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

Summary of findings

Overall summary

Our rating of this service went down. We rated it as requires improvement, because:

- Not all leaders understood and managed the priorities and issues the service faced.
- Staff did not always follow up to date policies.
- Staff did not always complete or update risk assessments for each patient to remove or minimise risks.
- Not all staff had the skills and competencies to carry out their roles.
- The service did not always manage patient safety incidents well.
- The service did not always identify and escalate relevant risks and issues or identify actions to reduce their impact.
- Multi-disciplinary team (MDT) meetings were not always effective in providing good care.
- Medical records were not always completed fully.
- The service did not always manage infection risk well.
- Patient outcomes to improve care and treatment were not always monitored.
- Not all staff had an annual appraisal.
- Equipment was not always stored correctly.

However:

- All ward areas and theatres were clean, tidy and free from clutter.
- The design, premises and equipment kept people safe.
- There was enough staff to provide the right care and treatment
- We saw the correct use of personal protective equipment (PPE).
- Policies were up-to-date and contained current national guidelines and relevant evidence.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Outpatients	Good 	We did not inspect this core service at this inspection.
Medical care (Including older people's care)	Good 	We did not inspect this core service at this inspection.
Surgery	Requires Improvement 	Our rating of this service went down. We rated it as requires improvement because we rated safe as inadequate, effective as requires improvement and well led as requires improvement. We did not inspect caring or responsive as part of this inspection.
Termination of pregnancy	Inspected but not rated 	We did not inspect this core service at 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 79 beds in the hospital and two inpatient wards; Lea ward is on the ground floor and has 43 single ensuite rooms, Gade ward is on the first floor and has 24 single ensuite rooms. At the time of our inspection, Lea Ward was using 42 beds and Gade Ward was using 13. The 12 day-case pods were not in use as they were awaiting refurbishment.

There are six operating theatres, three with laminar flow for orthopaedic surgery. The services include, but are not limited to, orthopaedics, gynaecology, general surgery, urology and ophthalmology. Pre-assessments are carried out within the day care unit where patients are seen in preparation for their admission to hospital.

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, allied health professionals such as physiotherapists who are employed by the hospital.

At the time of our inspection, there was an interim hospital director and interim director of clinical services.

Since the start of the COVID-19 pandemic, Spire Bushey have had a contract with the local NHS trust for NHS patients to have surgery at Spire Bushey.

We last inspected the hospital in 2016. The hospital was rated Good overall. Surgery was rated requires improvement for safe and good for effective, caring, responsive and well led, giving it a rating of good overall.

How we carried out this inspection

We carried out an unannounced focused inspection of the surgical services at the hospital on 12 January 2021. We visited the ward, theatres, recovery and pre-op assessment clinic. We spoke with 16 members of staff, including consultants, nursing staff, allied professionals, senior leaders, administration staff and one patient. We reviewed 14 patient records.

We rated the service of surgery as we found some areas where improvement was required at this inspection. We have not aggregated these ratings to a location level as we did not inspect all core services provided by this provider.

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 MUST take is necessary to comply with its legal obligations. Action a provider 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.

Summary of this inspection

Action the service MUST take to improve:

We told the service that it must take action to bring services into line with legal requirements. This action related to surgical services.

- The service must ensure there are leaders in post to have oversight, manage ongoing incidents, make decisions, manage performance and risk, and assess and respond to patients' care. Regulation 12 (1) (a)
- The service must ensure that they follow their own elective criteria for surgery policy and ensure patients are suitable and safe to have their surgery at the hospital. Regulation 12 (1) (a)
- The service must ensure the pre-operative assessment process is clear when escalating patient concerns and they follow their own policies. Regulation 12 (1) (a)
- The service must ensure the American Society of Anaesthetists (ASA) scores are documented for each patient and accurately reflect patient needs. Regulation 12 (1) (a)
- The service must ensure there is clear leadership and support for the pre-operative assessment team. Regulation 17 (1).
- The service must ensure staff are skilled and competent to carry out their roles. Regulation 12 (2) (c)
- The service must ensure that all incidents are identified, and actions taken in a timely manner. Regulation 12 (1) (a).
- The service must ensure that the risk register identifies all risks and that these are actioned and reviewed in a timely manner. 17 (1) (2) (b)
- The service must ensure MDT meetings are effective in decision making when reviewing patients care and surgical procedures. Regulation 12 (2) (c)
- The service must ensure that patients, risk assessments and care are carried out and documented in patients' medical records. Regulation 12 (2) (b)
- The service must ensure NEWS (National Early Warning Score) observations and scores are carried out and documented in patients' medical records. Regulation 12 (1) (2) (a)
- The service must ensure they comply with social distancing guidance. Regulation 12 (1) (2) (h)
- The service must ensure they monitor patient outcomes to improve care and treatment. Reregulation 17 (1) (2) (a)

Action the service SHOULD take to improve:

We told the service that it should take action because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall.

- The service should ensure that all staff have an annual appraisal.
- The service should ensure that medical gases are stored securely and safely.
- The service should ensure that the transfer bag is stored correctly and has a checklist.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires Improvement	Inspected but not rated	Good	Good	Good	Good
Termination of pregnancy	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated	Inspected but not rated
Medical care (Including older people's care)	Good	Good	Good	Good	Good	Good
Surgery	Inadequate	Requires Improvement	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Outpatients

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

Inspected but not rated

Termination of pregnancy

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

Good

Medical care (Including older people's care)

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

Requires Improvement

Surgery

Safe	Inadequate
Effective	Requires Improvement
Well-led	Requires Improvement

Are Surgery safe?

Inadequate

Our rating of safe went down. We rated it as inadequate because:

Mandatory training

The service provided mandatory training in key skills to all staff.

The mandatory training was comprehensive.

