Spire Healthcare Limited

Spire Bushey Hospital

Inspection report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

Overall summary

Our rating of this service improved. 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, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients. Key services were available seven days a week.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

However:

- The chair of the Medical Advisory Committee (MAC) and Director of Clinical Services were not permanent staff
- There was not full oversight of what was on the risk registers
- The medication cupboards in theatre were not locked
- Not all agency staff inductions were complete

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good 	Our rating of this service improved. We rated it as good because we rated safe, effective and well led as good. We did not inspect caring or responsive as part of this inspection.

Summary of findings

Contents

Summary of this inspection

Background to Spire Bushey Hospital

Spire Bushey Hospital is a purpose-built private hospital managed by Spire Healthcare. The hospital provides care for private patients who are either covered by their insurance companies or are self-funding. Patients funded by the NHS, mostly through the NHS referral system can also be treated at Spire Bushey Hospital. There are two inpatient wards, Lea Ward is on the ground floor and Gade Ward is on the first floor. There are 80 patient bedrooms, 68 with en suite and 12 day care rooms. On the day of our inspection Gade Ward, which is used for day cases, was not in use. There are six operating theatres, four with laminar flow. The services include, but are not limited to, orthopaedics, gynaecology, general surgery, urology and ophthalmology. Pre-assessments are carried out at Spire Bushey Diagnostic Centre, which is a short distance from the main hospital site. All patients are admitted and treated under the direct care of a consultant and medical care is supported 24 hours a day, seven days a week by an onsite resident medical officer (RMO). Patients are cared for and supported by registered nurses, care assistants and allied health professionals such as physiotherapists who are employed by the hospital. At the time of our inspection, there was a hospital director and interim director of clinical services.

We last inspected the service in January 2021 and in response to the concerns we found we issued the hospital with a Section 29A warning notice. We carried out a further focused inspection on 28 September 2021 to follow up on their compliance to the warning notice.

How we carried out this inspection

We carried out an unannounced focused inspection of the surgical services at the hospital on 28 September 2021. We visited the ward, theatres, recovery and pre-operative assessment clinic. We spoke with 15 members of staff, including consultants, nursing staff, senior leaders and administration staff and one patient. We reviewed 10 patient records.

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

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 medication cupboards are locked
- The service should ensure all agency staff have a complete induction

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

Safe	Good
Effective	Good
Well-led	Good

Are Surgery safe?

Good

Our rating of safe improved. We rated it as good.

Mandatory training

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

Nursing staff received and kept up to date with their mandatory training. There were 11 mandatory training modules to be completed annually, with a target for all teams of 95%. In October 2021, compliance rates among the pre-operative assessment team were 100% for all modules. Theatre staff compliance was at 98% for all training and for ward staff only one module, Compassion in Practice, was below target at 93%. The training year ran to the end of March 2022, meaning there was six months for the remaining staff to complete their mandatory training.

The overall compliance rate for life support training was 96%. Of the four staff who had not completed any training, three were new starters and one was absent from work. There were plans to introduce a virtual resus training programme in October 2021.

Medical staff completed mandatory training via their employing NHS trust. The agency Resident Medical Officers (RMO) completed their mandatory training through their agency and at Spire on induction.

The mandatory training was comprehensive and met the needs of patients and staff. Training included infection control, safeguarding and manual handling.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training was a standard agenda item at the team meeting and minutes confirmed this.

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.

All staff received training specific for their role on how to recognise and report abuse.

As at October 2021, adult safeguarding training had been completed by 89% of pre-operative assessment staff, 97% of theatre staff and 88% of ward staff. Safeguarding children training had been completed by 89% of pre-operative assessment staff, 95% of theatre staff and 91% of ward staff. The end of year training target of 31 March 2022 was 95% compliance.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Safeguarding adults and children policies were in-date and accessible to all staff. There was a flow-chart which included local leads and contact details for the local authority safeguarding teams.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of what a safeguarding concern would be and knew who to contact for support. The safeguarding leads, including their photographs were displayed on noticeboards in theatre and on the wards.

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.

At this inspection three of the bedrooms were still without second clinical hand wash basins. One had a portable handwash basin installed and had been risk assessed as safe to use by the Infection, Prevention and Control (IPC) lead. Another was being used as a storage room. The third one was attached to another room via folding doors. Day case patients were nursed in this room, which had an en suite bathroom with a hand basin and hand gel was available inside and outside the bedroom. The use of this room was under review and any clinical works required would be included within the capital expenditure Plan for 2022.As rooms were being refurbished and basins installed, the risk level had been reduced and a risk assessment put in place.

Department of Health Guidelines 2013 HBN009 state that 'Ensuite single bedrooms should have a general wash-hand basin for personal hygiene in the ensuite facility in addition to the clinical wash-basin in the patient's room'. Whilst this guidance applies to all providers of NHS care, it is in relation to new build NHS hospitals.

