Spire Healthcare Limited

Spire Liverpool Hospital

Inspection report

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

Ratings

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

Summary of findings

Overall summary

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

We inspected two key questions for safe and well-led. Our previous rating for effective, caring responsive was good. These ratings remain the same.

- 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.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Staff did not always receive the rota with sufficient notice so they could make plans.
- Not all staff had completed training in basic life support (BLS).

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 stayed the same. We rated it as good. See the overall summary above for details.

Summary of findings

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Summary of this inspection

Background to Spire Liverpool Hospital

Spire Liverpool Hospital is operated by Spire Healthcare Limited. The hospital was registered with the Care Quality Commission (CQC) by Spire Healthcare Limited in July 2016. Spire Liverpool Hospital is a private hospital in Liverpool, Merseyside. The hospital also has contracts with Liverpool and Merseyside clinical commissioning groups (CCG) to provide treatment for NHS patients. The hospital primarily serves the communities of Liverpool and its surrounding areas. It also accepts patient referrals from outside this area.

The hospital has two wards with a total of 30 single rooms, a six bedded day-case unit, four operating theatres (one of which is a mobile theatre and two are laminar flow theatres mainly used for orthopaedic surgery). The physiotherapy, pharmacy and sterile services are available on site.

The inpatient treatment includes urology, ophthalmology, orthopaedics, minor hand surgery, minor neurosurgery, ear, nose and throat (ENT), gynaecology, endoscopies, general surgery (such as upper and lower gastrointestinal surgery) and cosmetic surgery.

The hospital is registered to provide services for the whole population and sees and treats mainly patients aged 18 years old and over. The hospital provided seven surgical procedures to patients 16 to 17 years old from August 2021 to July 2022.

The hospital provides surgery, outpatient and diagnostic imaging services.

How we carried out this inspection

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process. We inspected the safe and well led key questions of the surgery service and carried out the unannounced part of the inspection on the 10 August 2022.

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

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure staff receive the rota with sufficient notice to be able to make plans.
- The service should ensure all staff complete training in basic life support (BLS).

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
Overall	Good	Good	Good	Good	Good	Good

Good

Surgery

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

Are Surgery safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The service provided statutory and mandatory training using a combination of 'face to face' training and e-learning. We reviewed the staff training matrix and found most staff had completed their mandatory training (98%).

The mandatory training was comprehensive and met the needs of patients and staff. The mandatory training requirements included courses covering quality improvement, infection control, - safeguarding children and adults, fire safety, health and safety, manual handling and equality and diversity. Records provided by the service showed 70% of staff completed training in basic life support (BLS), 22 staff completed training in immediate life support and two staff completed training in adult life support. Managers said the availability of 'face to face' course had been impacted by the COVID-19 pandemic. Staff completed quarterly simulator training exercises on BLS and paediatric basic life support.

Managers monitored mandatory training using a training matrix and alerted staff when they needed to update their training. Managers monitored mandatory training and staff received alerts when training needed to be refreshed. - Nurses and healthcare assistants were required to complete annual refreshers and demonstrate their competency where necessary. Staff we spoke with told us they received reminders to complete mandatory training and they were also reminded at staff meetings. Staff we spoke with told us they had enough time to complete their mandatory training.

Consultants completed mandatory training with their substantive NHS employer and provided annual confirmation of completion of this training to the service in line with the practising privileges policy.

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. Safeguarding children and adults formed part of the mandatory training programme for staff. Staff told us they had received safeguarding training. Clinical staff received safeguarding children and adults training to level two (100%). The safeguarding lead and the registered manager received safeguarding children and adults training to level four. The safeguarding lead supported staff in escalating their concerns and with the referral processes to the relevant local authorities. The service ensured there was a staff member with level three training on duty when children were booked in.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of concerns they would report and knew the contact details for the agencies they would report to. An up-to-date safeguarding vulnerable adults policy, with flow charts for the escalation of concerns, was available.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff understood the importance of supporting equality and diversity and ensuring care and treatment were provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of patients with protected characteristics.

