Spire Healthcare Limited

Spire Norwich Hospital

Inspection report

Old Watton Road
Colney
Norwich
NR4 7TD
Tel: 01603456181
www.spirehealthcare.com/norwich

Date of inspection visit: 6 April 2022
Date of publication: 21/06/2022

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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Inspected but not rated

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff 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, supported them to make decisions about their care, and had access to good information.
- Leadership was effective at all levels. Leaders demonstrated the capacity and capability needed to deliver good care and treatment. Leaders ran services well using reliable information systems and there was a strong staff development culture. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff evidenced their commitment to improving services continually.

However:

- Staff did not use sterile service department sheets consistently when counting instruments pre and post-surgery and they did not always operate a dirty instrument disposal method.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Inspected but not rated	**Inspected but not rated** • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff 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, supported them to make decisions about their care, and had access to good information. • Leadership was effective at all levels. Leaders demonstrated the capacity and capability needed to deliver good care and treatment. Leaders ran services well using reliable information systems and there was a strong staff development culture. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff evidenced their commitment to improving services continually. However: • Staff did not use sterile service department sheets consistently when counting instruments pre and post-surgery and they did not always operate a dirty instrument disposal method.

Summary of findings

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Summary of this inspection

Background to Spire Norwich Hospital

We carried out this unannounced focused inspection because at we received information giving us concerns about the safety and quality of the services. Our inspection identified no significant safety or quality concerns.

Spire Norwich Hospital is part of Spire Healthcare Limited. Spire Norwich offers comprehensive private hospital services to patients from Norfolk and East Anglia. The hospital is located on the outskirts of Norwich with easy access to main driving routes and the local NHS Trust. Healthcare is provided to patients with private medical insurance, those who self-pay and patients referred through NHS contracts.

Hospital facilities include an outpatient service, diagnostic imaging service, inpatient and outpatient physiotherapy service, pharmacy, 29 bed inpatient ward plus two bed enhanced care area, 18 bed day procedure unit. Theatre provision includes four theatres, three with laminar flow and a sterile services department.

Activity from April 2021 to March 2022:

- 7,184 procedures performed in theatres.
- Three serious incidents
- One never event

Spire Norwich Hospital had the following surgery relevant service level agreements in place:

- Provision of critical care services (Intensive Therapy Unit/High Dependency Unit) at the local NHS Foundation Trust.
- Provision of pathology services (biochemistry, haematology, histology) with a private pathology service.
- Provision of consultant microbiology support with the local NHS Foundation Trust
- NHS sub-contract with the local NHS Foundation Trust - provision of surgery for NHS patients.

During the inspection we spoke with 22 staff members including senior leadership staff, consultants, other doctors, nursing staff, operating department practitioners, health care assistants and administrative staff. We did not have the opportunity to speak with patients. We reviewed 10 patient records and observed clinical and surgical practice.

How we carried out this inspection

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

Areas for improvement

Action the service SHOULD take to improve:

- The service should ensure staff use sterile service department sheets consistently when counting instruments pre and post-surgery and that staff follow best practice guidance in the disposal of dirty instruments. (Regulation 12)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Surgery

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

Are Surgery safe?

Inspected but not rated

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. For example infection prevention control and health and safety training. Training schedules, including annual refreshers started every year from 1 April to 31 March. Records showed that year to date 96% of staff had completed mandatory training against a target of 95%.

The mandatory training was comprehensive and met the needs of patients and staff. Training was delivered face to face and online. The pandemic had impacted staff training. For example, staff told us some training had to be cancelled or delivered online instead of face to face. The service implemented a new professional development initiative to support a standardised approach to training to improve compliance.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers had oversight of staff training compliance. Staff told us that they were alerted when training updates were required to ensure compliance and to support their development.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff completed a minimum of level two annually for both adults and children. Qualified staff also completed level three safeguarding for both adults and children. Records showed that year to date 97% of staff had completed safeguarding training for adults and children against a target of 95%.

Safeguarding leads supported staff within the organisation. The leads were safeguarding level four trained. Staff could access the leads for support and advice in matters relating to safeguarding patients.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us about specific patient concerns that they had identified and escalated appropriately.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had access to an up to date safeguarding policy. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff knew how to access and use the service chaperoning policy. There were notices in patient areas advising patients that they were entitled to have a chaperone present for consultations, examinations and surgery.