Government guidance was available on COVID-19 with posters displaying wash hands, cover face, make space. There were one-way floor markings, plastic screens around the nurses' stations and signs stating the number of people that could be in a room/area. There were floor markings to indicate whether an area was red or green.

There was an IPC display on the ward which detailed leads, committee meetings, COVID guidance and the bare below elbow requirement.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. There was a cluttered room on the ward, which we were told was temporary due to another room being refurbished. 'I am clean stickers' were used in all areas to signify they were clean and ready for use.

The service generally performed well for cleanliness. IPC audits completed included environment, hand hygiene, bare below the elbow and PPE. Results for June, July and August 2021 were all above 95% compliance. All staff were required to complete IPC training annually and the deadline was 31 March 2022. As of October 2021, the completion rates were 100% for pre-operative assessment staff and 98% for ward and theatre staff.

Staff used records to identify how well the service prevented infections.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw the correct use of (PPE) such as disposable gloves, aprons and masks. PPE was available in all clinical areas. Staff in theatres wore

appropriate theatre clothing (scrubs) and designated theatre shoes were worn. This was in line with best practice (Association for Perioperative Practice (AfPP), Theatre Attire (2011). Staff followed the hospital's policy on infection control, for example, we observed staff complying with 'arms bare below the elbow' and not wearing jewellery. Face masks were worn by all staff, which was in line with COVID-19 guidance.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were used throughout the department. In theatre, we observed clean and dirty flows of instruments. The Central Sterile Supply Department was on site with clean and dirty lifts for access.

Staff worked effectively to prevent, identify and treat surgical site infections. There were systems to prevent and protect people from a healthcare associated infection and ensure standards of hygiene and cleanliness were maintained. This was in line with current guidance from the National Institute for Health and Care Excellence (NICE) Quality Standard (QS) 61: Infection Prevention and Control (April 2014). There were three surgical site infections between October 2020 and September 2021, this was a rate of 0.06 per 100 patients.

Environment and equipment

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

The design of the environment followed national guidance.

The ward environment and equipment were clean and free from dust. Inpatient rooms were clean and tidy. The operating theatre layout was clutter free.

Staff carried out daily safety checks of specialist equipment.

Emergency equipment for the wards was stored in the corridors with clear access. Records indicated that the resuscitation trolleys and their contents were checked daily in line with hospital policy. The trolleys were secured with tags which were removed monthly to check the entire contents were in date. Items had details of service date on them and were dated for next service. Theatres also had a difficult airway trolley which was checked daily.

We found medical gas cylinders were now securely stored against the wall in a separate area, labelled and checked. In recovery there was a transfer bag which had been checked. The emergency drug box and anaphylaxis box were labelled and sealed. On both the ward and in theatres there were posters displayed with the locations of other emergency equipment. Fridge temperatures were checked daily and within range.

The service had enough suitable equipment to help them to safely care for patients.

There was an equipment register and loan equipment was available if required. There were bariatric chairs and commodes if needed.

The hospital also recorded implants used on national registers, such as the breast implant register and national joint register (NJR). This showed which patient received which type of implant and when, to allow tracking if needed.

Staff disposed of clinical waste safely.

Good

Surgery

Assessing and responding to patient risk

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

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

The National Early Warning Score (NEWS2) was used to identify deteriorating patients. Staff recorded routine physiological observations, such as blood pressure, temperature, and heart rate, all of which were scored according to pre-determined parameters. At our previous inspection we found that these were not always documented and escalated appropriately. We reviewed 10 records during this inspection and found all had NEWS completed correctly. NEWS audits for June, July and August 2021 showed 100% compliance.

Staff told us that if a patient's NEWS score indicated they were deteriorating they would escalate it to the nurse in charge.

Staff now completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

There was a new pre-operative assessment manager, and the team had been relocated to the Spire Bushey Diagnostic Centre with redesigned facilities. All referrals went to the Director of Clinical Services first to confirm that the procedure met their criteria, before going to the Pre-operative Assessment (POA) team. There was a new electronic pre-operative assessment (EPOA) system which was being implemented across Spire hospitals with Bushey as the pilot. There was a flow chart for staff to follow and if they had significant concerns a multi-disciplinary (MDT) meeting would be held. We saw evidence of this being requested in the notes we reviewed. The hospital held weekly planning meetings with the interim director of clinical service, pre-operative assessment, theatre staff, ward manager, physiotherapy and pharmacy to discuss all surgical admissions for the following week to review care needs.

The service used the American Society of Anaesthetists (ASA) classification system to grade the patients' level of risk before surgery. For example, patients classified as ASA1 were low risk and healthy, while ASA3 patients were higher risk, with severe systemic disease. ASA grades were recorded at pre-assessment by the nursing team, and on admission for surgery by the anaesthetist in the patient record. At our last inspection we found these scores were not always documented and the scores often differed between the POA nurse and the anaesthetist.