The hospital had a defined recruitment pathway and procedures to help ensure that the relevant recruitment checks had been completed for all staff. These included a disclosure and barring service (DBS) check; occupational health clearance, references and qualification and professional registration checks.

The hospital had an up-to-date chaperone policy.

There were 18 reported safeguarding incidents in the previous 12 months. Records showed they were investigated and reported in line with the service's policy. The safeguarding lead attended external adult safeguarding meetings and child protection board meetings when required.

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.

Clinical areas were clean and had suitable furnishings which were clean and well-maintained. All ward and theatres we visited were clean and had suitable furnishings which were clean and well-maintained. Seamless easy-clean floor covering was used throughout all clinical areas, waiting rooms and toilets. Store areas were tidy and free from clutter.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Items seen were visibly clean and dust-free and we saw a daily cleaning check list.

The service consistently performed well for cleanliness. There were regular infection prevention and control audits and the service consistently performed to a high standard from August 2021 to July 2022. The audits included hand hygiene in theatre (97%), bare below the elbow (100%), urinary catheter continuing care (100%), infection prevention and control (100%) and personal protective equipment (98%).

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The hospital completed daily cleaning checklists for the ward and theatre. All public areas had cleaning schedules. We reviewed a sample of checklists which were up-to-date.

Good

Surgery

Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with personal protective equipment (PPE) such as gloves, aprons and face visors. We observed all staff wore PPE where necessary. Hand-washing and sanitising facilities were available for staff and visitors.

All patients were screened for potential infections such as methicillin-resistant staphylococcus aureus (MRSA) prior to admittance in line with hospital policy. Records showed there were no MRSA, methicillin-susceptible Staphylococcus Aureus (MSSA), escherichia coli (E. coli) *or C.difficile* from August 2021 to July 2022. The hospital reported 42 surgical site infections (SSI) from August 2021 to July 2022.

Staff worked effectively to prevent, identify and treat surgical site infections. Three of the theatres had a laminar flow system, which circulates filtered air to reduce the risk of airborne contamination of wounds and sterile equipment. We saw that the ventilation system within theatres had been regularly checked for bacteria.

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' families. The hospital had been renovated which included updating the rooms on the ward, installing compliant handwashing sinks and new bathrooms. The wards and theatres were designed to allow a good flow between the ward and theatre. Staff had a view of the rooms from the nurses' station. There were individual ensuite rooms and patient privacy was maintained at all times. There were four rooms and bathrooms that had been adapted for patients who were visually impaired or had dementia.

The service had undertaken a Legionella, a health and safety and a fire risk assessment. Records showed the action plans had been implemented to mitigate the risks identified. Staff demonstrated how they had access to evacuation routes in the event of a fire. Water outlets and sinks were flushed to reduce the risk of Legionella build-up in line with Health and Safety Executive (HSE) guidance.

Staff carried out daily safety checks of specialist equipment. The ward and theatres were equipped with enough monitoring equipment for the number of patients treated. Staff carried out checks on equipment such as the resuscitation trolley, emergency call bells and fridge temperatures. Resuscitation equipment was located on a purpose-built trolley and was visibly clean. Single-use items were sealed and in date. Resuscitation equipment had been checked daily and an up-to-date checklist confirmed all equipment was ready for use.

The ward and theatre areas were well equipped and faulty or damaged equipment was repaired or replaced quickly. We reviewed equipment logs and saw that equipment used was serviced within appropriate time frames. Stock and equipment, including disposable instruments, were well managed and recorded.

We saw that theatres had a difficult intubation and a cardiac arrest trolley appropriately sited in accordance with the hospital policy. A quarterly audit was completed for the cardiac arrest trolley and results for September 2021 to July 2022 showed 100% compliance.

Staff disposed of clinical waste safely. Clinical waste disposal was provided through a service level agreement. Clinical waste and non-clinical waste were correctly segregated and collected separately.