Cleanliness, infection control and hygiene

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

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records we reviewed were up to date and demonstrated that all areas were cleaned regularly in line with hospital policy.

The service generally performed well for cleanliness. Staff carried out weekly and monthly cleaning audits using a handheld electronic device to record compliance and whether there were any shortfalls. Staff had access to an up to date infection control policy (IPC) to help control infection risk. Data from the provider demonstrated good compliance with IPC audits in the three months before our inspection. We saw audit compliance data recorded as 100% across five different IPC audits. For example, from January 2022 to March 2022, the service had 100% compliance with a sharps audit, 99% compliance with a hand hygiene audit and 98% compliance in a hospital cleanliness audit.

Leaders told us many of the infection prevention control audits were paused across the Spire group for the period October to December 2021 to ease pressure on teams though the pandemic to increase surgical activity. Additional protocols were in place in response to the pandemic. There were visible adaptations for the arrival of staff, patients and visitors at the hospital to limit the risk of cross infection, for example patients were screened for COVID-19 prior to admission. Patients were given a Spire coronavirus test and isolation pathway instruction leaflet which clearly outlined processes for safety in advance of surgery. For example, patients scheduled for surgery were instructed to self-isolate immediately following a COVID-19 swab.

Staff followed infection control principles including the use of personal protective equipment (PPE). In all areas we visited, staff decontaminated their hands appropriately before and after patient care. Staff were bare below the elbows to aid effective hand washing. They used PPE in line with the provider's infection prevention and control policy and disposed of the items correctly. We saw recorded audit compliance data which demonstrated 100% compliance with personal protective equipment procedures.

Staff cleaned equipment after each patient contact and labelled equipment at the end of each list to show that it was clean and ready to use for ongoing use. Staff used I am clean stickers to demonstrate that equipment was clean and ready for use. The new laminated version of the "I am clean" system was not fully embedded, but stickers were still in use. Cleaning records we reviewed were up to date and demonstrated that all areas were cleaned regularly in line with hospital policy.

Staff worked effectively to prevent, identify and treat surgical site infections. Patients who underwent surgery at the hospital in the previous 12 months totalled 7,184. There were 24 infections post-surgery in this period, a rate of 0.3%. All

patients undergoing orthopaedic surgery, breast augmentation or those who had a recent hospital admission were screened pre-operatively for MRSA and Methicillin-sensitive Staphylococcus aureus (MSSA). Over the previous 12 month period there were two positive cases of MRSA. One case was identified pre-operatively and one in the outpatient department; neither were reportable to Public Health England.

All infections were investigated by the infection control lead and where required mitigation was put in place.

Staff had access to an up to date policy for safe standards in the perioperative environment that applied to all surgical staff. We observed one pre-surgical count which was not marked on the sterile service department sheet until the final instrument count was completed. This would not be seen as best practice.

There was clear flow through processes in theatre for surgical instruments to prevent cross contamination. This was tracked by the internal tracking system for all surgical instrument sets.

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.

Patients could reach call bells. Each bed space on the recovery bay had a call bell system which were within the reach of patients. We did not observe any call bell use to demonstrate whether staff were prompt in responding to the bell to meet patient needs.

The design of the environment followed national guidance. The theatre department had a bay for four single patient beds which were suitably equipped to meet the needs of patients in recovery post-surgery. There were four theatres including three with laminar airflow. The inpatient ward had 29 beds for the care of postoperative patients. The day procedure ward had 18 beds for the care of postoperative patients.

Staff carried out daily safety checks of specialist equipment. We saw staff carry out these checks. Anaesthetic machines were checked daily and this was recorded appropriately. Ward staff completed daily checks of the emergency resuscitation trolleys. We reviewed quarterly emergency resuscitation trolley checking audits from 1 November 2021 to March 2022 which showed 98% compliance.

Theatres had an implant register. Staff used theatre registers in each theatre and the hospital inputs into National Joint Registry and Breast and Cosmetic Implant Registry. Staff collected the data to record the details of patients who had breast *implant* surgery so that they can be traced in the event of a product recall.