The ASA grading in pre-operative assessment by nurses and anaesthetists was audited regularly to assess whether the changes made were impacting ASA compliance. The target was to achieve greater than 90% compliance, while recognising that where the POA nurse over-grades a patient, it would not be a safety concern. Compliance had been improving since the audit began, with results for June at 90% and July 100%. For August, compliance had dropped to 88%, but this equated to one patient. A one to one had been held with the nurse involved.

Of the ten records we reviewed at this inspection, one had a different score whereby the nurse had scored the patient at higher than the anaesthetist. This was an over-grade and therefore not a safety concern.

Staff knew about and dealt with any specific risk issues.

Nursing staff used nationally recognised tools to assess patients' risk of, for example, developing pressure ulcers (Waterlow), malnutrition (malnutrition universal screening tool (MUST)), falls, infection control, and risks associated with moving and handling. At our last inspection, we found that these were not always completed in line with policy. At this inspection, they had been completed in all ten sets of notes we reviewed.

Good

Surgery

National guidance states all surgical patients should be assessed for risk of venous thromboembolism (VTE) (a condition in which a blood clot forms most often in the deep veins of the leg, groin, arm, or lungs) and bleeding as soon as possible after admission to hospital or by the time of the first consultant review. Reassessment of VTE and bleeding risk should be undertaken at the point of consultant review or if the patients' clinical condition changes (NICE, Venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism [NG89] (March 2018)). VTE risk assessments were completed daily and correctly for all patients in the records we reviewed. A VTE audit was completed monthly and for June, July and August 2021, compliance was 100%.

Sepsis is a serious complication of infection. Early recognition and prompt treatment have been shown to significantly improve patient outcomes. Staff received training in sepsis management and all patient rooms had a sepsis screening tool assessment sheet. There was a sepsis trolley on the ward which contained the equipment and medicines staff needed to treat sepsis.

Staff shared key information to keep patients safe when handing over their care to others.

The hospital had a transfer agreement in place with the local acute NHS trust should a patient require a higher level of care. Patient notes were given to the ambulance staff with a transfer handover sheet.

Nursing staff completed a discharge summary letter for the patient's GP which could be sent via an online system or for the patient to take to their GP.

Shift changes and handovers included all necessary key information to keep patients safe.

The theatre team held a 'huddle' at the beginning of every day. These meetings were documented for staff to refer to. Ward staff held early morning handovers from the night staff to the day staff. These ensured the safe handover of patients and allocation of work was completed. During our inspection, we observed a crash huddle in which the resus team roles were allocated. These were held every morning, attended by the RMO, resus lead and ILS team. The Director of Clinical Services led the huddle we observed as the RMO was in training.

We observed the complete World Health Organisation (WHO) surgical safety checklist pathway. Although most staff were fully engaged, the consultant anaesthetist was not fully engaged in the initial check in process. WHO recommends both the anaesthetic practitioner and anaesthetist complete a full check of the patient including consent and medical history during the initial sign in process. All staff within the operating room completed the required processes in line with WHO, handover to the recovery nurse was also performed as per recommended guidance.

Swabs and instrument checks were completed correctly. The service audited WHO checklist compliance and results showed June, July and August 2021 at 100%.

Staff were supported by an RMO if a patient's health deteriorated who was on duty 24 hours a day and was available on site to attend any emergencies.

The RMOs were able to contact the consultants for further support including out of hours. They had contact details for each speciality provided at the hospital if they could not reach the surgeon who had done the procedure.

Good

Surgery

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 However agency staff did not always receive a full induction.

The service had enough nursing and support staff to keep patients safe.

Data we reviewed, and observations made during our inspection confirmed there was enough staff to provide the right care and treatment. The service had also recruited additional Healthcare Assistants.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Theatre planning meetings were held on a Thursday, the rotas were then reviewed for the following week. A new staffing acuity tool was being implemented which calculated requirements based on occupancy and acuity. The new tool produced an increase in the number of patients to nurse ratio and staff told us this did not always feel manageable. We raised this during the inspection and were told that the change was made because the previous tool was designed for larger hospitals and it was felt it did not work at Spire Bushey. Although staff had more patients it was still below the recommendation and would take time to adapt as previously, they were over staffed.

The operating department used guidance set out by the Association for Perioperative Practice (AfPP) in 2015 related to safe staffing levels; 'Safe Staffing Levels for the Peri-operative Environment as a staffing tool (2015)'. Theatre lists were planned in advance and staffed accordingly. There were opportunities to escalate concerns at the daily huddle. On call staff were allocated.

The ward manager could adjust staffing levels daily according to the needs of patients.

Staffing was reviewed the day before and escalated to the Director of Clinical Services if agency cover was required. Staff told us that if they had a particularly unwell patient, additional staff could be requested.

The number of nurses and healthcare assistants matched the planned numbers.

For the year to September 2021, the hospital reported 100% of shifts were filled.

The service had reducing vacancy rates.

Vacancy rates had been steady at three since June 2021 in pre-operative assessment and declining in the other departments. On the ward, rates ranged from seven in May 2021, to five in September 2021; in theatres they had reduced from 10 in May to three in September.