Good

Surgery

A patient safety and quality review had been undertaken by the corporate team, led by the clinical assurance director, in March 2022. The report identified areas of improvement in the theatre environment and an action plan had been implemented.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff ensured they had adequate knowledge of the patient's health, any relevant test results and their medicines history. There was a comprehensive pre-operative assessment process that was used for all patients. The hospital had an effective process for assessing patients prior to admission. Patients had a pre-operative assessment to ensure they met the inclusion criteria for surgery and to allow any key risks, that may lead to complications during the anaesthetic, surgery, or post-operative period, to be identified.

Patients with complex co-morbidities would not routinely be admitted for treatment. Admissions were only considered on the presentation of all relevant clinical evidence, a risk assessment and the mitigation of risk and with the agreement from all parties involved in the care of the patient. If there were any risks identified these were discussed by the treating clinicians.

Staff completed risk assessments for each patient on commencement of their treatment, using a recognised tool, and reviewed this regularly, including after any incident. The service used a modified 'five steps to safer surgery' checklist based on guidelines from the WHO Surgical Safety Checklist. We observed the theatre team undertaking the 'five steps to safer surgery' procedures, including the use of the WHO checklist. From December 2021 to July 2022 an audit of the WHO Surgical Safety Checklist in theatre found 99% compliance.

Staff responded promptly to any sudden deterioration in a patient's health. The service had a deteriorating patient policy where patients would be referred to another nearby hospital for specialised care which the hospital did not provide. Staff participated in simulated emergency scenarios quarterly to ensure they maintained skills in responding to a patient collapse or cardiac arrest.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning score (NEWS2) tool to assess for patients at risk of deterioration. From September 2021 to July 2022 the NEWS2 audit found 96% compliance. There was a structured communication tool for handing on information to a clinical colleague about a deteriorating patient. Staff used the situation, background, assessment, recommendation and decision(SBARD) communication tool.

The service transferred 15 deteriorating patients to an NHS hospital in the previous 12 months and records showed the service followed its policies and procedures. There was a service level agreement for patient transfers to the local NHS hospital.

The hospital had procedures for the recognition and management of sepsis and staff described how they would identify a deteriorating patient. Staff completed training on sepsis as a part of mandatory training modules such as infection prevention and control and life support. A standalone sepsis module was available, and all theatre and ward - staff completed it (100%).

Good

Surgery

Staff knew about and dealt with any specific risk issues. Each ward and theatre area had a "huddle" each morning to review any risks including patient safety risks and plan how to address these. We observed a service wide huddle which provided information on any risks and staffing requirements for each day.

In October 2021 the hospital started assisting the NHS trust with patients who were on the trust's waiting list for more than 104 weeks for surgery. All patients who have waited over 52 weeks since referral for first definitive treatment require a clinical harm review to be undertaken. The service had a clinical prioritisation programme and harm reviews were conducted to determine which patients needed to have surgery immediately. From April 2022 to June 2022 133 patients had been reviewed and prioritised.

Staff shared key information to keep patients safe when handing over their care to others. This ensured continuity of care when people moved between services or received care from different staff in this service. Clinicians wrote to the patient's general practitioner after gaining the patient's consent.

Following surgery, patients were provided a 24-hour helpline for advice and help if needed.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. The surgical nursing team included a theatre manager, a scrub, anaesthetic, recovery and theatre support team. A senior member of staff was always on shift when the service was in operation. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants (HCAs) needed for each shift in accordance with national guidance.

The staff to patient ratio requirement was calculated in line with a national safer staffing guidance. The hospital calculated staffing levels in the morning, afternoon and night. - Staff said there is always senior staff on shift and an on-call team in the unexpected event of readmission or returns to theatre. The service monitored the staffing to ensure it provided safe and responsive care.

The manager could adjust staffing levels daily according to the needs of patients. All theatre lists were pre-planned so the number of staff required for each shift, on the ward and in theatres, could be pre-determined. Staff levels reflected demand on the service and known treatment support needs. However, staff told they did not always receive the rota with sufficient notice to be able to make plans. For example, a rota was received on a Friday which started the following Monday. -

Managers limited their use of bank and agency staff and requested staff familiar with the service. From May 2022 to July 2022 bank and agency use in theatre was 18% and, on the ward, it was 17%. The hospital had recently undertaken a recruitment drive to increase staffing and there were currently two vacancies for staff nurses and one HCA.