The mandatory training programme was tailored to the skill requirement of staff and was dependent upon their role. Courses included infection control, safeguarding and manual handling.

Managers could see which members of staff in their team had completed training which was recorded in a spreadsheet and discussed at the monthly ward meetings.

There were 11 standard mandatory training modules to be completed annually, with a target for all teams of 95%. In December 2020, compliance rates among theatre staff were 100% for two of the modules and 93-94% for the rest. Among ward and pre-op assessment (POA) staff, compliance rates were all below the target, ranging from 78-88%, but the training year ran from April to March meaning the teams had three months to complete any outstanding modules. We were told that resus training had been a challenge during the pandemic as it had to be delivered face to face.

In theatre, 48% of staff had advanced life support (ALS), 48% of staff had immediate life support (ILS) and 96% had basic life support (BLS). Among ward staff, 70% had ILS and 35% had BLS. Staff who had completed ILS may not need to complete BLS as well. Staff in key roles were prioritised for reduced capacity sessions to ensure social distancing could be maintained. Each day there was a hospital resus huddle where the resus response team and key roles were allocated. Every theatre must have minimum staffing with resus training, and this was discussed and confirmed at the theatre huddle each day. We were told training had been arranged for December 2020 and January 2021 to ensure those whose BLS training had expired was refreshed.

Medical staff received and kept up to date with their mandatory training.

Medical staff completed mandatory training via their employing NHS trust. This was checked and updated by Spire Bushey Hospital. Records of mandatory training for visiting consultants were held on site. Resident medical officers

(RMOs) completed mandatory and yearly update training. The hospital received training certificates that verified RMOs training status. This included ALS, European paediatric advanced life support (EPALS), blood transfusion, infection prevention and control, safeguarding children level three. Additional training, such as use of the hospital's electronic incident reporting system, was provided to RMOs and consultants as required.

Cleanliness, infection control and hygiene

The service did not always manage infection risk well. Handwashing basins were not available in each of the patients' rooms, this was identified at the last inspection. We saw that staff did not always comply with social distancing guidance. However, 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.

There was hard flooring in clinical areas, but some of the ward corridor was still carpeted. The carpeted areas of the wards had been risk assessed and a cleaning schedule was in place. There were handwashing facilities and hand sanitiser gel dispensers available in corridors, ward areas and clinical areas. Some patient rooms had clinical handwash basins in the bedrooms but 36 did not. 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 all providers of NHS care, it is relation to new build hospitals. These were on the risk register and there were plans to install them. This had been raised at our last inspection in 2016. If a patient required infection control/isolation a room with a clinical basin would be used. We saw there was a refurbishment plan and the work would be completed by the end of April 2021.

Government guidance was available on COVID-19 with posters displaying wash hands, cover face, make space. There were one-way floor markings in some areas. However, we saw eight staff gathered around the nurses' station with minimal social distancing and some staff were leaning over the desk facing other staff which did not comply with government COVID-19 guidance on social distancing in the workplace. We raised this during the inspection and post inspection we were told that signs had been put up stating the number of people that could be in a room/area and COVID-19 guardians were being appointed.

The hospital had up-to-date policies for infection, prevention and control (IPC) and related topics such as personal protective equipment (PPE) and isolation precautions. Staff could access these for guidance through the hospital's electronic system. The ward manager was the IPC lead and there were link nurses.

Ward areas were clean and mainly had suitable furnishings which were clean and well-maintained.

All ward areas and theatres were clean, tidy and free from clutter. 'I am clean stickers' were used in all areas to signify they were clean and ready for use.

Staff followed infection control principles including the use of (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. We saw an 'arms bare below the elbow' audit carried out for December 2020 for all departments, where compliance was 100%. Face masks were worn by all staff, which was in line with COVID-19 guidance.

Requires Improvement

Surgery

The service performed well for cleanliness. We saw the Patient-Led Assessments of the Care Environment (PLACE) for 2019 which showed the hospital scored 100% for cleanliness. Spire Healthcare introduced a new national IPC (Infection Prevention Control) audit programme in October 2020 which included hand hygiene audits, environment audits and PPE procedures audits. All staff were required to complete IPC training annually and the deadline was 31 March 2021. As of December 2020, the completion rates were 94% for theatre staff and 78% for ward and POA (pre-op assessment) staff.

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

Staff worked effectively to prevent, identify and treat surgical site infections.

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 10 surgical site infections between January to December 2020, this was a rate of 0.12 per 100 patients.

Temperatures and changes in symptoms of anyone entering the hospital were checked at reception. Patients were swabbed 72-hours before surgery for COVID-19 and then asked to self-isolate. If they tested positive, they were advised to self-isolate for ten days. The policy was not to book surgery for 90 days, but this was re-assessed if the procedure was time critical.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, we found medical gases stored in theatre corridors and checklists for some emergency equipment was not available.

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

The theatre manager told us that they have access to enough equipment and that loan kit is available.

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.

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. Operating theatre layout was clutter free, and there was safe distance of two metre trolley spaces in recovery in line with government guidelines.

Staff disposed of clinical waste safely.

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 and malignant hyperthermia kit located in accessible area. Malignant hyperthermia is a type of severe reaction that occurs to particular medications used during general anaesthesia. However, there was no evidence of a checklist to ensure that all emergency equipment would be available if required. In recovery there was a transfer bag with no checklist and staff were unsure where it was or who normally checked it. We raised this on inspection and staff located the checklist and checked the bag.

We found storage of medical gases in corridors and raised this on inspection. Following the inspection, we were told an additional storage rack had been ordered for the medical gases. Until it arrived, they had been moved to a place of safety.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not always identify and quickly act upon patients at risk of deterioration. Staff did not always assess, monitor or manage risks to people who use the services. Opportunities to prevent or minimise harm were missed.