The service had reducing turnover rates.

For the year to September 2021, the turnover rate in pre-operative assessment was 0%. In theatres it had been below 2% every month apart from July 2021 where it was 5.4%. Rates on the ward had been declining since June 2021 at 6.4% to September 2021 at 2.4%

Good

Surgery

The service had reducing sickness rates.

Sickness rates had been declining on the ward and in pre-operative assessment since May 2021. In September 2021 it was 0.06% on the ward and 0% in pre-operative assessment. In theatre, between January and July 2021 sickness rates were below 5%. Rates for August and September 2021 were higher at 13.8% and 7.7% respectively.

The service had reducing rates of bank and agency nurses.

For the year to September 2021, bank and agency usage in pre-operative assessment was below 3% every month, with no usage at all in July and August 2021.

In theatres and on the ward, rates had been below 4% every month apart from July 2021 on the ward which was 4.83%.

Managers limited their use of bank and agency staff and requested staff familiar with the service.

The use of agency staff was kept to a minimum. Heads of department were encouraged to liaise with other departments to arrange cover before escalating to the Director of Clinical Services to request agency cover. There was a system used which helped request agency staff that were familiar with the hospital.

Managers made sure all bank and agency staff had a full induction and understood the service.

Agency staff were given an induction on the day. There was an agency induction checklist. However, of the two we checked in theatre one was found to be incomplete.

Medical staffing

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

The service had enough medical staff to keep patients safe.

Patient care was consultant-led. Consultants were available for advice and/or to review admitted patients. They provided 24-hour on-call cover for patients post-operatively and were required to be within a 40-minute drive of the hospital when off site. At our previous inspection, staff told us it could be challenging to reach them, and that although it was mandatory for all admitting consultants to visit their patients at least once per day, they often had to chase them. At this inspection access to doctors had improved. There was a list for those on annual leave and cover detail. Consultant daily visits were audited and compliance for June, July and August 2021 was 100%. We were told that if a consultant did not visit their patient in a 24-hour period, it would be reported as an incident to ensure it was escalated and included in each consultant's annual appraisal and biennial review.

All consultants who worked at the hospital did so under practising privileges. This is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in a private hospital or clinic.

The hospital had a medical advisory committee (MAC) whose responsibilities included ensuring new consultants were only granted practising privileges if deemed competent and safe to practice. All consultants carried out procedures within their scope of practice within their substantive post in the NHS.

Immediate medical support was available 24 hours a day, seven days a week.

This was covered by two agency RMOs who worked seven days on, seven days off. In addition to this, there was another RMO employed directly by Spire to provide support on the hospital's busiest days. They worked Wednesdays, Thursdays and Fridays 8am until 8pm.

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.

We reviewed ten sets of notes during our inspection and found they were legible, up-to-date and contained all relevant information regarding patients' care and treatment.

Not all patient records included the referral letter. We were told following the inspection that this was because some patients self-referred. To share information with all their hospitals, Spire circulate information called 48-hour flash reports. They issued one of these reports advising hospitals to ensure that this was clearly documented by the consultants. A single patient record audit was completed monthly and showed 100% compliance for June, July and August 2021.

Risk assessments were completed from the start of the patient's pathway in pre-operative assessment through to admission.

Nursing staff completed a discharge summary letter for the patient's GP which could be sent via an online system or for the patient to take to their GP.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

The hospital used a paper-based system for recording patient care and treatment. We saw these were stored securely to protect confidential patient information and that staff could access them easily.

Medicines

The service used systems and processes to safely prescribe, administer and record medicines. However, they were not always stored correctly.

Staff followed systems and processes when safely prescribing, administering and recording medicines.

A comprehensive medicines management policy was in place, which covered obtaining, prescribing, recording, handling, storage, security, administration and disposal of medicines. Medicine records were completed appropriately – including allergies and VTE assessments.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

The pharmacy team completed regular audits of medicines.

Staff did not always store medicines in line with the provider's policy.

In theatre, cupboards containing stock medicines were in the main corridor and left unlocked. We raised this with the theatre manager who advised that the main theatre door was locked and could only be accessed by security cleared staff. However, these doors closed slowly, and we observed access could be gained by others. The theatre manager told us that there were plans to create one lockable cupboard, but that installation had been delayed. The cupboards were locked at the end of each day as shown on a checklist. After our inspection, we were told that a locked roller door would be installed to secure the medicines.

Medicine cupboards containing small stock levels were in the anaesthetic rooms. These were also left unlocked while the room was in use. Cupboards containing controlled drugs were all locked.

Staff monitored, and recorded temperatures where medicines were stored to ensure they were effective and safe for patient use. Medicines that needed to be kept below a certain temperature were stored in locked fridges. Ambient and fridge temperatures were checked daily and stored within the correct temperature range. Staff knew what to do if temperatures were out of range. All medicine checked was in date.

Pharmacy attended multidisciplinary team meetings across the hospital and the 10 at 10 meetings.