All staff had a period of induction, and supervision where required, on commencing work at the hospital. Nursing staff had completed their Nursing and Midwifery Council re-validation checks and updates to develop their competencies.

The hospital reviewed staff absence and recruitment and retention information.

Good

Surgery

Medical staffing

The service had enough medical staff to keep patients safe. There were 103 surgeons working under practicing privileges. The hospital performed surgeries in the following disciplines urology, ophthalmology, orthopaedics, minor hand surgery, minor neurosurgery, ear, nose and throat (ENT), gynaecology, endoscopies, general surgery (such as upper and lower gastrointestinal surgery) and cosmetic surgery.

Assessments of applications for practising privileges, from doctors and allied health professionals, were carried out by the Medical Advisory Committee, which reviewed and approved the scope of practice submitted by an applicant. Records we checked showed that the service monitored compliance with the practicing privileges policy.

- There were 43 anaesthetists working under practising privileges. Anaesthetists covered the theatres and wards and were available for emergency surgeries. Resident doctors (RD) covered the day-to-day care of patients on the ward. RD were provided by an external company and there was always an RD on duty 24 hours every day.

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 comprehensive, and all staff could access them easily. The hospital used paper and electronic records, to document patient information securely. Diagnostic images, reports and histopathology results could be viewed electronically. Records could be accessed across the departments, allowing continuity of record keeping. Bank staff could access the records they required.

We viewed six patient care records, which contained the patient's consent form, written theatre record, including observations and discharge information. Records we reviewed were completed appropriately.

Records were stored securely. Paper records were stored securely in a locked cabinet when not in use. Staff completed training in information governance and data protection.

The hospital completed audits such as the single patient record from November 2021 to June 2022 which showed 98% compliance and a pe-operative documentation audit from October 2021 to June 2022 which showed 91% compliance. There was an improvement in the pre-operative document audit score from 72% in October 2021 to 100% in the previous six months.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed best practice when prescribing, administering, recording and storing medicines. The hospital had a medicines management policy, which ensured staff practices were in line with national guidance.

Staff stored and managed all medicines and prescribing documents safely. Medicines were stored in locked cupboards away from the patient areas. Medicine fridge temperatures had been checked and logged appropriately.

Controlled medicines were administered in line with published guidance. Medicines were within date and stored in a secure locked cupboard. Controlled medicines were regularly reviewed and audited to ensure the hospital complied with the standard operating procedures and regulations. The service completed quarterly audits of controlled medicines register and records showed 92% compliance from October 2021 to June 2022 while the security and storage of controlled drugs was 82%.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. Staff said patients were given advice about the medicines prior to surgery as well as post-surgery.

Pharmacists provided cover daily and at weekends and operated a 24/7 on call service to meet the demands of the service.

Staff completed medicines records accurately and kept them up to date. Records we checked showed allergies were recorded where necessary and entries were complete. The service completed several audits to ensure staff followed best practice guidelines. A medicine prescribing audit from December 2021 to July 2022 achieved 91%, medicines storage on the wards 94% and medicines storage in theatre was 95%.

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. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. The hospital had an open incident reporting culture and staff were able to tell us what incidents they would report and how they would report them. They told us the hospital was very proactive in encouraging staff to record incidents on the incident reporting system. Staff said they were encouraged to report 'near miss' situations.

Staff raised concerns and reported incidents and near misses in line with the hospital's policy. We reviewed the incidents data for the previous 12 months and found they were reported and investigated in line with the service's procedure. Incidents were categorised into areas such as infection control, treatment, equipment, medication and operations cancelled. For each incident, the actions taken, and lessons learned were recorded where applicable.