Staff used a nationally recognised tool to identify deteriorating patients, but this was not always used correctly, documented and escalated 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. We reviewed 14 records and found two showed gaps with the recording of NEWS. One patient did not have NEWS observations completed accurately and the other did not have NEWS observations recorded for an hour and a half post-surgery whilst waiting to be transferred for enhanced care at the local trust. This meant that patients who were deteriorating, or at risk of deteriorating were not always recognised and treated appropriately. A NEWS audit commenced in October 2020 and showed 85% compliance for October 2020, 95% compliance for November 2020 and 85% compliance for December 2020 despite staff having training and awareness raised in June 2020 of the need to complete NEWS scores. Following our inspection, we saw that the audit result for January 2021 was 99%. During our inspection we were told there were escalation processes and that they had highlighted them more to staff as they had been treating higher acuity patients. Staff we spoke to were aware of the process for managing deteriorating patients and told us that the higher acuity patients were cared for by enhanced recovery unit (ERU) nurses. Following the inspection, we were told that daily NEWS spot checks had been implemented.

Staff did not always complete risk assessments in line with policy for each patient pre-admission and on admission, using a recognised tool, and this was not always reviewed regularly.

In March 2021, the hospital agreed to operate on patients from a local trust to help with surgical waiting lists during the pandemic. Patients for elective (planned) surgery underwent a telephone nurse led pre-operative assessment before their operation. Questions included the patient's past medical history, allergies, current medication, and previous anaesthetic and/or infection risk. Patients attended the hospital for routine tests such as MRSA screening and blood tests prior to admission. This was in line with national guidance (NICE, Routine preoperative tests for elective surgery [NG45] (April 2016)). Patients also attended for a pre-operative COVID-19 swab three days prior to their surgery and were told to isolate prior to admission, which was in line with national guidance. However, we found and were told that the process to escalate concerns about patients' suitability to have their operation at Spire Bushey was not clear. Nurses would email surgeons or anaesthetists with concerns or questions and would often have to chase them for a response. The hospital had elective surgery criteria that had been shared with the local trust, but this had not always been adhered to.

Requires Improvement

Surgery

We reviewed a medical examiner report for one patient that questioned the suitability for this patient to have their surgery at Spire Bushey. The report stated 'The question has been raised about whether it was appropriate for this patient to have their surgery at Spire Bushey Hospital. The records suggest that the patient was more frail than their age and past medical history suggest. It is not clear whether this was recognised pre-operatively or whether it would have made any difference to where the surgery was carried out. I note that the patient was transferred to an NHS ITU bed within hours of his deterioration, which may not have happened any sooner had he had the surgery in an NHS hospital'.

Between April 2020 and October 2020, we saw an increase in patients that were transferred to the local trust following surgery for enhanced care, indicating that they were not suitable to have their surgery at Spire Bushey. The rate of incidents per 100 admissions in 2020 was 7.9 compared to 4.3 for the same period in 2019. Three patients were transferred immediately after surgery, we reviewed these patient notes and found that the complexity of the surgical procedure was not one that was usually carried out at the hospital according to Spire Healthcare elective surgery admission criteria policy.

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. Any patients who were identified as high risk by the pre-operative nursing team were referred to an anaesthetist prior to their admission, however staff told us that they often had to chase for a response. The ASA score was not always clearly documented and often differed between the pre-operative assessment nurse and the anaesthetist. We reviewed 10 sets of notes from patients that had a recorded incident during their care at Spire Bushey and found that for five records they had been recorded correctly. In the other five records we found the following:

- Patient A notes documented the ASA score by the pre-operative assessment nurse as ASA 2, on the day of surgery the anaesthetist recorded the ASA score as 3.
- Patient B we could not find any ASA scores recorded in the notes.
- Patient C had an ASA score 1 recorded by the pre-operative assessment nurse, but nothing documented by the anaesthetist.
- Patient D did not have an ASA score documented by the pre-operative assessment nurse and had ASA score 1 circled on Theatre Front sheet ASA score 2 ticked on anaesthetic record.
- Patient E did not have an ASA score recorded by the pre-operative assessment nurse and had an ASA score 3 documented by the anaesthetist on the day of surgery.

The hospital had implemented an additional process to review patients care that was transferred by the local trust to ensure suitability. MDT meetings were held with staff from both the local trust and Spire Bushey to review and agree cases. The interim director of clinical service implemented a review of each patient's medical notes in January 2021 to confirm their suitability for surgery. If the pre-operative assessment nurse had any concerns about patient's suitability or concern, they would also raise this with the interim director of clinical services. This additional process was recently implemented to ensure senior clinical decisions were made as to whether patients were safe to have their surgery at Spire Bushey hospital. Following the inspection, we were told that the hospital carried out additional training for the pre-operative assessment teams to improve their communication, access and escalation with anaesthetists, this was not yet fully embedded.

The hospital also implemented a weekly planning meeting 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.

Requires Improvement

Surgery

Staff did not always deal with all specific risk issues.

We were not reassured that risk assessments of patients' care were always being carried out.

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. Of the 14 sets of notes we reviewed, one patient had falls assessment missing for three days of their seven-day hospital stay and this patient had a history of falls. The fluid balance charts were only partly completed on some days and none recorded on other days.

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.

The corporate critical care lead provided training in sepsis as part of mandatory training for staff. Sepsis is a serious complication of infection. Early recognition and prompt treatment have been shown to significantly improve patient outcomes.

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. A consultant, anaesthetist and/or nurse would escort the patient during transfer if indicated. Transfer arrangements were determined by the consultant and anaesthetist. There was a transfer handover sheet that we saw was completed for patients that were transferred. The patient notes were given to the trust and Spire Bushey staff made calls to follow up on the patients' progress.

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. We reviewed the documentation and found the discussion included equipment, staffing, and case mix.