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.

The hospital used an electronic reporting system to report all incidents. Staff told us they were encouraged to report incidents and felt confident to do so.

Staff raised concerns and reported incidents and near misses in line with the provider's policy.

The service had no never events on any wards since the last inspection. 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.

The never event which occurred in December 2020 had been investigated. The report found that the accountable items check failed in robustly checking the integrity of used drill bits at final count. Recommendations, which included a review of practice to ensure scrub practitioners identify the items that require scrutiny after use, were shared.

Managers shared learning about never events with their staff and across the service.

Staff were aware of the never event that had occurred in December 2020.

Staff reported serious incidents clearly and in line with the provider's policy.

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

Good

Surgery

Regulation 20 of the Health and Social Care Act 2008 (Regulated activities) regulations 2014 was introduced in November 2014. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff now received feedback from investigation of incidents, both internal and external to the service.

We found improvements had been made by increasing the 'rapid response' meetings from monthly to weekly, meaning managers investigated incidents more promptly. Learning from incidents was collated by the governance lead and shared with all department heads at the daily 10 at 10 meetings and shared with all staff in the weekly 'Feedback Friday' newsletter. Incidents were also a standard agenda item on the monthly ward meetings. The ward manager used an app to share information with the team and on the staff noticeboard. There was also a daily huddle at midday to share information. Updates from Spire were received via the 48-hour flashes.

Staff met to discuss the feedback and look at improvements to patient care.

On Thursdays a "rapid response" meeting was attended by all managers to identify areas for improvement and share learning.

There was evidence that changes had been made as a result of feedback.

The discharge process was adapted to include a final check of patients' rooms following an incident where a patient left their own medication behind.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Incidents were reported on Datix and allocated to the department or area to investigate. Any immediate actions identified would then be completed. They were reviewed at the monthly clinical effectiveness and quarterly governance meetings. Three times a week there was a quality huddle where any increase in incidents was tracked and any safety alerts were actioned.

Managers debriefed and supported staff after any serious incident.

Are Surgery effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

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

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

Policies were stored on an online system which all staff had access to. We reviewed eight policies and found all were within the review date. Policies were current and based on professional guidelines, for example, National Institute for Health and Care Excellence (NICE) and Royal College guidelines.

The hospital had elective surgery criteria that had been shared with the local NHS trust. Additional processes had been implemented to ensure the patients taken were suitable for treatment at Spire Bushey. This included a review by the Director of Clinical Services when the referral came through before being sent to the Preoperative Assessment team.

A Short-Dated Bookings Policy was created in May 2021 with clear guidance for staff to follow.

We saw that a monthly American Society of Anaesthetists compliance audit had been implemented.

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

Nutrition and hydration

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

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Food was prepared on site in the hospital kitchen and met the nutritional requirements of patients, staff and visitors to the hospital. Menus included vegetarian and vegan and gluten free options. There were kosher options to cater for the large Jewish population locally.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.

We observed MUST assessments were completed in all the records we reviewed.

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

Staff used the Malnutrition Universal Screening Tool (MUST) to assess, monitor and record patients' nutrition and hydration needs. This was in line with national guidance (NICE, Patient experience in adult NHS services [QS15] (February 2012)).

Staff ensured there was effective management of nausea and vomiting. They would offer anti-sickness medication for patients who reported feeling nauseated, check it had worked and if necessary, offer an alternative anti-sickness medicine.

Pain relief

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

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. There was a pain assessment tool for use with non-verbal patients.

Patients received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

The hospital monitored any unplanned transfers of care to another hospital, readmission to the hospital and returns to theatre. Between October 2020 and September 2021, the hospital reported there were:

- 10 unplanned transfers to another hospital
- 10 unplanned returns to theatres
- 20 unplanned re-admissions to the hospital

This was an improvement on the 12 months prior to our last inspection.

The service participated in relevant national clinical audits.

The hospital submitted Patient Related Outcome Measures (PROMS), which helped the NHS measure and improve the quality of care patients experienced during and after elective surgery. Spire Healthcare ceased collecting patient reported outcome measures (PROMs) data during 2020 due to the COVID-19 pandemic, but it recommenced from March 2021. Data for 2021 was not available.

The hospital entered information onto registers such as the National Joint Registry (NJR). Information was collected on all replacement operations and monitored; these registries ensured all medical device implants could be traced if concerns were raised about the quality or possible adverse effects. This allowed for longer term national reporting of outcomes.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff used the results to improve patients' outcomes.

Venous Thromboembolism (VTE) risk assessments were regularly audited for completion. June to August 2021 results showed 100% compliance.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

The hospital had a comprehensive audit schedule covering all clinical areas. Completed audits included action plans to address any concerns. Audits were discussed at the monthly clinical audit and effectiveness meetings.

Managers used information from the audits to improve care and treatment.

Managers shared and made sure staff understood information from the audits.

Good

Surgery

Audit updates were a regular item on the ward meeting agenda and displayed on the ward.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN).