The service had two never events in the previous 12 months. A comprehensive root cause analysis was conducted after each never event and a duty of candour delivered to the patient. - The provider introduced a standardised clinical harm review proforma to be used when potential harm was identified. Where clinical harm was identified, it was mandatory for the hospital to report it to the national governance team to ensure shared learning across the Spire group. The learning from never events was shared with staff to prevent recurrence.

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 gave examples of incidents where the duty of candour requirements applied.

There was evidence that changes had been made as a result of feedback. Staff discussed learning from incidents at clinical effectiveness meetings. For example, staff reinforced the terminology of time out immediately before incision to support multi-site surgery and prevent the wrong site surgery.

Safety thermometer

Good

Surgery

The service used monitoring results well to improve safety. Staff collected safety information and had plans to share it with staff, patients and visitors.

The hospital used safety thermometer data to monitor its performance and identify any significant risks. The service continuously monitored safety performance through the hospital assurance monitoring tool. The hospital reviewed monthly data for pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter associated urinary tract infections.

Records showed there were four cases of hospital acquired venous thromboembolism (VTE – blood clots) and 14 patient falls in the reporting period August 2021 to July 2022. Staff reviewed these to determine how safety could be improved.

Are Surgery effective?

Good

Our rating of effective stayed the same.

We did not inspect this key question at this inspection. The previous rating of good remains.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

Are Surgery caring?

Good

Our rating of caring stayed the same.

We did not inspect this key question at this inspection. The previous rating of good remains.

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

Are Surgery responsive?

Good

Our rating of responsive stayed the same.

We did not inspect this key question at this inspection. The previous rating of good remains.

Good

Surgery

We undertook this inspection as part of a random selection of services which have had a recent Direct Monitoring Approach (DMA) assessment where no further action was needed to seek assurance about this decision and to identify learning about the DMA process.

Are Surgery well-led?

Good

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

Leadership

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

Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver effective and sustainable care. The hospital's senior management team comprised of the hospital director, a director of clinical services, a finance director and an operations director.

The surgical service had an established management structure which included the deputy director of clinical services, pre-operative assessment manager, ward manager, theatre manager and sterile services manager. Each manager had clearly defined roles and responsibilities. This was supported by an effective recruitment program ensuring that the skills and abilities of leaders matched the job profiles required within the hospital.

We found all managers had the skills, knowledge and experience to run the service. Leaders demonstrated an understanding of the challenges to quality and sustainability for the service. For example, the recruitment and retention of staff, adequate staffing levels to match the increase in activity and the impact of COVID - 19.

The leadership team demonstrated an understanding of local and national priorities and responded accordingly. An example of this was the response to the COVID-19 pandemic and the way the hospital adapted to keep patients and staff safe.

The hospital promoted leadership development and succession planning. Managers supported staff to develop their skills and take on more senior roles. We saw examples of staff development. For example, the physiotherapy manager had been promoted to the deputy director of clinical services. Staff were encouraged to complete training in leadership and management.

The hospital had an apprenticeship scheme where six health care assistants were enrolled on the nurse's apprenticeship programme with two operating department practitioners and two sterile services decontamination technicians also completing apprenticeship programmes. Managers demonstrated leadership and professionalism. Staff we spoke with said managers were accessible, visible and approachable.

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. Leaders and staff understood and knew how to apply them and monitor progress.

Good

Surgery

The hospital had a clear vision and strategy. The universal and shared purpose was to 'make a positive difference to people's lived through outstanding personalised care'.

The principles for clinical quality involved providing evidence-based practice in a safe and caring environment and promoting an open leaning culture. Activity and performance included increasing operational efficiencies and introducing value services; the patient journey involved listening and responding to patients and ensuring ease of access to treatment; people and culture included training and development and staff wellbeing.

Plans were consistently implemented, and had a positive impact on quality and sustainability of services. The hospital's objectives were regularly reviewed to ensure the sustainability of the service.

There was a systematic approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. The strategy had clear goals and objectives which were used to measure its success. It was developed through engagement with staff and senior staff members. Quality measures included patient experience, clinical outcomes, staff engagement, recruitment, retention and development.

