.

The service had recently completed a successful recruitment of international nurses, which were due to start work in April 2023.

Managers made sure all bank and agency staff had a full induction and understood the service. All staff, regardless of status, were required to complete their induction to the service. Mandatory training was facilitated by the agency and assurance of compliance was provided to the registered manager; however, local competencies were completed on site. They were always supported during their shifts by the nurse in charge.

Agency usage was high at 30% each month. However, with the exception of last-minute sickness cover, the agency staff used at Burcot Hall Hospital were all block-booked for 3 months in advance and worked at the hospital as their main employment base. Many of these staff had been with the team for many years but chose to remain employed on an agency basis due to their own work/life balance requirements.

The surgeons who performed the procedures were registered with the General Medical Council. The surgeons' availability was provided to the service well in advance, to enable lists to be scheduled accordingly.

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. Staff recorded all cosmetic implants on the Breast and Cosmetic Implant Registry.

Patient notes were comprehensive, and all staff could access them easily.

The service completed records for consultation, pre-operative, surgical and post operative care, which contained all documents required for the patient journey together. All records we reviewed were complete and held together in separate patient files. This ensured documents were less likely to become lost or misfiled. We reviewed 10 sets of records and found they were clear, legible and up to date.

We reviewed the most recent records audit, dated February 2023, which was 94% compliant against the service target of 100%.

Records were stored securely. All documentation was locked away when not in use.

Staff recorded all cosmetic implants on the Breast Implant Registry.

Medicines

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

Staff followed systems and processes when safely prescribing, administering, and recording medicines. The service had the support of a pharmacist who was on site most days. Staff said the pharmacist was always accessible and they could contact them on their mobile number when they were not on site. They had oversight of medicines management and ensured the service had the correct and sufficient medicines for both the theatres and the wards.

Good

Surgery

All appropriate checks were carried out prior to administering medicines, including patient name, date of birth and allergies. The medicines refrigerator in theatre was monitored by staff daily. This included a review of the minimum, maximum and current temperature to ensure medicines were stored correctly. All other areas for medicine storage had a daily temperature check to ensure cupboard medicines were stored at the correct temperature.

Staff reviewed patients' medicines and provided specific advice to patients about them. Staff were knowledgeable about the medicines involved with the procedures and therefore provided patients with detailed advice, including side effects and contraindications where applicable.

Staff stored and managed medicines and prescribing documents in line with their policy. The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff regularly reviewed the most up-to-date Medicines and Healthcare products Regulatory Agency alerts which were distributed to ensure there were no complications with the medicines they frequently prescribed. If there were any alerts applicable to the service, the registered manager ensured all staff were aware of this.

The service had a medicines' management policy and antimicrobial policy for staff to follow. We found the antimicrobial policy contained specific details about antimicrobial prescribing for the service according to local guidance.

Oxygen was available within the service and was stored correctly for use in theatres.

Incidents

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

Staff knew what incidents to report and how to report them. There was a positive reporting culture within the service and staff received feedback on incidents raised. The service had an incident reporting policy which was in date.

The service had no never events during the reporting period of October 2022 to March 2023. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

We reviewed incident investigation reports for 3 incidents between January and September 2022, which were detailed and included actions and learning from incidents. We saw they had 'lessons learnt' boards around the clinical areas. There were no serious incidents reported for the service since transition, from October 2022 to March 2023. Serious incidents are events in health care where there is potential for learning, or the consequences are so significant that they warrant using additional resources to mount a comprehensive response.

Staff understood the duty of candour. Staff we spoke with understood the duty of candour process and the need for being open and honest with patients when errors occur. Senior staff members were able to explain the process they would undertake if they needed to implement the duty of candour following an incident which met the requirements. Compliance with duty of candour requirements was captured on the patient records.

Good

Surgery

Staff met to discuss the feedback and look at improvements to patient care. Review of incidents was completed by the ward/theatre manager and escalated for review by the registered manager and shared at team meetings and huddles amongst all staff.

We were told of examples of learning from incidents, such as the provision of an emergency grab bag in the clinic area in addition to the resuscitation trolleys around the hospital.

Is the service effective?

Good

Our rating of effective was 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. The service met cosmetic surgery standards published by the Royal College of Surgeons.

Staff followed policies to plan and deliver care according to best practice and national guidance. The service ensured their policies, procedures and processes were compliant with the recommended clinical guidance. For, example perioperative care in adults (2020) National Institute for Health and Care Excellence guideline.

While many policies were in date, some were still awaiting sign off. When the hospital changed provider in October 2022 there was a full review of all policies and where updates or amendments were required, they had been processed. However, there were some new policies which were not in place yet. For example, the complaints policy was in draft form at the time of the inspection as there had been a number of changes made to the original policy to reflect the improved way in which the new service dealt with complaints, including the option of an external review. Following the inspection, the service provided the final version, which showed a comprehensive complaints process going forward.

Staff competence was monitored including staff awareness of policy and procedure changes. We observed staff signature lists to identify when they had reviewed specific guidance. This was monitored by the registered manager. All policies had been reviewed and where updates were required, these were done in a timely way. The service sought external advice as part of their process, for example they sought a diabetes GP review of their draft diabetes policy before sign off.

Staff protected the rights of patient's subject to the Mental Health Act and followed the Code of Practice. All patients who attended a consultation for a surgical procedure had a psychological assessment prior to any surgery being completed. Patients who required additional mental health input were signposted to agencies for support.

The service had implemented an audit plan and we saw evidence of audits being conducted. Audits which were regularly conducted included but were not limited to hand hygiene, infection prevention and control and WHO checklist.

Nutrition and hydration

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Nutrition and hydration were an important aspect when undergoing a surgical procedure. Staff provided patients with drinks to maintain hydration which included water and hot drinks as required.

Good

Surgery

Patients undergoing weight loss procedures were given appropriate advice pre-operatively and comprehensive instructions regarding post-operative nutrition and hydration in line with their specific procedure.

Pain relief

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

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. For patients who did experience pain, they were appropriately managed. All patients had a supply of pain relief to take home with them, and the aftercare leaflet provided details of advised medicines regimes.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

At the time of the inspection the service did not participate in any national clinical audits. However, they were compliant with the requirement to submit data to the National Joint Registry and the Breast and Cosmetic Implant Registry. In 2022 the service reviewed national audits and did not identify any they felt they could partake in, however, they said they would continue to review them periodically and partake as appropriate.

The service submitted data to meet the requirements of the Private Healthcare Information Network (PHIN). Although there had been a gap in this due to the transition of services.

Staff regularly reviewed patients post procedure. The service was yet to complete any official outcome studies or audits, but staff told us their patients were happy with the results of the procedures. Patients undergoing procedures completed a satisfaction survey and outcomes were reviewed post-surgery to ensure the procedure was successful. This was monitored through Medical Advisory Committee (MAC) meetings.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time, including hand hygiene, medicines management, clinic safety and the environment. All results had demonstrated compliance.

Managers used information from the audits to improve care and treatment. For example, the audit of pre-operative risk assessments prompted a review of the assessment process and amended, more detailed questions were identified in order to improve the quality and quantity of information obtained from patients regarding psychological and medical history that patients had previously thought irrelevant.

Improvements were checked and monitored through repeated audits and discussions during audit meetings, which we saw through review of the last 2 sets of meeting minutes.

The clinic had no cases of unplanned transfer of a patient to another hospital. We reviewed the transfer policy which set out criteria for transfer and by which method. It also stated that the decision to transfer a patient out of Burcot Hall Hospital would be made by the anaesthetist in conjunction with the operating surgeon. An assessment of the patient's condition must be made by the clinician to determine whether or not an emergency transfer is required.