Every morning there was a crash huddle, attended by the RMO, resus lead and ILS team in which the resus team roles were allocated.

Wards 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.

We observed a huddle on the ward at 2pm. This was led by the nurse in charge and was attended by nurses and physiotherapists. Staff were updated on the issue in theatre which had led to some procedures being cancelled. There was a key topic for the week highlighted (this week was communication). Regular items included NEWS triggers, safeguarding concerns, infections, pain triggers, whether any patients needed an interpreter, any patients at risk of pressure ulcers or falls and discharge needs. Staff told us they found these useful.

Requires Improvement

Surgery

We observed the complete WHO surgical safety checklist pathway. We observed all staff being fully engaged with team/ safety briefings, sign in, time out and debrief. Swabs, needles, instruments and sharps were counted to prevent foreign body retention and subsequent injury to the patient by two members of staff, a registered perioperative practitioner or senior health care assistant appropriately trained/scrub trained. The service audited WHO checklist compliance and results showed compliance at over 90% for both October 2020 and November 2020 and 100% for December 2020.

Staff were supported by an RMO if a patient's health deteriorated. The RMO was on duty 24 hours a day and was available on site to attend any emergencies. The RMOs had contact numbers for the consultants and anaesthetists for advice or to raise concerns about patient care.

Nurse staffing

The service had enough nursing and support staff, but not all had 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 ward and theatre teams had enough nursing and support staff to keep patients safe. However, the POA staff required additional training to assess patients' suitability to have their surgery at the hospital. Following the inspection, we received an action plan that included additional training and support from a corporate lead for the POA team to ensure they had the correct skills and experience to carry out this role.

Data we reviewed, and observations made during our inspection confirmed there was sufficient staff to provide the right care and treatment. During the pandemic, NHS medical staff from the local trust supported theatre staff with surgical procedures. We were told NHS staff integrated well into the team and support was given by managers to conduct additional activity.

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.

The ward manager used a safe staffing acuity tool. This looked at the acuity of each patient that would be on the ward and allocated the safe number of staff per shift. The monthly rota included details of who had ALS/ILS training and the nurse in charge for the day and night shifts. There was a separate rota for each day which showed the supernumerary shift co-ordinator. There was also an ERU lead for patients with enhanced monitoring.

In recovery, the nursing team leader reported good safe staffing levels, with minimal use of agency staff. The scrub team leader stated safe staffing levels were maintained in theatres.

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

The acuity level of the patients was entered into the electronic staffing tool which generated a guide to the minimum staff required. This was reviewed daily at 1pm. If more staff were required, the supernumerary nurses in charge and ward manager could support if required if they were unable to arrange bank or agency staff to cover the shift at short notice.

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

Requires Improvement

Surgery

We saw from the staffing rota and the staff on duty at the time of our inspection that actual staffing levels matched planned staffing levels. The number of nurses, healthcare assistants (HCA) and operating department practitioners (ODP) in each department matched the planned numbers. From January to December 2020, the hospital reported 100% of shifts were filled.

The vacancy rates for December 2020 were:

- 12.15% in Theatre
- 2.46% in Wards
- 18.18% in POA

We were told that the high vacancy rate in theatre related to an increased establishment created in June 2020 with the aim of increasing operating days to six per week from five. This had not yet commenced and would not until they had enough staffing.

The high vacancy rate in POA had been caused by an establishment increase following a staffing review in October 2020. Wards were currently supporting this activity whilst recruitment was undertaken.

Sickness rates varied from between 11% to 2.6% in 2020 on the ward and between 7% to 1% in theatre. A significant proportion of this absence was due to staff isolating in line with government guidelines.

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

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

Medical staffing

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

The service had enough medical staff to keep patients safe. The service always had a consultant on call during evenings and weekends.

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 30-minute drive of the hospital when off site. However, staff told us it could be challenging to reach the anaesthetist at the trust who was dealing with the Spire Bushey list. It was mandatory for all admitting consultants to visit their patients at least once per day, but staff told us that they often had to chase them.

Arrangements were made for the lead anaesthetist at the trust to be their point of contact when others were unavailable. A rotation was put in place for review of patients the day after surgery.

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. During the pandemic medical staff from the local NHS trust worked at Spire Bushey to provide support for the surgical patients. An interim fast-track process was implemented to allow providers to grant practicing privileges so consultants could start work immediately in hospitals where they did not already have practising privileges.

Immediate medical support was available 24 hours a day, seven days a week. This was provided by four RMOs who worked a shift pattern of four days on. They attended daily nurse handovers. The RMO said they felt well supported by the ward manager and had access to all consultants and anaesthetists. Following our inspection, we were told that a second RMO was on site during the day to provide additional support.

Records

Records of patients' care and treatment were not always documented in full. The information needed to plan and deliver effective care, treatment and support was not always available at the right time. They were stored securely.

Medical records were not always fully completed. We reviewed 14 sets of patient records during and after the inspection and found patients' care, NEWS observations, ASA scores, falls assessments and fluid balance charts were not always documented. Of the five records we reviewed during the inspection, two showed gaps with the recording of NEWS.

The ASA score classification system to grade the patients' level of risk before surgery were not always clearly documented and often differed between the pre-operative assessment nurse and the anaesthetist. We reviewed 10 sets of notes from patients that had a recorded incident during their care at Spire Bushey. In five we found the ASA score had either not been recorded or differed between pre-op and the anaesthetist.

Of the notes we reviewed, one patient had falls assessment missing for three days of their seven-day hospital stay and this patient had a history of falls. The fluid balance charts were only partly completed on some days and none recorded on other days.

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.

Incidents

The service did not always manage patient safety incidents well. Managers investigated incidents but lessons learned were not always identified and shared in a timely manner 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.

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.