The clinical scorecard enabled the hospital to benchmark its clinical performance indicators against other Spire Healthcare hospitals. The scorecard was shared widely each quarter with each hospital. Each hospital had an action plan which was reviewed periodically by the central clinical team, and locally through clinical effectiveness meetings. Improvement is checked and monitored.

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.

Staff completed a variety of mandatory and role specific training. Competencies were required for each role and included sepsis, transfer and VTE. We saw that competencies were recorded in a file for each member of staff.

At our previous inspection we had concerns with the assessment of ASA scores by the pre-operative assessment (POA) nurses. There had been an increase in training and competencies to address this. POA nurses completed the course and received more support through spent time with the anaesthetist in clinic. There was a more robust induction for agency and new members of staff.

The role of the Medical Advisory committee (MAC) included supporting the hospital senior managers to ensure that all consultants were skilled, competent and experienced to perform the treatments undertaken. Practising privileges were granted for consultants to carry out specified procedures using a scope of practice document, these were reviewed annually. Registration with the General Medical Council (GMC), the consultants' registration on the relevant specialist register, disclosure barring service (DBS) check and indemnity insurance were all checked by the hospital and ratified by the MAC. An email was automatically generated to remind a consultant if for example their appraisal or indemnity was overdue or expired.

Resident Medical Officers (RMO) had their competencies assessed, mandatory training provided and updated and annual appraisals by Spire. They worked in line with guidelines and a handbook to ensure they were working within their sphere of knowledge.

Managers gave all new staff a full induction tailored to their role before they started work.

Students employed as healthcare assistants were given a three-week induction and paired with mentors. They were able to rotate to other areas. There were plans for induction of new staff to be extended by a week to ensure mandatory training was completed before they started work on the wards. The aim was for staff to be multiskilled, meaning they could work in other areas when needed.

Managers now supported staff to develop through yearly, constructive appraisals of their work.

A stricter appraisal programme had been implemented. The only staff who had not received an annual appraisal were either on maternity leave, long term sick or new starters. Staff told us they found the appraisal helped with progression and they were encouraged to pursue interests such as leading in particular areas. Staff told us that they would like more training in other areas but understood that this had been restricted due to the pandemic.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Ward meetings were held monthly and minuted.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Nurse apprenticeship training had been implemented for nine staff.

Managers made sure staff received any specialist training for their role.

Managers identified poor staff performance promptly and supported staff to improve.

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

During the pandemic, the hospital worked with the local trust to take extra patients for surgical procedures.

MDT meetings could be triggered at any time. Every Thursday a theatre planning meeting was held to discuss each patient, attended by the Director of Clinical Services, ward, theatre and pre-operative assessment managers, pharmacy and physio. If anyone had concerns about a patient, an MDT meeting could be requested. The pre-operative assessment team would arrange the meeting which would be attended by the Director of Clinical Services (DCS), anaesthetist, ward and theatre staff. These meetings were minuted and the decisions documented in the notes. We saw evidence of this in the records we reviewed.

MDT meetings were mandatory for any patient who scored ASA3 because these patients were higher risk, with severe systemic disease.

Staff worked across health care disciplines and with other agencies when required to care for patients.

Patients were advised of their potential length of stay at the pre-operative assessment. A board in the patients' rooms was updated throughout their stay. The aim was for patients to be discharged in the mornings. Pharmacy was advised and relatives were informed. Elderly or vulnerable patients would be kept in, rather than being discharged in the evening. Any delayed discharges were reported at the daily 10 at 10.

GPs were advised of discharges via an online system, or a copy was printed, and the patient asked to give it to their GP. Consent was obtained from patients prior to sharing with GPs.

Seven-day services

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

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Consultants were always on-call for patients under their care. Patients were seen daily by their consultant, including weekends. If the consultant was not available, they arranged cover by another consultant. The ward had a list for those on annual leave and cover detail. The RMO and ward staff had a list of contacts for all consultants and anaesthetists for each patient. Staff told us medical staff could be easily contacted when needed. Anaesthetists were available via an on-call rota if a patient needed to return to theatre. There was 24-hour RMO cover in the hospital to provide clinical support to patients, consultants and staff.

The pharmacy was open from 8am to 4pm Monday to Friday, and from 8am to 2pm on Saturdays. Out of hours there was an on-call pharmacist for support. If a patient required medicines out of hours, these were dispensed by the RMO. If controlled drugs were needed, the on-call pharmacist would attend the hospital to dispense them.

Diagnostic testing was available seven days a week.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance.

Patient records we reviewed showed consent was obtained in accordance with hospital policy.

Good

Surgery

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

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff told us the majority of admitted patients had the capacity to make their own decisions. Patients who lacked capacity were identified during the pre-operative assessment process. If a best interest decision had to be made, this would be with the consultant, but these were rare.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records.