There was 1 readmission to theatre within 30 days of discharge between October 2022 and March 2023.

Good

Surgery

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. All staff involved in the patients' journey were able to demonstrate their extended knowledge and skills within the field of general or cosmetic surgery. There was a vacancy for a designated clinical team leader to have complete oversight of the clinical services, however, the service had been unsuccessful in recruitment and had gone back out to advert. The director of clinical services planned to continue with the role in the interim.

All clinical staff had competencies reviewed and monitored by their clinical manager and reviewed for final sign off by the registered manager. There were competency-based assessments completed when nursing staff commenced their work at this location and on an ongoing basis. We saw evidence of this during our inspection.

Managers gave all new staff an induction tailored to their role before they started work. All staff, including those who worked under practicing privileges were required to complete the induction.

Competency checklists were completed in healthcare assistant (HCA) new starter competency booklets and registered nurse self-assessments. Competencies include gastric bypass, gastric band, gastric sleeve, cosmetic procedures, the national early warning score, venepuncture, blood glucose machine, assisting minor operations, medicines management and wound care. HCA competencies also included pre-operative assessment and chaperone for HCAs.

Managers supported staff to develop through yearly appraisals of their work. Staff had the opportunity to identify training needs with the manager. The manager told us that if staff approached them with additional training then this would be facilitated through the service. We saw evidence of appraisal meetings within all staff files we reviewed, the theatres were 100% compliant and the wards were 96% compliant. The lower compliance was due to 3 new starters and 1 appraisal was overdue, however, a date was identified for this to take place. In addition to this the clinical lead for the service also had more regular meetings with staff on a 1 to 1 basis in order to offer development and updates more regularly.

Managers supported staff to attend team meetings or access to notes when they could not attend. Minutes were shared to all staff and a newsletter included important elements taken from meetings.

Managers had processes in place to identify poor staff performance promptly and would support staff to improve. However, this had not been an issue since the transition and therefore the managers had not been required to use these processes.

Staff who worked under practicing privileges followed a specific recruitment process to ensure they were suitable and competent to work at the service. As part of this process, staff were required to provide evidence to the managers of their competence. We saw evidence of this in staff personal files.

There was a practicing privileges framework used for consultants wishing to practice at the hospital. The registered manager reviewed the practising privileges annually. If there were any concerns about an individual's performance or revalidation process these would be escalated to the nominated individual.

Good

Surgery

We reviewed the records of the consultants with practising privileges. We saw evidence of up to date revalidation, annual appraisal, General Medical Council registration, indemnity insurance, Disclosure and Barring Service checks (to check if a person has a criminal record) immunisation status and relevant training such as mandatory training and cosmetic procedures. Each consultant with practising privileges also had a responsible officer. A nominated responsible officer is a requirement of the General Medical Council revalidation process who provides support with appraisal and revalidation.

We reviewed 10 staff records. There was evidence of 1 to 1 meeting with managers and annual appraisals. Staff told us they had regular meetings with their manager.

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. Staff communicated with the patient's GP when consent had been given to ensure any additional care needs were met following the procedure.

All staff held joint meetings in order to share and raise any concerns that may support changes in practice. For example, the timely running of theatres and ward discharges.

The service held a variety of multi-disciplinary meetings such as safeguarding, audit, MAC, clinical governance and any staff could request to attend for their own learning.

Staff could refer patients for further mental health assessments if they showed signs of mental ill health or depression after their initial consultation.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The service ran as demand required. The service had appointments in the evening and weekend to allow patients to easily access the service. Staff told us how they could be flexible to accommodate patient requests or if there was an increase in demand.

There was a telephone service available to patients who had undergone a procedure. All patients were given this number after their procedure. This was a 24-hour service as there was always a resident medical officer on site for advice, alternatively patients were advised to contact their GP or the local NHS provider where appropriate.

Health promotion

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

The service gave relevant advice and information to promote healthy lifestyles throughout their patient journey. The information given by staff was to ensure they gave patients the best opportunity for wound healing and prevention of complications. We observed dietary advice being given to patients undergoing surgical procedures in order to enhance and improve results as well as general health.

Good

Surgery

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 and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to patient records that they could all update.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff told us it was extremely rare a patient who lacked capacity would attend their service.

There was an in-date policy to ensure all staff acted in line with legislation and all staff completed electronic learning on this.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available and we saw they clearly recorded consent in the patients' record.

Staff at the service complied with the Royal College of Surgeons Professional Standards for Cosmetic Surgery by ensuring there was a minimum of 14 days between initial consultation and the procedure. To ensure patients fully understood they were seen twice preoperatively by the surgeon.

Staff were aware of Deprivation of Liberty Safeguards. However, staff told us they had never provided care and treatment to a patient who was deprived of their liberty, or who they thought needed depriving of their liberty.

Is the service caring?

Good

Our rating of caring was 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. Each consultation was individual to the patient's needs.

We spoke with 4 patients. The feedback was overwhelmingly positive, and patients used words such as 'fantastic care', 'lovely staff', 'really attentive' and 'compassionate manner'. We also looked at online reviews and cards which were displayed in the reception and ward areas, they were all very complimentary of the service.

Patients we spoke with told us they would recommend the service to their friends and family. Many patients returned for further procedures and many family members had also visited the service.

Good

Surgery

Patients said staff treated them well and with kindness. Sensitivity and kindness were a theme of the feedback we saw and heard.

Staff followed policy to keep patient care and treatment confidential. Staff ensured blinds and doors were closed during the procedures and consultations.

The service provided chaperones to patients who required one. There were numerous signs around the clinic area promoting the assistance of a chaperone. All healthcare assistant staff had completed a chaperone module on their electronic learning to ensure they were suitable to offer this role.

Staff were discreet and responsive when caring for patients, we heard this particularly from patients undergoing weight loss surgery. Staff took time to interact with patients in a respectful and considerate way.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff told us patients often became emotional when they discussed issues they had with confidence preoperatively. They told us it was important they provided them with support to enable them to go forward with their journey.

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. Staff took a holistic approach to the care and treatment they provided for patients. All staff understood the personal, cultural and religious needs of the patient and ensured the appropriate advice and support was provided for them.

The service had access to mental health support when required and all patients we spoke with were complimentary of the consistency of support throughout their journey.

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. Staff took the time to ensure all patients and any family members understood all the information given to them. They encouraged them to ask any questions about the care and treatment if they had not understood to begin with. Patients told us they understood the information they received, however, would feel comfortable asking further questions if required.

Staff talked with patients in a way they could understand. Staff we spoke with told us of various approaches to ensure patients understood the treatment options on offer. We were told of an example of a poor experience for a patient who was blind, the service took action to ensure this level of care was not repeated and put actions in place to improve the patient experience in future. This included the availability of all information and consent forms to be offered in braille.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We spoke with 4 patients during the inspection and all patients were positive about the staff and their experience. Several patients had returned for further treatment and recommended the service to their family and friends.

Good

Surgery

Staff supported patients to make informed decisions about their care. Surgical staff ensured the discussions around physical changes to a patient's body/face were completed collaboratively between them and the patient. During this process, they discussed with the patient the best treatment options available to them to ensure expectations were managed and clear. People's emotional and social needs were considered as being equally as important. Staff demonstrated understanding of the impact a person's care or treatment or could have on them and those close to them, both emotionally and socially.