The rate of incidents per 100 admissions in 2020 was 7.9 compared to 4.3 for the same period in 2019. There were 26 patients transferred to the NHS trust in 2020 compared to 16 patients in 2019 this included both inpatients and outpatients; 10 inpatients in 2019 and 16 inpatients in 2020, some patients were transferred straight from outpatients. In

Requires Improvement

Surgery

April and May 2020 incidents increased to 12.6 per 100 admissions; in June it was 7.6, July was 6.8, August was 6.2 and September was 7.5. We did not see that any immediate actions were taken following these increases. At our engagement meeting in November 2020, senior staff told us that following incidents that occurred in September 2020 they had reviewed and stopped complex surgical gynaecology cases. This was following the transfer of two patients to a local NHS trust following complex surgery who required enhanced care needs however the appropriateness of other specialities was not reviewed at this time. In January 2021 senior managers told us they had also stopped all complex colorectal surgical cases and an additional process had been put in place to review all surgical cases. This was several months after the increase in patient transfers incidents had first been identified. Therefore, we were not reassured that managers took actions following incidents or that lessons were learnt in a timely manner. We were not assured that the POA process and ASA scores were assessed correctly and this had not been recognised by the service prior to our inspection.

The service had one never event in December 2020, which was still under investigation.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

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

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

Learning from incidents was collated by the governance lead and shared with all departments.

Incidents were discussed at daily staff huddles. Staff we spoke to were aware of an incident that had occurred the previous day. Learning was shared at department meetings, sent to work emails and included in the 48-hour flashes. There was also a closed social media page which enabled the ward manager to check who had read them. Learning from incidents was also discussed at one to ones where examples of incidents were given, and staff asked to confirm what had happened and confirm the learning.

Are Surgery effective?

Requires Improvement

Our rating of effective went down. We rated it as requires improvement because:

Evidence-based care and treatment

Managers did not always check that staff followed guidance and policies.

Requires Improvement

Surgery

Staff had access to up-to-date policies to plan and deliver high quality care according to best practice and national guidance, but these were not always followed.

Policies were stored on an online system which all staff had access to. We reviewed six 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. Clinical indicators such as venous thromboembolism assessment compliance, national early warning score documentation, infection control, consent procedures, patient satisfaction and staff training were measured. However, the hospital had elective surgery criteria that had been shared with the local NHS trust when they agreed to take extra patients for surgical procedures during the current pandemic, but this had not always been adhered to. Between April 2020 and October 2020, we saw an increase in patients that were transferred to a local NHS trust for enhanced care following surgery.

The hospital did not follow the Spire Healthcare Adult Pre-Operative Assessment Policy and Standard Operating Procedure dated February 2020, which states 'Short notice booking may be appropriate to facilitate admission and elective surgery within seven days following a robust risk assessment. A short notice booking policy should be in place locally to underpin this practice.' We were told on inspection that patients were attending pre-operative assessment between five and seven days prior to surgery. The root cause analysis (RCA) action plan (dated October 2020) for an incident that occurred in August 2020 states that patients should be seen 10 days prior to surgery, but this was not adhered to. We reviewed 10 sets of notes and saw that seven patients were seen in pre-operative assessment between one and five days and that one patient had their pre-operative assessment the same day as their operation. We did not see any evidence of short notice booking forms in the notes we reviewed. Service leaders told us post-inspection that a local short notice booking policy was implemented in January 2021.

The hospital did not follow the Spire Healthcare Adult Pre-Operative Assessment Policy and Standard Operating Procedure dated February 2020 which states 'A POA audit schedule must be in place to audit the effectiveness of the service and to help improve quality and outcome'. The hospital carried out an ASA score comparison audit in December 2020 and in January 2021 comparing the ASA scores. The December audit showed that in the 14 cases audited there was consistency in ASA scores of both healthcare professionals. However, the January 2021 audit showed that a different ASA score was documented for four out of the 12 patients. The action plans included feedback and training. We were concerned that audits had not commenced until November 2020 although we identified issues with different ASA scores being documented from notes in July and August 2020.

Staff used surgical pathways which were in line with national guidance. This included for example, integrated care pathways specific for a day case procedure.

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. We saw evidence of this in the notes we reviewed. Relevant paperwork was completed at time of insertion of implant and was documented in the NJR by theatre staff.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They did not always use the findings to make improvements and achieve good outcomes for patients.

Requires Improvement

Surgery

The hospital monitored any unplanned transfers of care to another hospital, readmission to the hospital and returns to theatre. All occurrences were logged on the hospitals incident system and investigated. Between January and December 2020, the hospital reported there were:

- 26 unplanned transfers to another hospital (in 2019 10 were inpatients and 6 were outpatients. In 2020 16 were inpatients and 8 were outpatients)
- 8 unplanned returns to the theatres
- 31 unplanned re-admissions to the hospital (within 31 days of discharge)

Unplanned transfers had increased from 16 in 2019 but there had not been a correlating increase in the number of patients admitted for surgery. Despite the increase a review of all surgical procedures and introducing an additional process to ensure patients were suitable for surgery at Spire Bushey was not implemented until December 2020, which was several months after the increase in transfers occurred.

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

The hospital had an audit schedule in place across a 12-month period covering all clinical areas, environmental issues and customer relations.

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

VTE risk assessments were regularly audited for completion. The audit assesses VTE risk assessment, provision of patient information, and compliance with NICE guidance re: VTE prophylaxis for patients undergoing hip and knee arthroplasty surgery. From October to December 2020, results showed compliance was between 75% and 85%. We were told all patients were prescribed NICE compliant pharmacological VTE prophylaxis and that the primary area of non-compliance was there being no evidence of adult patients having been informed that aspirin is not specifically licensed as VTE prophylaxis. Given the widespread and NICE approved use of aspirin as VTE prophylaxis this question has been removed from the audit meaning a compliance increase is expected in Q1 2021.