A monthly audit showed 100% compliance for June, July and August 2021 with the completion of consent forms, including detail of the risks and benefits of surgery and forms being re-signed on admission where consent has been obtained in advance.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was an up-to-date consent policy for staff to follow. They told us they would go to the Director of Clinical Services for advice.

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system.

Are Surgery well-led?

Good

Our rating of well-led improved. 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.

Since our last inspection, there was greater stability among the leadership team. A permanent Hospital Director had been appointed. The interim Director of Clinical Services (DCS) was expected to be in post until March 2022. The interim Medical Advisory Committee (MAC) chair and heads of department supported the senior management team.

The management structure had been reviewed and new positions recruited, including a deputy director of clinical services and health and safety manager. A lack of clear leadership and support for the Pre-operative Assessment (POA) team had been an issue at our last inspection. This had been addressed by relocating the team to the Spire Bushey Diagnostic Centre and appointing a manager. The ward and theatres were led by ward and theatre manager.

Good

Surgery

The leaders had the skills and abilities to run the service and understood the priorities and issues the service faced. Staff told us they were very visible and approachable in the service for patients and staff. The Hospital Director and DCS completed a daily walkaround and attended the theatre huddle. The hospital director spoke with some patients each morning.

It was felt that the re-structure of the hospital allowed for better development of staff. The finance lead was on a management programme and there were plans for the ward manager to do this. Heads of department were empowered to address issues themselves before escalating.

The hospital director and MAC chair met each week. Discussions were documented and described as honest, robust and supportive.

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 provider's vision was: To be recognised as a world class healthcare business and its values as an organisation were:

- Driving clinical excellence
- Doing the right thing
- Caring is our passion
- Keeping it simple
- Delivering on our promises
- Succeeding and celebrating together.
- Our people are our difference, it's their dedication, warmth and pursuit of excellence that sets Spire Healthcare apart.

The vision, mission and values were displayed on the ward and screen savers.

The clinical strategy for the hospital was based on the Spire Healthcare purpose to 'make a positive difference to our patient's lives through outstanding personalised care'. There were three key areas of focus which included clinical quality, patient safety and medical and clinical governance.

Progress against this strategy was being made through improvement work following the previous inspection. The hospital was scoring higher in the patient satisfaction surveys and work was ongoing to develop staff.

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 met with were welcoming, friendly and passionate. It was evident that staff cared about the services they provided and were committed to providing the best possible care to their patients. Staff told us that they felt supported

by their departmental managers. The leadership team were proud of how staff had adapted to the changes throughout the pandemic. Staff felt they were kept up-to-date and although the changes had felt overwhelming, they understood they were important and felt that the service was safer with the patients being taken. We were told that the culture of the service had improved since our last inspection, staff worked together more and made shared decisions.

The daily 10 at 10 meetings included 'daily shouts' where the teams could share feedback about a member of staff who had been particularly supportive or received a compliment.

Processes and procedures were in place to meet the duty of candour. Where errors had been made or where a patients' experience fell short of what was expected, apologies were given, and action was taken to rectify concerns raised. When incidents had caused harm, the duty of candour was applied in accordance with the regulation.

The hospital had a freedom to speak up guardian, posters were displayed on the wards and staff were aware of who it was. All staff said they felt that the senior leadership team and their managers were very approachable and felt they could raise any concerns.

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.

There were governance structures, processes and systems of accountability to support the delivery of good quality services and safeguard high standards of care. The hospital's governance and assurance framework were supported on site and by Spire Healthcare, such as medicines management and infection control. Each committee had terms of reference which were reviewed annually. The committees met regularly and fed to the MAC, and corporate quality governance board.

We reviewed the minutes of the last three MAC meetings and saw they discussed incidents, complaints, audits, new appointments and practising privileges.

Clinical effectiveness meetings had been increased from quarterly to monthly. 'Rapid Response' meetings had been increased from monthly to weekly for managers to review incidents. Discussions were therefore current, and incidents were investigated more promptly.

The 10 at 10 daily call with all department heads was very detailed. Each department fed back their staffing situation including how many agency staff there were. There were updates including any returns to theatre, patient transfers, new incidents reported, safeguarding issues, IPC, complaints, consultant daily visit compliance and any issues from the resus huddle. It was checked that the RMO had enough rest overnight. Leaders on site were clarified and mental health first aiders identified. Any flash alerts were shared. There was also a 'shout outs' slot for special recognition to be shared.

There was a clear policy about the introduction of new surgical techniques. Applications were reviewed with the local MAC and corporately to ensure the supporting evidence was sufficient to ensure the safety and effectiveness of the procedure. They had to set out the risk and benefits to patients of the procedure, as well as the cost.