Staff had sensitive discussions with patients about the cost of the treatment at the consultation stage of the patient journey. They ensured all potential costs were covered to ensure patients had full payment details prior to deciding on whether to go ahead with surgery or not.

Is the service responsive?

Good

Our rating of responsive was good.

Service delivery to meet the needs of local people. The service planned and provided care in a way that met the needs of local people and the communities served.

Managers planned and organised services, so they met the needs of people accessing specific surgical procedures. The managers of the service understood the patient group well and had ensured the service offered a variety of procedures.

Facilities and premises were appropriate for the services currently being delivered. The managers had ensured the environment was comforting and calming for patients who attended for care and treatment. There was a large waiting area and reception. Consulting rooms were accessed from this area on the ground floor giving easy access for all. Patients had areas to change which protected their privacy and dignity and kept their personal belongings with them.

There was a large, free car park at the service for patients to use. The hospital was in a rural location, however, the nearest train station was only a few minutes away by car or taxi. If patients had any concerns about transport to or from appointments, the service would provide a taxi for them to attend.

Managers monitored and took action to minimise missed appointments. Where patients did not attend, they were contacted to ascertain the reason. The appointment could be rearranged, however, if there was any possible way to support the patient to attend as planned then the service provided that support.

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. There was a system for referring patients for psychological assessment before starting treatment, if necessary.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had an equality and diversity policy which staff followed which covered meeting the needs of individuals with a disability.

Good

Surgery

The service could provide patients with information leaflets in alternative languages, including braille if required, and had access to language line.

Staff would identify, during the booking process, if the patient had any additional needs. Staff would then ensure their needs were met during both the consultation and surgical phase, if the patient went forward with the procedure.

The service had access to a mental health services for patients who required additional support. Staff also told us they could arrange for patients, who were anxious about a procedure, to visit the hospital ahead of their treatment and staff would try to relieve some of their anxieties.

The service provided care and treatment for a diverse range of patients. All staff at the service ensured they understood the needs of each patient to enable them to offer the best treatment options to them.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The food was made on site and menus prepared for the wards in advance, however, if there were any preferences, these were eagerly met by the catering team.

The service had a dining area away from the main hospital areas where staff could get hot and cold meals and drinks throughout the day.

Access and flow

People could access the service when they needed it and received the right care.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within the patient agreed timeframes. Patients were at the centre of the decisions made around appointments and dates for surgery. The service was open 7 days a week to ensure patients could access the hospital when it suited them. Surgical procedures were booked around patient preference and surgeon availability.

The service had a website where patients could find a range of information and book their consultation, or patients could contact the service over the telephone to arrange.

Managers and staff worked to make sure patients did not stay longer than they needed to. On the day of our inspection, all appointments ran on time and theatres ran according to plan. The service did not have any cases of staff at the service cancelling patients' appointments and told us they would try every available opportunity before deciding to cancel any appointments or surgery. Staff did tell us, if they ever did need to do this, they would ensure their appointments were rearranged as soon as possible. Most patients had day case procedures and did not require an overnight stay, however, if they needed to stay overnight, they were regularly reviewed in order to agree a discharge as soon as possible.

Patients had their follow up appointments planned out for them. A follow up call was completed within 24 hours of the procedure, which was documented on the consultation. Further physical follow ups were completed according to individual patient requirements. For example, patients returned for post-operative wound care, however, we were told that sometimes if patients felt they had healed appropriately they may not attend for that appointment, which was their choice and not something that the service could predict.

Good

Surgery

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.The service had a system for referring unresolved complaints for independent review.

Patients, relatives and carers knew how to complain or raise concerns. The service displayed information about how to raise a concern on their website, verbalised this on admission and discharge and all patients were given access to a QR code during their stay to encourage them to leave a review online regarding their experience. Prior to the transition the service used a system of sending emails to patients and using devices to obtain feedback and were relaunching this, ensuring patient feedback also meets the requirement of Private Healthcare Information Network (PHIN) data reporting.

Due to the new complaints policy not being finalised at the time of our inspection there was no information displayed in patient areas. The service had new posters planned to display once the policy had been signed off.

Staff were involved in the creation of the new complaints policy and understood how to handle them. If a patient wished to raise a concern, they were encouraged to do this verbally in the first instance to ascertain whether there was an easy resolution. The patient was then encouraged to put their complaint formally in writing for it to be processed in line with the complaints policy. When patients were not satisfied with the hospital's response, they had an option for their complaint to be reviewed externally.

Managers told us they would investigate complaints and identify themes. At the time of our inspection, the service had received 5 complaints. These were managed in line with the service's policy. Staff explained that when a complaint was made, the patient received an automatic acknowledgement of receipt and they were contacted by the complaints manager within 48 hours to explain the procedure and try to resolve any immediate issues where possible.

The service was also dealing with complaints which were made prior to the transition, which was impacting on the workload, however, they had made huge progress against the previous backlog and new complaints were within timeframes, in line with their policy.

Where patients had attended for consultation and pre-operative assessment prior to the transition, the service were offering to honour their procedure as a gesture of goodwill. They were also providing revisions in line with their revisions policy, which detailed that they would only be carried out when it was clinically necessary.

Staff could give examples of how they used patient feedback to improve daily practice, such as menu options and consultation process.

Is the service well-led?

Good

Our rating of well-led was good.

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. They supported staff to develop their skills and take on more senior roles.

The service was led by the registered manager who was the director of clinical services with the support of the head of operations, they were responsible for the overall running of the hospital. At the time of the inspection there was a vacancy for a clinical services manager who the ward sisters, theatre manager and theatre leads would report to. The leadership team also included a head of governance and governance manager as well as a patient care manager.

All staff spoke overwhelmingly positive about the leaders of the service. All leaders were visible and approachable and knowledgeable about the services provided. Clinical staff felt particularly supported by the director of clinical services and head of operations and described them as being 'always accessible and really focused on improving the patients' experience'. We observed staff discussing treatment options with patients and it was clear they were knowledgeable about the services they provided their patients.

The non-clinical staff described their induction as 'brilliant'. They explained that they were encouraged to spend time in all clinical areas, including theatre in order to understand everyone's role and to better understand their challenges. The director of clinical services maintained their skills and knowledge through continuing clinical practice and competency assessment.

Staff told us they felt the leaders had an ongoing interest in staff development and improving services. Staff were able to access a range of training at the service to enable them to develop their skills and progress in their roles.

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 had their corporate vision and core values in place which was displayed around the hospital. The values were patient care, innovation, accountability, integrity and one team. The vision was 'trusted experts, delivering solutions that empower people to make their lives better' and the mission was 'to make Transform Hospital Group the elective healthcare provider of choice by delivering outstanding care, continuous innovation and exceptional member experiences'.

All staff were aware of the vision and values and aligned themselves to them.

The service had a plan which provided staff with a strategy for achieving the vision and delivering care. The strategy was developed involving all staff and welcoming feedback which was discussed, and the strategy evolved until it was agreed collectively.

Within the business plan were aims and objectives for the service to achieve. Progress against these aims and objectives was measured through audits. The service had supported the NHS throughout the COVID-19 pandemic by providing orthopaedic surgery for example and planned to tender for a number of new contracts in order to support the NHS locally and assist with the surgical post-covid recovery plan.

Good

Surgery

Culture

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

Leaders modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. There were processes to support staff and promote their positive wellbeing. Staff told us about Wellness Wednesdays where the staff could choose any 5 items from the diner and could take time out. They had coffee mornings and met with staff regularly to gain feedback regarding challenges and achievements.