We were told that the findings of a step-down audit showed that consultants did not always document in the patient notes when the patient could step down from enhanced care. An action from the audit was for a sticker to be added to the beginning of patient notes for consultants to sign, confirming that the patient could step down. We saw evidence of this in the records we reviewed.

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

Audits were allocated to staff, who were all encouraged to be involved in their completion. There was an audit effectiveness link nurse who sent results to the heads of department (HODs) who then shared the results with their teams.

Local audits were managed by the hospital at a local level and all audits were discussed when relevant at the monthly clinical effectiveness meetings. Minutes from the meeting were shared during the governance meetings.

The hospital entered information onto registers such as the 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.

Requires Improvement

Surgery

Spire Healthcare ceased collecting patient reported outcome measures (PROMs) data during 2020 due to the COVID-19 pandemic. This decision was based on the change in their work stream and contract with the NHS, who collect their own data. Spire Bushey Hospital plan to recommence PROMs collection from 25 January 2021.

The hospital reported surgical site infections (SSI). The aim of the national surveillance program was to enhance the quality of patient care. This was achieved by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark, and to use this information to review and guide clinical practice. The surgical site infection surveillance service provides an infrastructure for hospitals to collect data on 17 surgical categories spanning general surgery, cardiothoracic, neurosurgery, gynaecology, vascular, gastroenterology, and orthopaedics. The hospital reported on categories which included hip and knee operations. There were 10 surgical site infections January to December 2020, this was a rate of 0.12 per 100 patients.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. Prior to the pandemic, the hospital submitted data to the Private Healthcare Information Network (PHIN). PHIN had not been asking hospitals for updates during the pandemic, this was planned to resume March 2021.

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, and with central committees such as the executive Safety Quality and Risk Committee and board level Clinical Governance and Safety Committee. Each hospital has an action plan which is reviewed periodically by the central clinical team, and locally through local clinical effectiveness meetings.

Competent staff

The service made sure that most staff were competent for their roles. However, the POA nurses did not always record their assessment of patients correctly and required additional training. Managers had not appraised all staff's work performance, POA staff had not had appraisals.

Ward and theatre staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients, however the POA nurses did not always record their ASA score of patients and they often differed from the anaesthetists ASA score.

Following our inspection and the concerns we highlighted with assessing ASA scores, the hospital carried out an ASA score comparison audit. Additional training for POA nurses, a review of leadership and support was being implemented as an action from the audit.

Staff completed a variety of mandatory and role specific training. Competencies were required for each role and included emergency assessment breathing circulation, sepsis, transfer, communication. The competencies were recorded in a file for each member of staff. We saw two, one was complete and the second was in progress. Competencies were included on the mandatory training spreadsheet which was discussed at monthly ward meetings.

The physio lead attended train the trainer training for PPE to cascade donning and doffing to the whole department. Outpatients physios were upskilled to work on the ward. They shadowed the lead physio until they felt confident.

The corporate critical care lead reviewed audits such as NEWS and supported staff with training and competencies to improve the results.

Requires Improvement

Surgery

The role of the 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. During the pandemic, an interim fast-track process was implemented to allow providers to grant practicing privileges so consultants could start work immediately in hospitals where they did not already have practising privileges. We reviewed the files of four consultants and saw information such as DBS, GMC registration, appraisal, qualifications, confirmation of health status (hepatitis B) declared as available and up to date and signed by the responsible officer.

RMOs had their competencies assessed, and mandatory training provided and updated. They worked in line with guidelines and a handbook to ensure they were working within their sphere of knowledge. They had a yearly appraisal facilitated by their Responsible Officer, usually with a local consultant who was trained as an appraiser as part of the provider's national appraiser panel.

Managers supported staff to develop through yearly, constructive appraisals of their work, however not all staff had an up to date appraisal.

At the time of our inspection, not all staff had received their appraisal for year ending 28 February 2021.

There had been no appraisals completed for the POA team. There was nursing support from another Spire hospital from an experienced POA lead to support a review of training and appraisals for 2020/21 which would be reviewed when a substantive lead was in post.

In Theatre, all staff had appraisal discussions in 2020, and approximately 50% had their end of year appraisal completed. Others were scheduled or being scheduled in line with the deadline.

In the wards, 29 out of 37 permanent staff had their appraisal completed for 2020, with three new staff not yet eligible, one staff member on long term sick and all other staff booked for January 2021.

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

This included local orientation to their department. Aspects of the induction were prioritised according to the importance for their job role. The induction checklist included a section for role specific mandatory training requirements. There were systems and processes in place to support student nurses who worked on wards and departments. Students were allocated mentors, so they had a point of contact during each shift. Mentoring sign off was included in the competency files.

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

Staff on the ward told us that appraisal discussions were held throughout the year and that they found the process helpful, particularly if there was an area in which they needed to improve as they could work on this straight away, rather than waiting until the end of the year.

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

As well as learning needs identified at one to ones, opportunities were offered. For example, there were some link roles available such as pain management.

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

Staff were given the time to attend departmental meetings and huddles. Minutes were available for those unable to attend. Agenda items included incidents, audit results and action plans, new policies and procedures, new NICE guidelines, patient feedback and themes from complaints. They also discussed training, building improvements, any new staff and students.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. However, decisions taken to ensure patients suitability for Spire Bushey were not always appropriate.

Staff held regular 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. The MDT meetings held between both parties were not always effective in decisions taken to ensure patients were suitable for surgery at Spire Bushey. There was an increase in transfers post-surgery as the post-operative care could not be provided at Spire Bushey. Senior managers attended the meetings and made the final decisions on which patients to treat at this hospital. The work commenced in March 2020 and the memorandum of understanding was not fully in place until August 2020. Due to the increase in patients that were transferred post-surgery, we were not assured that the patients agreed to have surgery at Spire Bushey were always appropriate and complied with the elective surgery criteria policy.