Staff we spoke with understood the vision and quality measures of the service and how it had set out to achieve them. The staff worked in a way that demonstrated their commitment to providing high-quality care in line with this vision.

The service had a statement of purpose which outlined to patients the standards of care and support services the service would provide.

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.

Managers supported an open and honest culture by leading by example and promoting the service's values. We heard this was promoted by having an open-door policy, interacting with staff daily and doing walk around the service every day.

There were high levels of satisfaction among staff and the hospital had a diverse workforce. Staff were proud of the hospital as a place to work and spoke highly of the culture. Staff said they enjoyed working at the service; they were enthusiastic about the care and services they provided for patients. They described the hospital as a good place to work.

The service provided opportunities for staff development. For example, the physiotherapy manager was promoted to the deputy director of clinical services and six health care assistants (HCA) were complete nursing apprenticeships. A new clinical education programme had been implemented in January 2022 which provided additional courses such as aseptic non touch technique (ANTT), venepuncture and cannulation and venous thromboembolism (VTE).

The- hospital had a raising concerns policy. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. The hospital had a Freedom to Speak Up Guardian who was readily available for staff. All staff we spoke with said they felt that their concerns were addressed, and they could easily talk with their managers. Staff reported that there was a no blame culture when things went wrong. Records showed that where concerns were raised these were fully investigated and the learning was shared with staff.

The hospital created a learning environment so staff could learn from feedback, incidents and complaints. Staff were proficient at recording incidents and 'near miss' situations and learning from them.

Good

Surgery

The patient experience forum met in August 2021 and was attended by the director of clinical services, clinical governance lead, patient experience co-ordinator, hotel services manager and patients. All managers worked collaboratively to improve patients' experience throughout the entire organisation. There was a "you said, we did" poster showing improvements that had been made following the patient forum such as increasing the number of staff available to answer telephone calls and improving menu options for a special diet.

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.

Governance arrangements were proactively reviewed at every level of the organisation through a variety of processes from the ward to the board and from the board to the ward. Information was filtered up from and down to staff. There were various committees with a lead responsible for the meetings and escalating issues.

The provider's board and other levels of governance in the organisation, at both provider and hospital level, functioned effectively and interacted with each other appropriately. The hospital had various meetings which passed information to the committees, such as the medical advisory, health and safety and risk, clinical governance committee and patient experience committee. . Staff discussed the sustainability of the service, future developments such as new services and procedures, the level of activity and quality assurance.

There was an effective clinical governance structure which included a range of meetings that were held regularly. These included the clinical audit and effectiveness, clinical governance, heads of department, departmental, senior management, medicines management and infection prevention and control.

The managers evaluated information and data from a variety of sources to inform decision making that would deliver high quality care to their patients. Staff had the opportunity to discuss changes they wanted to implement.

The medical advisory committee (MAC) represented the professional needs and views of medical practitioners and advised the senior leaders on medical policy and standards. The MAC reviewed the clinical performance of consultants who have been granted practising privileges. They provided a quarterly forum for consultation and communication between medical practitioners and the hospital's senior management team.

Staff were clear about their roles and accountabilities. Clear accounting lines and accountabilities were utilised to ensure oversight and timely information was provided on key performance indicators. The senior management team ensured qualitative and quantitative information was monitored, reviewed and reported.

The hospital director told us learning was cascaded to staff. All staff members had a work email account and updates were sent to staff via email.

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.

Good

Surgery

There was a systematic programme of clinical and internal auditing to monitor quality and operational processes. The service had a comprehensive list of audits and risk assessments that were completed on a regular basis. Staff understood the risk management policy and actively contributed to it. Records showed audits were discussed at various management and staff meetings.

The service reviewed how it functioned and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. The service had key performance indicators (KPI's) in relation to quality, performance, human resources and finance which were regularly reviewed. The service continuously monitored safety performance through the hospital assurance monitoring tool. These outcomes were discussed at regular management, governance and staff meetings.