Leaders encouraged pride and positivity in the organisation and focused attention on the needs and experiences of people who use their service. Behaviour and performance inconsistent with the vision and values would be identified and dealt with in a timely and effective manner, regardless of seniority.

All staff we spoke with told us they felt supported, valued and respected by their managers and their colleagues. Staff told us they enjoyed working at the hospital and were proud to be associated with the service, since the transition has taken place. One staff member said 'it's refreshing to be around people who want to do great things'.

Staff told us they felt they could raise any concerns with the managers without fear of reprisal. The service had a whistleblowing policy in place to support this process. The head of governance was trained by the national guardian's office to undertake the role of the Freedom to Speak Up Guardian (FTSU) and cascaded the training to several colleagues in the hospital, including the registered manager so that the service had a number of FTSU champions. FTSU champions are responsible for; supporting staff to raise their concerns, acting as independent and impartial source of advice to staff through listening to issues raised, and agreeing with the colleague speaking up, what might be the appropriate action to take.

All staff knew who the FTSU champions were and were happy to speak with them if they needed to. The FTSU guardian reported to the Medical Advisory Committee (MAC) and the Clinical Governance and Compliance Committee, any themes for discussion and resolutions.

Teams worked cohesively, team meetings were joint and any concerns or ideas for the team could be shared and implemented. We also observed information from these meetings and reviews fed into the MAC, for further discussion and implementation as necessary.

Equality and diversity was actively promoted, and the causes of any workforce inequality identified, and action taken to address these. Staff, including those with protected characteristics under the Equality Act, felt they were treated equitably.

The service had an open and honest culture. Any incidents or complaints raised would have an open and honest 'no blame' approach to the investigation, however, in circumstances where errors had been made, apologies would always be offered to the patients and staff would ensure steps were taken to rectify any errors. Staff were aware of the duty of candour regulation; however, they had not had any incidents which met the criteria where formal duty of candour had been required to be implemented.

Good

Surgery

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. The duty of candour regulation only applies to incidents where severe or moderate harm to a patient has occurred.

Governance

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

The service had an in-date clinical governance policy which provided a clear structure for governance processes.

Governance of the service was discussed at a quarterly MAC meeting, in addition less formal meetings took place in the interim between the director of clinical services and the governance leads. We saw the notes from 3 MAC meetings. The content was relevant to the governance of the service and included items such as incidents, complaints, clinical policies, National Institute for Health and Care Excellence guidance, current activity, and practising privileges.

The registered manager was responsible for meetings with third party providers. Service level agreements were usually reviewed annually. We reviewed the service level agreement for collection and transfer of controlled waste, which clearly described the expectations.

Practising privileges were reviewed annually by the head of governance, agreed and granted by the medical director. A policy was in place which described what consultants should have in place and what information they should provide. This included identity checks, references, General Medical Council Registration, Disclosure and Barring Service checks, indemnity insurance, appraisal documentation and vaccination status.

The hospital had 300 consultants/anaesthetists who worked with the hospital. A responsible officer was allocated to consultants who did not work in the NHS, and those who did most of their work with Transform Healthcare Holdings Limited and were connected to the organisation as their designated body (a designated body is an organisation that a licenced doctor has a professional, educational or employment connection with that provides them with support for revalidation), this meant that the General Medical Council revalidation process was overseen, and the consultants complied with all the requirements. Appropriate terms and conditions were in place to ensure those who were granted practising privileges adhered to policies and procedures.

We heard from staff and service leads that the governance arrangements changed significantly since October 2022. The development of a cohesive management structure with the addition of a head of governance and governance manager had meant that there was increased monitoring and oversight of risks to ensure performance and safety was upheld.

Staff were clear about their roles, what they were accountable for, and to whom. There was an increased awareness and monitoring of training and competency of all staff which enhanced and developed their previous experience in the role.

The service had a range of comprehensive policies for staff to follow, which they were involved in the development of. These were consulted on with all staff and written by the relevant manager then reviewed during governance meetings. All polices were version controlled and had dates for review.

Good

Surgery

We reviewed 5 staff files (randomly selected) of various roles, professions and employment statuses. We found all staff files complied with the Schedule 3 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. The service also had a recruitment policy to ensure all staff adhered to the requirements.

Management of risk, issues and performance

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

During our inspection, we reviewed the local risk assessments and found the risk assessments were extremely detailed and had ownership. We also observed they were regularly reviewed, and the risks identified reflected the risks which staff spoke of. Examples of risk assessments completed were (but not limited to), infection control, IT and governance and Control of Substances Hazardous to Health Regulations products.

The service employed an external company to conducted health and safety audits to ensure the risk to patients and staff was minimal. This reviewed fire safety, the environment, electrical safety, first aid boxes and water safety. Any areas identified on these audits as non-compliant were rectified immediately.

We reviewed the hospital's risk register as part of the inspection and saw that risks were regularly reviewed, actions taken, risk scores amended and closed when appropriate. The closed risks remained on the register for information only and we could see what actions had taken place to mitigate or remove a risk. For example, risk of potential injury to staff, visitors and patients should access ladder to the scaffolding not be secured. Actions in place were that maintenance staff ensured access was restricted and signs erected to inform all of restricted access.

Planned industrial action for ambulance services was also added to the risk register. The service ensured communication with providers and surgeons/anaesthetists by emailed prior to lists that fell on days when strikes were planned to make them aware and to check all were happy to proceed with lists. Additional scrutiny of patients' files to pre-empt any concerns regarding medical histories and re booked where necessary.

The service had a health and safety policy in place which contained the procedures for staff to follow in unexpected events.

The service had an audit programme in place to ensure performance was constantly reviewed and improvements to the care and treatment patients received could be implemented. For example, a proportion of patient notes were checked on a monthly basis for accuracy and completion of The National Early Warning Score and World Health Organisation checklists were also audited by the relevant lead.

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.

The hospital had a policy for records and information management which covered data protection, access to health records and confidentiality. On the day of our inspection, we saw that patient paper records were handled and managed in line with the policy and data protection standards. In the 10 patient records we reviewed we saw that information was clearly documented, comprehensive, dated and signed.

Good

Surgery

The service had introduced a computer system which was still in the process of being fully implemented in terms of patient records. The system made the record keeping accessible for all and across the organisation to ensure they had all information needed to provide safe patient care. We saw that data reports could be exported, saving time for tasks such as monitoring of performance, complaints and incidents.

All staff had access to relevant areas of the electronic system in line with their role, which included the electronic training system. All staff received training on information governance and General Data Protection Regulations and the new system reduced the risk of data breaches.

The service had a website available which was regularly reviewed by staff. This enabled patients to complete their own research on the procedures provided at the service as well as the service itself. Information about the terms and conditions of treatment and payment was also provided.

The service did not advertise the procedures and treatments provided. Patients who attended the service had either completed a search on the internet or the service was recommended to them.

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 held regular team meetings to engage with staff members who worked at the service. In between these meetings, staff received regular emails and calls from the managers of the service. All staff we spoke with told us how approachable the director of clinical services was and that if they had any concerns, they would be confident to raise them.

The service had mechanisms in place to receive feedback from patients. Patients were encouraged to leave feedback on discharge or to send feedback through email after discharge in the interim period while they are finalising their complaints and feedback processes. Patients were also regularly asked if they were happy and whether they needed anything else to improve their experience and those were acted upon immediately where possible.

The director of clinical services and the head of operations both had good relationships with the local trusts, and where appropriate would liaise with GP surgeries and other local providers to ensure patients received joined up care and could easily be referred onto other services for support if required, for example mental health services.