The service had enough suitable equipment to help them to safely care for patients. An external maintenance provider attended the hospital to service and safety check equipment. All the equipment we checked had been serviced and safety checked within the required timeframe. The theatre had an airflow system in place that was checked and maintained in line with hospital policy to maintain air quality in theatre.

Staff disposed of clinical waste safely. Waste was separated with colour coded bags for general and clinical waste. Sharps bins were assembled correctly and not overfilled. These were disposed of in line with national guidance. The appropriate controls were in place for substances hazardous to health in line with Control of Substances Hazardous to Health good practice guidelines. Cleaning equipment was stored securely in locked cupboards.

Inspected but not rated

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. Staff used NEWS2 to identify deteriorating patients. Leaders monitored NEWS2 compliance and we saw recorded compliance was 97% against a 100% target. Staff knew about and dealt with any specific risk issues. Staff we spoke with knew how to escalate a deteriorating patient and had access to support from the resident medical officer (RMO).

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed risk based pre-operative assessments in line with pre-operative assessment guidance. Staff used a sepsis care bundle for the management of patients with presumed/confirmed sepsis. The hospital used the sepsis six care bundle to identify and treat patients with early signs of sepsis.

Staff knew about and dealt with any specific risk issues. All patients identified as a falls risk had their lying and standing blood pressure recorded preoperatively. Falls risk assessments and mobility assessments were completed within 24 hours of admission to the ward. Patients identified as at risk of a fall were issued with “yellow socks” which not only had a non-slip surface but also alerted staff members to the fall risk for that patient when they were mobilising.

Staff completed venous thromboembolism (VTE) assessments and monitored patients in line with the provider policy. Audit results provided by the hospital showed 94% compliance rate against a goal of 100%.

The divisional resuscitation lead facilitated the resuscitation training programme. The programme included basic life support, immediate life support, advanced life support, paediatric basic and immediate life support and European paediatric advanced life support training. Clinical staff completed immediate life support (ILS) or basic life support training (BLS) with an additional two members of staff who had completed advance life support (ALS) training. This meant that staff had the skills required to identify and manage a deteriorating patient. Daily department and resus safety huddles were held to share up to date key information between staff. Leaders planned an emergency response team to be on site daily to respond to any crash bell.

Staff access to resuscitation training and monthly training scenarios in line with the resuscitation policy, this was identified as a risk on the risk register. This was impacted by the pandemic. The hospital leadership team reviewed staff mix daily to ensure appropriately trained staff were available in all areas of the hospital. The resident medical officer was both immediate and advance life support trained. We saw there was an action plan in place to address the concern. We also observed a morning huddle where each member of staff clearly stated their responsibilities to ensure appropriately trained and skilled staff were available.

Staff complied with the World Health Organisation (WHO) five steps to safer surgery surgical checklist including marking of the surgical site. The service monitored compliance through a record and observational audit. Data provided for the period 1 October 2021 to 31 March 2022 showed an average 100% compliance with the WHO checklist. There was a surgical safety guardian in theatre to oversee safety standards in theatres.

Staff were not observed to be consistent in their surgical count. They followed surgical checklist processes; however in one case observed they did not specifically detail the surgical counts. Surgical count was used to ensure accountability for all items used during an operation. We escalated this as a concern. Leaders were receptive to ensuring this was appropriately managed to ensure staff were consistent in their approach to avoid potential for errors.

The service had an up to date certificate of compliance for sterile services for assurance. The last compliance audit was in June 2020. The service had a certificate of compliance following this audit. The next audit was due in June 2023.

The service had a good relationship with the local NHS hospital and worked collaboratively in managing risks of patients. For example, the hospital had local agreements in place for the transfer of patients in an emergency.

Leaders recognised the need to monitor and manage cross match blood and blood supplies. We saw an updated blood transfusion policy and a blood transfusion agenda item where leaders discussed blood at monthly team meetings. For example, we saw documented reminders for ward staff responsibilities in relation to monitoring blood fridge supplies and outcomes from audits.