We observed team working in all areas of the hospital. MDT meetings, handovers and briefings took place regularly to ensure care and treatment was delivered to the patient. There were daily ward and theatre huddles of consultants, the RMO, physiotherapists, pharmacists and ward staff.

Each department had a daily huddle to discuss specific issues within that department. On the ward, prompts at the huddle included NEWS triggers, safeguarding concerns, infections, pain triggers, interpreters needed, pressure ulcers risk, any high risk of falls, discharges. There was also a key topic for the week discussed. In theatre, the manager and medical colleagues met weekly to discuss and review lists. We saw evidence of MDT working on daily huddle sheets, team briefing and debrief documents in theatre three.

An internal MDT for breast cancer was attended by a breast nurse, surgeon, radiologist, pathologist (who has read slides) and oncologist. MDTs for other cancers were completed at the trust who held and shared a record of the outcome. It was the consultant's responsibility to take the case to MDT.

All staff told us they had good working relationships with consultants and the RMO. We saw good interactions between all members of the team. Staff said they were all approachable and they worked well as a team.

Requires Improvement

Surgery

Are Surgery well-led?

Requires Improvement

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

Leadership

The new interim leadership team had the skills and abilities to run the service and understand the priorities and issues the service faced, however, they had only been in post for a short time. We had concerns about the stability of the leadership. Staff told us they were visible and approachable in the service for patients and staff.

During our inspection there was an interim hospital director, interim director of clinical services and interim MAC chair. The interim hospital director was transferred from another Spire hospital in November 2020 but was due to move back to their substantive post at the end of January 2021. An interim director of clinical services who commenced in October 2020 had returned to her substantive post at the end of December 2020. At the time of our inspection another interim director of clinical services had been at Spire Bushey Hospital for ten days. The interim MAC chair commenced in December 2020.

The future arrangements for the leadership team was unclear, due to the ongoing changes with the hospital director and director of clinical services and decision makers at the hospital. There was a continuing service level agreement with a local trust to take extra patients for surgical procedures during the current pandemic. We had ongoing concerns about stability of the leadership, as to who would have oversight, manage ongoing incidents, make decisions, manage performance and risk, and assess and respond to patients' care.

There was a management structure with defining lines of responsibility and accountability. The hospital's senior management team consisted of the hospital director, who had overall responsibility for the hospital, and the director of clinical services, however in the past three months there had been two hospital directors and three directors of clinical services in post. The medical advisory committee (MAC) chair and heads of department supported the senior management team. Each head of department reported to one of the senior managers. For example, heads of department in the surgery service reported to the director of clinical services.

The interim leaders were described as very visible and accessible. We were told that the interim hospital director visited theatre twice a week and that the interim director of clinical Services visited the ward daily and other leaders once or twice a week. Staff said they felt listened to and empowered by the new leaders and able to raise concerns. Following our inspection, the interim leaders shared our immediate feedback with staff and consultants to ensure their involvement with any decisions taken.

The ward and theatres were led by ward and theatre manager. Staff found them approachable and supportive. There were five teams on the ward who each reported to a senior nurse who shared learning from incidents and complaints with them and monitored their training and competencies. During our inspection there was instability in the leadership of the POA team. However, there was a corporate POA lead was on site to support the team and the ongoing leadership of the team was being reviewed. Following our inspection, we were told that both the ward manager and director of clinical services supported the team, and that a new POA Manager started 1 March 2021.

Staff received regular communication from the interim directors and senior managers to understand how the service was performing, its plans and the challenges it faced.

Requires Improvement

Surgery

During the inspection corporate leaders and staff from corporate critical care and POA were on site to support the team.

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.

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.

At the start of the pandemic staff were advised that they would be treating patients from the local NHS trust. They were aware that patients would not be COVID-19 positive but patients for surgical procedures.

Staff told us that the situation changed on a weekly basis and they were kept well informed.

Governance

Leaders operated governance processes, throughout the service and with partner organisations, however we were not assured of their effectiveness in decision making within MDT. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet.

There were governance structures, processes and systems of accountability to support the delivery of 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, infection control, and health and safety. Each committee had terms of reference which were reviewed annually. The committees met regularly and fed to the MAC, and corporate quality governance board.

MDT meetings and weekly calls were held with the local NHS trust to review patients transferred for surgical procedures at Spire Bushey. However, we were not reassured of how effective these meetings were or how decisions were made to accept patients for surgery at Spire Bushey. In September 2020 gynaecology cases were stopped and in January 2021 colorectal surgical cases were stopped both due to the increase in patients transferred following surgery. In January 2021, the hospital implemented an additional process of reviewing all patients' medical notes prior to accepting patients for surgical procedure.

We reviewed the minutes from the last three MAC meetings and saw they discussed incidents, complaints, audits, new appointments and practicing privileges. We saw in the minutes from July 2020 about the timing of POA appointments and

the need for anaesthetist clinics were discussed, but no clear actions or decisions were taken. In the November 2020 minutes we saw POA was discussed again, regarding timings of appointments and the need to fully assess patients prior to surgery, the minutes recorded 'This has not been working and has had an impact on the patients and lists. Additional resource has now been put in place to rectify this and the process amended. Improvements have already been seen with patients now being assessed in a timely manner prior to surgery.' We were not reassured that the concerns identified in July with POA had been fully recognised and actioned in a timely manner as further discussions with actions took place at the November MAC.

Clinical effectiveness meetings had been increased from being held quarterly to monthly. Incidents were discussed weekly at their 'Rapid Response' meetings, these had also increased in frequency from monthly to ensure incidents were reviewed and action taken in a timely manner.