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 registered manager told us that the members of the MAC met quarterly to discuss ways to improve and increase the service to ensure they were continuously improving the patients' safety and experience, to be the patients' first choice of provider.

All staff were encouraged to contribute their ideas about improving the service. Staff told us when they had suggested ideas in the past, all staff listened to them and where possible, their ideas were taken on board and improvements made.

Good

Surgery

The director of clinical services and head of operations had enthusiastic ideas about the direction of the service and the plans they aim to achieve. They were also keen to involve staff in shaping that journey and planning what their future as a service will look like. They were eager to involve the service in future improvements within the wider system in order to continue to support the local NHS economy.

Good

Outpatients

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

This service was not rated prior to this inspection. We rated it as good because:

Mandatory training

The service provided mandatory training in key skills to all staff and 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 topics, such as infection prevention and control, basic life support, safeguarding, moving and handling, health and safety.

Managers monitored mandatory training and alerted staff when they needed to update their training; 4 staff members (2x qualified nurses and 2x healthcare support workers) were 100% compliance with in-date mandatory training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns; 4 staff members (2x qualified nurses and 2x healthcare support workers) 100% compliance with level 2 adult and level 2 children safeguarding training and some senior staff were trained at level 3.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves, and others from infection. They kept equipment and the premises visibly clean.

Our observations and review of records showed that staff followed the provider's infection prevention and control (IPC) policy. Staff followed infection control principles including the use of personal protective equipment (PPE) such as gloves and aprons.

Good

Outpatients

We observed handwashing protocols that took place during the inspection. Staff were compliant with the times and stages at which handwashing should be done. Regular audits were completed to assess and monitor the staffs' compliance with the IPC policy. From November 2022 to February 2023 hand hygiene audit showed 100% compliance with hand hygiene requirements and 96% with IPC.

All outpatient areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

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.

The design of the environment followed national guidance. We reviewed the hospital "Health and Safety Floor Walk" December 2022 audit for the environment checks and found a compliance rate of 94% against hospital target of 100%. Action plans had been implemented and areas for improvement were being actioned.

The consultation room was used for pre-operative consultation, dressing removal and storage of patient notes. The consultation room had a demarked area for patients which included an examination couch. The demarked patient area had disposable curtains for privacy should this be required. These were in date.

The service had enough suitable equipment to help them to safely care for patients. This included equipment required to complete patient observations, such as blood pressure and temperature monitoring and weighing scales.

Staff carried out regular safety checks of specialist equipment. This included checks of the patient observation equipment referred to above and emergency equipment, we found all checks were up to date. However, during the inspection we found 1 emergency trolley was unlocked with easy access to adrenaline. We raised our concerns with senior management who rectified our concerns immediately. All other emergency trolleys inspected during the inspection were locked and secure.

Staff disposed of clinical waste safely and effective systems were in place to ensure this waste was removed from the hospital in an appropriate, safe manner.

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.

All outpatients were under the care of an appropriate consultant who had practising privileges at the hospital. Practising privileges ensured that all health and social care professionals involved with patient or client care are qualified, competent and authorised to practice.

Staff completed risk assessments for each patient on consultation and pre-operatively and reviewed this regularly. These risk assessments also included psychological risk assessments. Assessments were recorded in each patient's notes book. We reviewed 6 patient records and found all assessments had been completed.

We saw all staff had completed their basic life support training and 50% of staff had completed their intermediate life support training.

Good

Outpatients

Staff responded promptly to any sudden deterioration in a patient's health. Staff used a nationally recognised tool to identify deteriorating patients and knew how to escalate them appropriately. The service used the national early warning score (NEWS2) to record and monitor potential patient deterioration. Monitoring included respiratory rate, oxygen saturations, systolic blood pressure, pulse rate, level of consciousness and temperature. We reviewed 10 notes and found all NEWS2 had been recorded and calculated correctly.

Staff knew about and dealt with any specific risk issues. For example, staff were able to access records that showed the risk assessments and management plans for patients who were attending outpatients' post-surgery. This enabled them to check that patients were compliant with post operation risk management advice, such as the use of compression stockings to prevent blood clots. Staff reminded patients of the agreed risk management plans where required and updated risk assessments if changes to risk had been identified.

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.

The service had enough staff of relevant grades to keep patients safe. The service had 1 whole time equivalent (WTE) nursing staff vacancy and there were no healthcare assistant (HCA) vacancies. Managers accurately calculated and reviewed the staffing numbers and skill mix needed for each shift and the numbers of staff on all shifts matched the planned numbers. Sickness rate within outpatient was 0% for both nurses and HCAs.

There were no medical staff employed directly by the service, with all consultants working under practising privileges. All consultants carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS or in their private practice. Consultants new to the hospital received a formal induction and could work under practising privileges only for their scope of practice covered within their NHS work.

Consultants with practising privileges were required to be contactable always when they had a medical patient at the hospital nursing staff told us that they could call and speak with the consultants at any time for advice if a patient had contacted them with a request for example if they required to amend time or date of an appointment.

The head of governance and compliance had oversight of practicing privileges arrangements for consultants. We saw evidence in the MAC minutes of decision-making for renewing or granting privileges.

Please refer to the main surgery report for further details on MAC and practising privileges.

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.

Patient notes were a combination of electronic and paper records and were comprehensive, legible, and up to date. However, some information such as doctors General Medical Council (GMC) number, and their printed name was not always completed although signature or initial was documented. All the records we viewed contained a contemporaneous account of each patient's journey. We saw that risks, such as allergies were clearly recorded as soon as the patient disclosed this information.

Good

Outpatients

Paper records were stored in locked cupboards in the consultation room. These records were easily accessible to staff. Electronic records were stored on a secure cloud-based record keeping system. We reviewed the hospital latest record keeping audit and found 78% of records were completed correctly against hospital target of 100%, areas of improvement highlighted was around doctors' signature, printed name and individual GMC number.

When patients transferred to a new team within or outside of the hospital, there were no delays in staff accessing their records. Summaries of each patients' care were shared with GP's and in medical emergencies records were shared with staff at the local NHS acute hospital.

Medicines

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

All patients were asked to share information about the medicines they were already prescribed and any known allergies. A record of this was kept and updated throughout each patient's outpatient journey.

Staff reviewed patients' medicines regularly and provided specific advice to patients about their medicines prior and post-surgery. This was documented in the patient record.

All pharmacy services were supplied by the Group Pharmacist.

Please refer to the main surgical report for further information at this hospital.

Incidents

Staff recognised incidents and near misses and reported them appropriately. 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.

There had been no never events within outpatients. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Staff knew what incidents to report and how to report them. Staff also told us they felt confident to raise concerns and report incidents and near misses should they occur.

Staff understood the duty of candour. We were told there were no occurrences of situations where the duty of candour was applicable. We were informed that should any situation that requires duty of candour to occur staff and managers would be open and transparent and would give patients and families a full explanation if and when things went wrong.

Please refer to the main surgical report for further specific incident information.

Good

Outpatients

Is the service effective?

Inspected but not rated

We currently inspect but do not rate effective for outpatients.

Evidence-based care and treatment

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

Pre-admission outpatient appointments were held to ensure the National Institute for Health and Care Excellence (NICE) Routine pre-operative tests for elective surgery guidance was followed. This included the completion of recommended tests prior to weight loss operation, such as blood tests and electrocardiograms, and meal preps prior to their weight loss surgery.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

The service had a local audit programme that included audits of records, risk assessments and a chaperone audit. We saw that where required action plans were devised and followed to improve the effectiveness of the care and treatment within the outpatient's department.

Please refer to the main surgical report for further information at this hospital.