Risks were identified and addressed quickly and openly. There was a risk management policy, setting out a system for continuous risk management. The service had a risk register which showed the actions taken to mitigate risks. Examples of risks included staff retention, a lack of accreditation for the endoscopy service, non-compliance with regulation and the impact of Covid-19. The risks for the endoscopy service had been mitigated by the corporate provider retaining a consultant endoscopy lead with responsibility for obtaining Joint Advisory Group on gastrointestinal endoscopy (JAG) accreditation and a GAP analysis would be undertaken by the JAG user group.

Staff discussed the risks to the service at various meetings and documented the progress of any outstanding actions. Progress on each action was reviewed at subsequent meetings.

The service had a business continuity plan that could operate in the event of an unexpected disruption to the service.

Information Management

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

The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant. The service had an electronic quality management system, which monitored the performance of the service through data collection on all aspects of the service including incidents, complaints, mandatory training and audits.

All staff had access, via secure logins, to the organisation's intranet to gain information relating to policies, procedures, national guidance and e-learning. All staff we spoke with were able to demonstrate the use of the system and retrieve information.

The service had arrangements and policies to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems were in line with data security standards. The service provided information governance training and most staff completed it (99%).

There were arrangements to ensure data or notifications were submitted to external bodies as required. Staff regularly submitted data to the National Joint Registry (NJR), Patient Related Outcome Measures (PROMS) and the Care Quality Commission.

Engagement

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

Good

Surgery

Managers and staff understood the value of engagement in supporting safety and quality improvements. Staff actively sought patient feedback and patients provided this through surveys, online feedback and emails. Staff acted on patient feedback and there was a "you said, we did" poster displayed which informed patients about the changes that were made.

The hospital completed an annual staff survey and had regular meetings where staff could discuss their concerns. The 2021 staff survey had a high response rate (83%). Records showed that 83% of staff said they were proud to work at the service and 85% would be happy with the standard of care if a friend of family member needed treatment.

Staff made contributions to decision making at the hospital and expressed their views at monthly staff forums. The hospital had a "staff said, we did" initiative which showed how they acted on staff feedback. For example, the hospital improved the lunch menu, added more variety for staff uniforms and increased staff recognition schemes.

The senior management team implemented "back to the floor" and "in your shoes" sessions across all the teams. For example, on a monthly basis the director of clinical services -did a shift on the ward, reception, housekeeping, kitchen or on another clinical team. This provided the senior management team with first-hand experience of any challenges experienced by the teams.

The hospital had a welfare room for staff, separate from the lunchroom, which was being refurbished. The welfare room provided a quiet, neutral room in a supportive environment for staff to take breaks.

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.

There were open and transparent reviews of incidents and complaints and learning was consistently shared with staff to improve patients' experience. The hospital reviewed and completed a root cause analysis for all serious incidents. Staff were supported by a national patient safety team who reviewed all serious incidents and supported with ensuring relevant action was taken at the weekly national incident review working group (IRWG).

The hospital used 48-hour flash reports to share learning from incidents and safety concerns across the Spire group. The reports had actions for each hospital to take to provide- assurances and the service actioned them.

There was a surgical safety guardian in theatre to drive and empower the highest safety standards. The surgical safety guardian was supported by a national Spire patient safety ambassador and regular clinical supervision meetings.

The patient experience committee discussed learning from complaints and patient feedback to ensure effective action was taken.

The heads of department (HOD) were supported by national clinical specialists for each service such as the wards, and theatres. Engagement calls were held fortnightly across all 39 Spire sites and this provided HOD the opportunity to discuss service specific issues, provide peer support and supervision. These sessions were supplemented by an annual national conference for each specialty area.

Good

Surgery

The hospital completed a number of quality improvement (QI) projects in the previous twelve months which included a national post-operative foot drop protocol, a reduction of falls national project and had recently launched a project to reduce the length of time patients stay in hospital following joint replacement surgery. The hospital was also undertaking QI projects on patient reported outcome measures (PROMS), patient discharge experience and pre-operative fasting times.

The hospital has been awarded the National Joint Registry data quality award each year since 2019.