Staffing

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

The service had enough staff to keep patients safe. In theatres, the service employed one whole time equivalent theatre manager, one whole time equivalent deputy theatre manager, 18.5 whole time equivalent scrub practitioners (four who were dual trained to cover anaesthetics), 4.24 whole time equivalent anaesthetic assistants, 6.4 recovery practitioners, 6.7 whole time equivalent healthcare assistants. Two additional recovery practitioners were due to take up employment in April 2022.

Staffing on the wards were made up of one whole time equivalent Ward Manager covering the inpatient ward and day procedure unit. There were 19.7 whole time equivalent registered nurses including a ward sister, two deputy sisters and 13.7 healthcare assistants. The day procedure unit employed 9.82 whole time equivalent registered Nurses, including one ward sister, two deputy sisters and 3.9 whole time equivalent healthcare assistants.

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

Managers used a safe staffing tool to calculate daily staffing requirement based on the acuity of patients. We looked at the daily staffing calculator sheets from December 2021 to March.

In addition to the actual staffing numbers there were two supernumerary staff on duty each day. A theatre co-ordinator and theatre manager coordinated staffing requirements on a daily basis. Theatre lists were postponed if insufficiently staffed.

The service had reducing vacancy rates. From March 2021 to February 2022 the vacancy rate was 6%.

The service turnover rates, from March 2021 to February 2022 was 17%.

The service had low sickness rates, from March 2021 to February 2022 the average monthly sickness rate was 3%.

The service had low rates of bank and agency nurses. Bank and agency staff use was limited to staff used before. We saw that one agency member of staff had been employed for over 12 months. Agency staff were given a longer contract to ensure that they were familiar with the service.

Inspected but not rated

Surgery

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 surgical service was consultant led with a resident medical officer on site seven days a week, 24 hours a day. Medical staff were employed through practising privileges. The hospital had 192 medical staff with practising privileges. To maintain practising privileges, members had to provide evidence of annual practice appraisal, indemnity cover, an up-to-date disclosure and barring service (DBS), status of Hepatitis B, Hepatitis C and HIV. Part of their practising privileges agreements was that they were required to have arrangements with other medical staff to provide cover, in the event of them being unavailable.

Consultants were required to live within 45 minutes of the hospital and remain on-call whilst their patients were in the hospital. In the evenings when consultants were not present on site, the resident medical officer (RMO) provided medical care. If a patient deteriorated the RMO would contact the consultant for them to come back and review the patient.

Consultants worked as a collective. This meant if they had issues with a patient, they could speak to another consultant who was on site at the time. Anaesthetists followed the same process which meant they could call a relevant consultant anaesthetist for support.

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 10 patient records and found them to be legible, signed and dated. All records contained pre-operative assessments as part of a pre-admission assessment. The records were contemporaneous and demonstrated an on-going plan of care. All records we reviewed had up to date risk assessments. Patient's GPs received written updates at appropriate times to keep them up to date with all treatment.

Staff carried out quarterly records audits. Audits reviewed from 1 November 2021 to 31 March 2022 showed an average of 95% compliance.

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

Records were stored securely. Patient records were stored in trolleys within staff areas of the ward and were secured with a keycode lock to prevent records being accessed by those who did not have permission to access records. Electronic records were *General Data Protection Regulation* (GDPR) compliant which meant personal data was stored and shared appropriately.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed systems and processes prescribing, administering, recording and storing medicines. We saw medicines appropriately stored in cupboards and fridges within locked rooms in line with legislation. There were systems to ensure compliance with safe storage and expiry dates for appropriate disposal in line with the provider's policy.

Controlled drugs were appropriately stored and managed in the department. We looked at recent records and saw stock levels matched the records which had been checked and signed appropriately by staff. Controlled drug audits were regularly carried out and formed part of the safety monitoring schedule.

Staff reviewed each patient's medicines regularly. We looked at 10 medicines records and saw they were accurately completed and kept up-to-date. Allergies were clearly displayed on patient records to alert staff. Staff stored medicines and prescribing documents safely within each patient's care record.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff talked through new medicines with patients to ensure they were clear about their use.

Staff learned from medicines safety alerts and incidents to improve practice. Alerts were shared at the daily safety briefs in departments and hospital wide.

The ward stored medicines in a temperature-controlled room secured with a keycode entry system. Staff recorded room temperatures daily. We reviewed the room temperature records over a six month period which demonstrated the checks were completed daily without gaps.