Nutrition and hydration

Patients attending the department could access food and drink if required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Self-served water and hot drinks were available to all patients within the outpatient's department. Staff said they would support patients to use these facilities if required.

Patients were usually only in the department for short periods of time. However, staff told us they could provide meals to patients if required via the hospitals catering facilities. This included the provision of specialist and modified diets if required to ensure patients individual needs were met.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain.

Patients were asked about their pain at each appointment and were advised appropriately in how to manage this.

Please see further insight around pain relief tool used in the main surgical report.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Good

Outpatients

Whilst the outpatient department did not specifically monitor patient outcomes. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time and used information from the audits to improve care and treatment.

Please refer to the main surgical report for further outcomes at this hospital.

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. Effective recruitment systems were in place to ensure staff were suitably skilled to work in their roles. Managers supported staff to develop through yearly, constructive appraisals of their work. The staff appraisal rate at the time of our inspection was 100%.

Staff told us they had the opportunity to discuss training needs with their line manager and they were supported to develop their skills and knowledge. This included the completion of specialist training to help them develop areas of specialism. For example, around weight loss programme and wound care.

Processes were in place to ensure staff were competent to carry out their roles. This included the formal completion of clinically based competency checks and reviews of doctors continued professional development.

Consultants applying for practising privileges had to demonstrate their competency prior to undertaking any new procedures in the department. This was done by seeking evidence from their NHS practice or private practice.

Multidisciplinary working

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

Patients could see all the health professionals involved in their care at one-stop clinics, such as weight loss review.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. It was also clear that each member of staff recognised their role and responsibility in the care of the patient and escalated any concerns effectively.

Seven-day services

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

The hospital was open 7 days a week including overnight. The hospital closes overnight by arrangement and only if all patients have been discharged. Clinics ran daily Monday to Friday 8am to 8pm and where required the clinic is open Saturday and Sunday according to patient need and surgeon availability.

Health promotion

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

Good

Outpatients

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle. All patients were asked lifestyle questions and participated in a health assessment to identify any health promotion needs. This included calculating each patients' body mass index and asking questions about smoking, alcohol and other substances that can be abused.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. This was clearly recorded in the patient notes.

Staff made sure patients consented to treatment based on all the information available. Information regarding their cosmetic procedure, risks and alternative treatments were offered to make informed choices.

Staff clearly recorded consent in the patients' records. All records we reviewed had accurately dated and signed consent. Additionally, the service's audits indicated 100% compliance with signing of consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Initial consent for surgery was completed by the consultant providing care in the outpatient's department. All patients undergoing surgery were consented by the consultant providing care during outpatient consultation. We did not observe any consultation appointments with individual consultant as these clinics were not running on the day of our inspection, however, upon reviewing patient individual records we saw evidence of consent being signed and dated from consultant and patient.

Is the service caring?

Good

This service was not rated prior to this inspection. We rated it as good because:

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 in a respectful and considerate way and made them feel comfortable in their interactions.

The 4 patients we spoke with said staff treated them well and with kindness throughout their patient journey.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Good

Outpatients

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 emotional support and advice when they needed it. We saw how staff supported patients and made them feel less distressed and concerned about their upcoming procedure and post operatively care and realist expectations around healing.

Staff understood the emotional and social impact that a person's care, treatment, and condition had on their wellbeing and on those close to them. We heard from a patient the importance staff had in making them feel valued and the impact this had on their self-esteem following their weight loss surgery.

Understanding and involvement of patients and those close to them

Staff supported and involved patients to understand their condition and make decisions about their care and treatment.

Staff made sure patients understood their care and treatment. We observed 4 patient clinics and saw staff interactions with their patient was very caring, staff explained the procedure and follow up care clearly and concisely and where happy to explain anything that was not understood.

Staff talked with patients, families and carers in a way they could understand, using interpreters where necessary.

Is the service responsive?

Good

This service was not rated prior to this inspection. We rated it as good because:

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of service users.

All procedures were carried out on patients aged 18 and above only.

Managers planned and organised services to meet the needs of their patients. Appointments were booked to accommodate people's available days and took into account recovery times.

Managers monitored and took action to minimise missed appointments.

Managers ensured that patients who did not attend appointments were contacted and offered new appointment dates, should this be the wish of the patient.

Managers planned and organised services, so they met the changing needs of the local population. Evening and Saturday morning outpatient appointments were available to ensure that patients who worked or had carer responsibilities could access an appointment at a time that suited them.

Good

Outpatients

Meeting people's individual needs

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

The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters when needed. The service had access to a telephonic interpreter service if required.

A person-centred approach was used to ensure patients received the support they needed to undergo agreed procedures within outpatients. The service offered patients tailored after care compression vests. These were important to support the healing process post-surgery.

Information about care and treatment was presented to people in a format that supported them to promote effective recovery. In addition to written and pictorial information about post-operative recovery and rehabilitation. Patients we spoke with told them they found this helpful as it helped to reinforce the advice given at outpatient appointments when they were completing their rehabilitation programmes in their home environment.

Access and flow

People could access the service when they needed it and received the right care whilst respecting agreed time frames. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were managed well.

People could access services and appointments in a way and at a time that suited them. All the patients we spoke with told us told us they had arranged appointments that were organised to meet their needs rather than the needs of the hospital.

Patients could book appointments through the centralised team or the website, and bookings administrative staff screened referrals and referred to the appropriate specialism.

A proactive and holistic approach to pre-operation assessments meant discharge planning began in the outpatient's department before a patient had been admitted for surgery. This proactive approach ensured patients had the right support and equipment in place to support and facilitate safe discharge which meant the risk of delayed surgical discharges was reduced.

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 and service users knew how to complain or raise concerns. The service complaints policy was available for patients to access. The service received 27 complaints in total for hospital informal complaints in the last year.

Due to the new complaints policy not being finalised at the time of our inspection there was no information displayed in patient areas. The service had new posters planned to display once the policy had been signed off.

Staff understood the policy on complaints and knew how to handle them. We spoke with staff who were able to identify how to support a complaint, be it informal or formal, and how it was escalated and managed by senior managers.

Good

Outpatients

Managers regularly reviewed feedback received through search engines, social media and feedback forms. They shared feedback with staff and learning was used to improve the service. We saw evidence of this resulting in the improvement of aftercare monitoring calls following an informal complaint and feedback from social media posts.

Is the service well-led?

Good

This service was not rated prior to this inspection. We rated it as good because:

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.

The department manager told us they were well supported and represented by the senior management team. They told us there were positive working relationships.

Please refer to the main surgical report for further information on leadership.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders and staff understood and knew how to apply them and monitor progress.

Staff understood the vision of the service and the delivery strategy.

Please refer to the main surgical report.

Culture

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

Staff we spoke with said they felt valued and cared for. They felt there was a good culture amongst staff and managers that promoted good relationships and quality of care for patients.

Leaders and staff we spoke with said they felt empowered to raise concerns and address any issues the service faced, openly and honestly.

Some staff described the staff and organisation as a 'family'. They told us they were well supported and felt valued as the management team took the time to get to know people by name.

Staff were proud of the organisation as a place to work and spoke very highly of the culture.

Good

Outpatients

Governance

Leaders operated effective governance processes, throughout the service. 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.

Audits were reported to the medical advisory committee where action plans to address the findings of the audits were recorded and lessons learnt identified. Staff we spoke with understood the management structure at the hospital and knew who they were accountable to.

Please refer to the main surgical report.