Practicing privileges is a term used when doctors have been granted the right to practice at an independent hospital. The policy included the granting of practising privileges, and roles and responsibilities. The hospital director and medical advisory committee (MAC) had oversight of practising privileges arrangements for consultants. We saw evidence in MAC

meeting minutes of discussion about renewing or granting of practising privileges. Most consultants also worked at other NHS trusts in the area. To maintain practising privileges, medical staff had to provide evidence of an annual whole practice appraisal, indemnity cover, an up to date disclosure and barring service (DBS) check and evidence of completed training. A biennial review was undertaken for each consultant's practice by the hospital director.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the Private Healthcare Information Network (PHIN). They also collected Patient Reported Outcome Measures (PROMS) data for certain surgical procedures, such as hip and knee replacements. The service participated in national audits including the National Joint Registry.

There was a systematic programme of internal audit used to monitor compliance with policies such as hand hygiene, health and safety and patient pathways. Audits were completed monthly, quarterly or annually by each department depending on the audit schedule. Results were shared at relevant meetings such as governance meetings.

Monthly ward meetings were held, regular agenda items included learning from incidents, training and development, audit results, risk management, complaints and patient feedback.

The hospital director had weekly meetings with the chair of the medical advisory committee (MAC).

An 'All hands' call was held on Mondays where the hospital director updated staff on all key messages. These were recorded for any staff unable to attend to access via an app.

There was also a weekly governance message issued.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They now identified and escalated relevant risks and issues and identified actions to reduce their impact. However, there was confusion about which register some risks were on. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

There were processes for identifying, recording and managing risks. Each department had a local risk register, alongside a hospital-wide risk register. Known risks and mitigation in the surgical service were discussed at senior team governance meetings such as the monthly clinical audit and effectiveness committee and the quarterly medical advisory committee.

The top risk was identified as the hospital 'not being able to recruit clinically trained and competent staff, requiring the regular use of agency staff'. There were plans to upskill HCAs and for nursing staff to be multi-skilled, allowing for flexibility between departments as well as ongoing development for staff to encourage them to stay at the hospital.

The surgical service had a risk register which we reviewed and found that each risk had a rating, a named risk owner and a review date. Risks included recruitment, ability to meet all POA standards, having complete contemporaneous patient records and patients being fluid starved longer than two hours. Staff had some awareness of risks to the service, but there was confusion over which risk registers they appeared on. We were told that COVID was on the hospital-wide risk register, rather than the surgery one but it was on both. Some risks staff mentioned, such as falls and pressure ulcers did not appear on either. During our inspection we saw a very cluttered sluice room which was not on the risk register, although we were told this was temporary during the refurbishment of another sluice room.

Good

Surgery

Improvements had been made to ensure the patients being accepted were suitable for surgery at Spire Bushey. This included an initial review by the DCS to approve the referral met the local criteria before it went to the pre-operative assessment team. Processes to escalate concerns were more robust. The POA could request MDT at any time and there were theatre planning meetings held the week before where there was another opportunity to request an MDT if they had concerns. These meetings were minuted and had the decision recorded in the patient record.

A 'Mandatory Mondays' newsletter had been implemented by the governance lead where RCAs and audits etc were chased. There was also a 'Feedback Friday' newsletter for all staff where safety information and learning from incidents was shared. For example, a patient had been told they could have water until 3pm, but they thought they could only have two small sips at 2pm. Learning shared was for staff to communicate clearly and to ensure patients fully understand.

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 service collected data and analysed it, in easily accessible formats, to understand performance. The information systems were integrated and secure. Data or notifications were submitted to external organisations. The provider had systems to ensure notifications of serious incidents causing harm to patients were reported in line with national requirements. The service used paper records. Nursing and medical patient records were combined within the same record. This meant all health care professionals could follow the patient pathway clearly.

Systems were in place to gather, analyse and share data and quality information with staff, key stakeholders and the public. The hospital had access to local information and other Spire Hospital information to benchmark services.

The service had a website where people could access information about the surgical procedures available and which would be useful when visiting the hospital. Staff had access to the intranet to gain information relating to policies, procedures, professional guidance and training.

A range of IT systems were used to monitor the quality of care. An electronic staffing safe care tool was used by the hospital to analyse staffing ratios against the acuity of patients.

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.

People's views and experiences were gathered and acted on to shape and improve the services and culture.

There was a patient satisfaction survey. The Hospital had improved from position 36 to 13 (out of the 39 Spire Hospitals).

A patient forum led by the Head of Business Development was held quarterly. Complainants were often invited to this for feedback. The Hospital Director visited a few patients each morning and fed back any issues identified. Learning was shared at the quality huddles which were held on Mondays, Wednesdays and Fridays.

A staff survey was distributed, and forums held in areas that did not score well, without the managers present. Action plans were then developed with the managers to address the issues.

Good

Surgery

The hospital continued to collaborate with the local NHS trust to ensure they were taking the correct patients and met quality key performance indicators.

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.

Spire Bushey were the first hospital in the Spire group to use the Electronic Pre-operative Assessment system. Which maps the whole patient journey.

In October 2021, a new virtual resus training programme was being introduced, whereby staff would complete simulation training every three months to maintain their skills via a simulation station that would provide real time one on one feedback. This was particularly important when most staff would not use their Basic Life Support (BLS) skills between annual training sessions.