Heads of department attended a monthly meeting with the senior leadership team. They received an update on the hospital, audits, complaints and all gave an update on their areas. Information from meetings was fed down to staff at their daily 10@10 meetings. Department leaders would share information at huddles and staff meetings.

There was a clear policy about the introduction of new 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 risks and benefits to patients of the procedure, as well as the costs.

There was a corporate "Spire Healthcare" practising privileges policy including consultants and medical and dental practitioners." 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 DBS check and evidence of completed training.

There were systems in place to ensure that data and notifications were submitted to external bodies as required. The hospital submitted data to the PHIN, but this was on hold during the pandemic. They also collected PROMs data for certain surgical procedures, such as hip and knee replacements, this too was on hold during the pandemic.

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.

The service participated in national audits including the National Joint Registry and Friends and Family Test (FFT). Patient Reported Outcome Measures (PROMs) had been ceased due to the pandemic.

All areas held team meetings. Monthly ward meetings were held for all the staff to attend. Ward minutes were reflective of the five domains of safe, effective, caring, responsive and well-led. Information was recorded in reflection of these and covered such things as incidents, training, medicines, audit results, complaints and patient feedback.

Management of risk, issues and performance

Requires Improvement

Surgery

Leaders and teams did not always use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and recognise actions to reduce their impact. Risks, issues and poor performance were not always dealt with appropriately or quickly enough. Some risks had been on the risk register for nearly five years.

The service did not identify risks such as the increase in incidents and the patients being transferred in a timely manner. Following our findings which we fed back to the service at engagement meetings, senior staff told us that in September 2020 they had reviewed and stopped complex surgical gynaecology surgery. However, a review of the appropriateness of other specialities were not carried out at this time. In January 2021 senior managers told us they had also stopped all complex colorectal surgical cases, reviewed the elective criteria for surgery and an additional process had been put in place to review all surgical cases. This was several months after the increase in patient transfers incidents had first been identified.

The surgical service had a risk register. The top three risks were: that the hospital was unable to meet all the POA standards due to limited staff and infrastructure, added May 2019; that patient care may have been compromised due to not having a complete and contemporaneous patient record, added February 2016; and that there was a risk to patient safety if staff failed to identify and respond to a deteriorating patient condition dated June 2020. Each risk had control assurances, actions and risk owner. However, the two highest risks related to pre-operative assessment service and had been on the risk register for nearly five years and eighteen months therefore we were not assured that actions had been taken in a timely manner to mitigate the risks as they were still ongoing.

Leaders and staff told us the biggest risk for the service was to ensure the safe care of patients being treated at Spire Bushey, to support and improve the POA process and the stability of leadership at the hospital.

At the time of our inspection the hospital had implemented an additional process to review patients' notes and suitability to have their surgical procedure carried out safely at Spire Bushey. MDT meetings was held with staff from both the local trust and Spire Bushey to review and agree cases. In January 2021, the interim director of clinical service commenced reviewing patients' medical notes to confirm their suitability.

The service did not always comply with the Government guidance on COVID-19. There were posters displaying wash hands, cover face, make space. There were one-way floor markings in some areas. Temperature checks were in place at reception and we observed all staff wearing a facemask. However, sometimes there was a lack of social distancing among staff. We raised this during the inspection as there was no guidance on how many staff were suitable in an area or room at any one time to comply with COVID-19 guidance. Following the inspection, we were told that signs had been put up stating the number of people that could be in a room/area and COVID-19 guardians were being appointed.

Information Management

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 however, decision-making and improvements were not always timely.

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.

Requires Improvement

Surgery

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.

Staff across the hospital described information technology (IT) systems as fit for purpose. 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure there is clear leadership and support for the pre-operative assessment team. Regulation 17 (1) • The service must ensure that the risk register identifies all risks and that these are actioned and reviewed in a timely manner. Regulation 17 (1) (2) (b) • The service must ensure they monitor patient outcomes to improve care and treatment. Regulation 17 (1) (2) (a)

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure there are leaders in post to have oversight, manage ongoing incidents, make decisions, manage performance and risk, and assess and respond to patients' care. Regulation 12 (1) (a) • The service must ensure that they follow their own elective criteria for surgery policy and ensure patients are suitable and safe to have their surgery at the hospital. Regulation 12 (1) (a) • The service must ensure the pre-operative assessment process is clear when escalating patient concerns and they follow their own policies. Regulation 12 (1) (a) • The service must ensure the American Society of Anaesthetist (ASA) scores are documented and correct. Regulation 12 (1) (a) • The service must ensure staff are skilled and competent to carry out their roles. Regulation 12 (2) (c)

This section is primarily information for the provider

Requirement notices

- The service must ensure that all incidents are identified, and actions taken in a timely manner. Regulation 12 (1) (a).
- The service must ensure MDT meetings are effective in decision making when reviewing patients care and surgical procedures. Regulation 12 (2) (c)
- The service must ensure that patients, risk assessments and care are carried out and documented in patients' medical records. Regulation 12 (2) (b)
- The service must ensure NEWS (National Early Warning Score) observations and scores are carried out and documented in patients' medical records. Regulation 12 (1) (2) (a)
- The service must ensure they comply with social distancing guidance. Regulation 12 (1) (2) (h)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Elective criteria for surgery was not always adhered too. • The pre-op assessment process and escalating concerns about patient suitability for surgery was not always clear, documented or timely. • There was an increase in incidents, in 2020 compared to 2019 and the need to transfers to local NHS trust after surgery. We did not see that immediate actions were taken and lessons learnt in a timely manner. • Medical records were not always fully completed and patients care, National Early Warning Score (NEWS) observations and American Society of Anaesthesiologists (ASA) ASA scores were not always documented. • The ability to manage the ongoing performance and risks in relation to the assessment and responsiveness to patient needs was at risk of being compromised due to the instability of the leadership team.