Management of risk, issues and performance

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

Performance issues were escalated to the appropriate committees and the board through clear structures and processes. Individual consultants were able to highlight issues and request to commence new procedures at the hospital. The MAC meeting minutes were sent out to all consultants with practising privileges.

Staff knew how to identify and escalate relevant risks and issues and identified actions to reduce their impact. The service used a risk register to monitor key risks. These included relevant risks to the organisation and action plans to address them.

Please refer to main surgical report for further information.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure.

The service had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The service provided mandatory general data protection regulation (GDPR) training to all staff. The service also had up to date and relevant policies to support this, such as their consent and GDPR policy.

The service audited their notes and patients records for completeness and compliance with the service policies. We were also told that electronic notes were stored on a secure cloud-based system that was only accessible to staff and was password protected.

Prospective patients were supported to access the information needed to make decisions about their care. The location's website was easy to navigate and displayed the services offered. Prospective patients were also directed to the Private Healthcare Information Network (PHIN) website to enable them to access the information required to make informed decisions relating to which doctor to request their appointment with.

Staff could access information such as policies and procedures in paper and electronic format. The policies we viewed were up to date and based on current evidence.

Good

Outpatients

Engagement

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

The service ensured that people considering or deciding to undergo cosmetic surgery were provided with the right information and considerations to take account of to help them make the best decision about their choice of procedure and associated risks. This was evidenced clearly in the patient's record and needed consent from the patient before proceeding with any procedures.

People's views and experiences were gathered and acted on to shape and improve the services and culture. The service had several ways to engage with the public and service users including social media feedback forums and a patient's suggestion box in the reception. Patients were encouraged to leave feedback on discharge or to send feedback through email after discharge in the interim period while they are finalising their complaints and feedback processes. Patients were also regularly asked if they were happy and whether they needed anything else to improve their experience and those were acted upon immediately where possible.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff were supported to access specialist training to develop their skills and improve patient care. This included training in, leadership, tissue viability and wound care.

Please refer to main surgical report.

Good

Diagnostic imaging

Safe	Good
Effective	Inspected but not rated
Caring	Good
Responsive	Good
Well-led	Good

Is the service safe?

Good

This service was not rated prior to this inspection. We rated it as good because**:**

Mandatory training

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

Staff received and kept up to date with their mandatory training. The mandatory training met the needs of patients and staff. Mandatory training included topics, such as infection prevention and control, basic life support, safeguarding, moving and handling, health and safety, equality and diversity. We spoke with a radiographer who told us they worked under practicing privileges and all completed training was shared with Burcot Hall Hospital.

Most mandatory training was available electronically with staff also receiving annual face to face training. The face-to-face training included basis life support, fire, moving and handling and infection prevention. Staff were assigned to mandatory training modules appropriate to their role. All staff were required to complete key modules, such as fire safety, information governance.

The lead radiographer told us that they were the only staff member that was currently working at Burcot Hall Hospital with practicing privileges. We saw evidence that they were fully compliant with all mandatory training.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse, and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Three levels of safeguarding training were available to staff dependent on their role. Training records showed us that safeguarding adult level 2 and safeguarding children level 3 was at 100%.

The radiographer manager told us radiographers received level 3 children's safeguarding training. Which included child sexual exploitation training. This was in line with the safeguarding children and young people intercollegiate document (2019).

Staff we spoke with said they had not had to report any safeguarding concerns. However, they knew who the safeguarding leads were and who to contact for advice should they have any safeguarding concerns.

Information about safeguarding was displayed on the noticeboard within the hospital to assist staff access timely advice and support from the safeguarding lead.

Cleanliness, infection control and hygiene

The service-controlled infection risk well; however, x-ray equipment was not always kept clean. The premises were visibly clean.

There was 1 x-ray room, the room appeared visibly clean with suitable furnishings. The room we inspected had hand-washing facilities, antibacterial hand gel, paper towels, and cleaning wipes available. We saw posters displaying the World Health Organisation's 'five moments for hand hygiene.'

Cleaning records for the x-ray machine were not kept up to date, we saw an example of their daily cleaning records and found latest check was dated June 2022. This did not demonstrate to us that equipment was cleaned regularly. We saw some dust on the x-ray machine, we raised our concerns with the radiographer who assured us that this was going to be rectified as soon as possible and told us that cleaners complete their own cleaning checks who also cleaned the x-ray machine. They also informed us that the x-ray machine was not used daily but would ensure it was cleaned daily despite if in use or not.

We saw antibacterial hand gels were available across the department and available for staff and visitors. Personal protective equipment was available and used as necessary. Staff had arms bare below the elbow when within the clinical area which is best practice to assist effective hand hygiene and infection prevention. We saw latest audit that showed us a 100% compliance rate for hand hygiene and infection prevention and control.

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.

Clinical waste was sorted and disposed of in appropriate, foot-operated waste bins. Sharps disposal bins were labelled correctly and not overfilled and did not appear to contain inappropriate waste.

The x-ray room was located on the ground floor of the hospital adjacent to outpatients and close to the main reception. The location made it easy for patients to go between outpatients and diagnostics if x-rays were requested. The service had enough suitable equipment to help them to safely care for patients.

The service was in the process of implementing a picture archiving and communication system (PACS) to store patient images. This consisted of local and off-site servers for clinicians to securely access and view images.

Staff carried out daily safety checks of specialist equipment. The service had a maintenance contract in place to attend to any faults identified in the running of the equipment, staff reported there was a prompt response to any defect identified in the equipment.

Good

Diagnostic imaging

Staff wore lead aprons to protect themselves from the risk of radiation exposure. There were 2 lead aprons available, that were tested annually to ensure their effectiveness. The radiographer told us that they recently had a new wall built within the x-ray room, this enabled the operator to make exposures from behind the new wall negating the need to wear additional PPE. We saw the lead aprons safety and cleaning checks were routinely done monthly and signed by the lead radiographer.

The service stored hazardous substances appropriately and in accordance with the Control of Substances Hazardous to Health Regulations 2002 (COSHH). COSHH is the law that requires employers to control substances that are hazardous to health.

We reviewed the hospital "Health and Safety Floor Walk" December 2022 audit for the environment checks and found a compliance rate of 94% against hospital target of 100%. Action plan had been implemented and areas for improvement were being actioned.

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.

The department had written and displayed local rules, as required by the Health and Safety Executive, in all areas for work with x-rays.

Systems to promote security and safety were in place and well managed. There were alarm systems for secure access areas and key coded locked doors. There were fire alarm procedures and extinguishers were available and well maintained.

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.

Staff comprised of one radiographer with plans in place for further 2 radiographers once they had completed their training. There were no radiologists employed directly by the service, with all radiologists working under practising privileges. All radiologists carried out procedures that they would normally carry out within their scope of practice within their substantive post in the NHS. Staff new to the hospital received a formal induction and could work under practising privileges only for their scope of practice covered within their NHS work.

All consultants were requested to provide documented evidence of an annual appraisal so that it could be used as part of their revalidation process.

There were no vacancies within diagnostic imaging. Sickness rate was 0%. All activity was scheduled in advance if a radiographer was required on site, this was arranged in agreement with the surgeon, anaesthetist, and radiographer to ensure availability.

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.

Good

Diagnostic imaging

Patient notes were comprehensive, and all staff could access them easily. Staff had completed mandatory on-line training, which includes information governance and the consequences of any breach in line with national legislation.

All computers observed were locked and password protected when not in use. Computers were in rooms out of public areas which reduced the risk of confidential patient information being seen by other patients or visitors.

Records were stored securely. We reviewed records during our inspection, please refer to the main surgery report for further details.

Incidents

Staff recognised incidents and near misses and reported them appropriately. 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. An electronic system was used to manage incident reporting. Please refer to the main surgery report for breakdown of incidents.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Staff we spoke with confirmed they had reported incidents such as the quality of x-ray information and images. They told us they received feedback following their reports of these incidents.

The service reported no never events. Managers shared learning with their staff about never events that happened elsewhere.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care.

Is the service effective?

Inspected but not rated

We currently do not rate effective for this type of service.

Evidence-based care and treatment

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

Staff followed up-to-date Burcot Hall Hospital policies to plan and deliver high quality care according to best practice and national guidance. We reviewed the standard operating procedures (SOPs) in place across the department and saw they were clear and up to date. We saw the SOPs were based on national guidance and regularly reviewed.

Good

Diagnostic imaging

The service used national diagnostic reference levels (DRLs) for each piece of scanning equipment that produced radiation. DRLs are used as a guide to help promote improvements in radiation protection practice. They can help to identify issues relating to equipment or practice by highlighting unusually high radiation doses.

The hospital had processes in place to ensure that they did not discriminate on the grounds of protected characteristics. The hospital had an up-to-date equality and diversity policy. Equality and diversity training was part of the mandatory training programme.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. The service adjusted for patients' needs.

Patients received information to advise about timescales for when they could eat and drink in advance. This was provided at the time of booking, in the appointment letter and by text message.

Water and hot drinks were available in the waiting room for patients and those attending with them.

Pain relief

The service managed patients' pain effectively.

We did not observe any patient interactions during this inspection as the service did not run on this day of inspection. However, staff told us they would ask patients if they were comfortable during their x-ray. If patient were uncomfortable patient would be seen to and made to feel comfortable.

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 participated in relevant national clinical audits. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw staff practice and records of images were audited against best practice and national guidelines such as completion of x-ray films. The audit was broken down to gender, rejected images and additional images.

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. There were records of radiographer's Health and Care Professional Council registration in line with the Society of Radiographers' recommendations.

There was information on the intranet and printed copies displayed for staff to access that covered up to date information about the local and national guidance.

Managers supported staff to develop through yearly, constructive appraisals of their work. Data provided showed, at the time of the inspection, 100% of staff were up to date with their appraisal. Staff said they found the appraisal process to be of value and development opportunities were identified through it.

Good

Diagnostic imaging

All radiologists working in the department had practising privileges which gave them the authority to work at the hospital. Appraisal information was shared by their main employer (usually a local NHS trust). This included their most recent appraisal, information with regards to training and competencies and their area of work and area of expertise.

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 held regular and effective multidisciplinary meetings to discuss patients and improve their care.

Patients could see all the health professionals involved in their care. There was effective team working between diagnostics staff and other staff groups within the hospital. We saw staff prioritised the patient experience and communicated well to meet their needs.

Radiologists were accessible and there was a good working relationship with staff across the hospital. Staff told us they could contact them for support and guidance.

Seven-day services

Key services were available to support timely patient care.

The service ran when and if needed, the radiographer, consultant and anaesthetist worked closely, the radiographer would be scheduled in advance for when a patient required an x-ray. The lead radiographer was the main point of contact for x-ray service. The service did not provide an emergency service and the radiographer could be called in if needed but this was normally scheduled.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. There was a range of information displayed on healthy living and health promotion. There were some leaflets available to advise patients about health issues including weight loss surgery.

Consent

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Consent training was completed and up to date.

Staff clearly recorded consent in the patients' records, in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available.

Patients were provided with relevant information including the benefits and risks of procedures at the initial consultation. Patients re-confirmed their consent to procedures on the day of the procedure.

Good

Diagnostic imaging

Is the service caring?

Good

This service was not rated prior to this inspection. We rated it as good because:

We were unable to observe direct patient and staff interaction during this inspection; however, some patient had agreed to speak with CQC over the telephone.

Compassionate care

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

Patient told us that staff took time to interact with them and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness.

Staff followed policy to keep patient care and treatment confidential.

Staff respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

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, support and advice when they needed it.

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

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.

Patients we spoke with told us they were kept up to date and were spoken to in a way they could understand and any questions they had; staff were able to answer questions which eased their anxiety.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make decisions about their care.

Patients we spoke with gave positive feedback about the service.

Good

Diagnostic imaging

Is the service responsive?

Good

This service was not rated prior to this inspection. We rated it as good because:

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of service users.

The hospital and department were clearly signposted and there was ample car parking close to the department. The facilities and premises were appropriate for the services being delivered. Managers planned and organised services to meet the needs of their patients. Appointments were booked to accommodate people's available days and considered recovery times.

Managers ensured that patients who did not attend appointments were contacted and offered new appointment dates, should this be the wish of the patient.

The waiting areas were suitable and comfortable for adults. There was enough seating, toilet facilities and drinks available.

Information was provided to patients prior to their appointments. Information included relevant information about the procedure, any fasting or samples required and directions.

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.

The provider's service policy stated that only those patients who were mentally competent and able to give informed consent were offered treatment.

The service could arrange appointments to suit the specific needs of patients, for example taking into consideration their work commitments, childcare responsibilities or travel constraints.

Interpreter services were available, and staff knew how to contact them.

Access and flow

People could access the service when they needed it and received the right care promptly.

Burcot Hall hospital carried out many orthopaedic cases for the local NHS trust to x-ray patients post operatively to ensure any replacements to hip or knee were in a correct position. Referrals for x-rays were taken from the patient's doctor or a consultant.

The service monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes.

Good

Diagnostic imaging

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received.

Staff understood the policy on complaints and knew how to handle them. Due to the new complaints policy not being finalised at the time of our inspection there was no information displayed in patient areas. The service had new posters planned to display once the policy had been signed off.

Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice.

Please refer to the main surgery report for further information on complaints.

Is the service well-led?

Good

This service was not rated prior to this inspection. We rated it as good because:

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced.

The department manager told us they were well supported and represented by the senior management team. They told us there were positive working relationships.

Please refer to the main surgical report.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.. Leaders and staff understood and knew how to apply them and monitor progress.

Please refer to the main surgical report.

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.

Staff we spoke with said they felt valued and cared for. They felt there was a good culture amongst staff and managers that promoted good relationships and quality of care for patients.

Managers and staff worked collaboratively and shared responsibilities to resolve issues quickly.

Good

Diagnostic imaging

Please refer to the main surgical report.

Governance

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

Staff we spoke with understood the management structure at the hospital and knew who they were accountable to. Audits were reported to the medical advisory committee where action plans to address the findings of the audits were recorded and lessons learnt identified.

Please refer to the main surgical report.

Management of risk, issues and performance

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

The medical advisory committee (MAC) highlighted actions for consultants about performance, risks, concerns and consultant practising privileges. Individual consultants were able to highlight issues and request to commence new procedures at the hospital. The MAC meeting minutes were sent out to all consultants with practising privileges.

Please refer to the main surgical report.

Information Management

The service collected reliable data and analysed it. The information systems were integrated and secure.

The service had arrangements to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The service provided mandatory general data protection regulation (GDPR) training to all staff. The service also had up to date and relevant policies to support this, such as their consent and GDPR policy.

Please refer to the main surgical report.

Engagement

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

The management team and other leaders engaged with staff through a variety of

communication methods to ensure their views on care and treatment were obtained and they were updated about best practice and changes to policies and processes.

Please refer to the main surgical report.

Good

Diagnostic imaging

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

Staff were supported to develop their skills and improve patient care.

Please refer to the main surgical report.