Staff kept medicines fridges locked and monitored the temperatures daily. We reviewed the fridge temperature records and found these were completed daily without gaps and all were within the safe temperature range.

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.

The hospital had established systems and processes in place for staff to report incidents and managers to investigate those incidents for learning. Leaders followed policy and process to ensure incidents were appropriately investigated, in some cases there were external reviews. Staff recorded appropriate detail, investigations were recorded when necessary, managers signed off incidents and shared outcomes with staff involved.

Staff knew what incidents to report and how to report them. Staff used an electronic reporting system. We looked at clinical and non-clinical incident data from 1 April 2021 to 31 March 2022 and saw 1,537 clinical incidents recorded as no harm caused, and 243 non-clinical incidents recorded as no harm caused. There were 99 low or minimum harm caused clinical incidents, 39 short term harm caused clinical incidents. Staff recorded one clinical incident as serious harm and three incidents resulted in death. All three incidents where patients had died were in the process of being appropriately investigated.

The service had one recent never event in the department. We saw that the hospital had followed process, notified relevant agencies, carried out initial and ongoing investigations and provided duty of candour. The root cause analysis was being undertaken for this incident and awaiting approval from the central incident review working group. This meant we did not have the outcome or learning to share. However, we did see records of staff discussions about the never event at the clinical governance committee February 2022. This included duty of candour and team guided debriefs.

Inspected but not rated

Surgery

Managers shared learning with their staff about never events and serious incidents that happened elsewhere. Staff received 48-hour flash reports and shared the learning from incidents and safety concerns from across the Spire group. We saw shared learning from incidents was a standard agenda item at daily meetings with staff.

Leaders discussed health and safety risk management at monthly meetings. Leaders discussed this agenda item to highlight reports and learning from regulatory inspections, the Health and Safety Executive and Medicines and Healthcare products Regulatory Agency. For example, we saw in minutes from one meeting updates from the Health and Safety Executive in relation to policy updates in working at height and natural rubber latex policy.

Staff reported serious incidents clearly and in line with the provider's policy. There was an open reporting culture and staff told us that they were encouraged to report incidents and received feedback on incidents that they reported.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw that duty of candour had been carried out appropriately for five incidents where it was required.

Staff received feedback from investigation of incidents, both internal and external to the service. Learning was shared during the daily safety briefings, on staff notice boards and by email.

Managers investigated serious incidents appropriately. All serious incidents were reviewed and investigated using route cause analysis (RCA). We looked at five RCA's and saw each incident was analysed with issues identified and actions taken to respond. Each incident had clear recommendations and lessons learned to be shared with staff. Action plans were allocated to designated leads and deadlines for completion monitored with progress overseen. The service had an RCA scrutiny panel which reviewed RCA's for consistency and robustness. We saw joint working with partner agencies when incidents occurred and there was joint patient responsibility. In some cases, patients and their families were involved in these investigations.

There was evidence that changes had been made as a result of feedback. For example, we saw that incidents were discussed at monthly clinical audit and effectiveness meetings. Staff reviewed themes and trends. Staff discussed the high number of patient information incidents and suggested a quality improvement project to help reduce the number of incidents.

Managers debriefed and supported staff after any serious incident. Staff had three recent serious incidents that required debrief and additional support. Clinical staff support was provided by an appropriate professional as a result of some of these incidents.

Are Surgery effective?

Inspected but not rated

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.

Inspected but not rated

Surgery

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policy and guideline documents on the hospital intranet. These were in accordance with best practice and national guidance. National guidance updates were discussed with clinical leads in meetings and shared with staff using email, at meetings and on intranet updates.

All surgical patients underwent a pre-operative assessment process which followed a documented pathway. Staff gathered all the relevant information to safely prepare patients for their surgery. This was in line with the Association of Anaesthetists and the British Association of Day Surgery guidance.

Staff used evidenced based tools to identify and treat patients with sepsis. We saw the sepsis tool was used in conjunction with the NEWS2 assessment tool to identify patients at risk of sepsis.

At safety meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Policy and pathway documents were inclusive of patients with disabilities and people with protected characteristics. Staff made appropriate adjustments for patients with complex needs and planned individualised care to meet these needs in line with provider policy.

Theatres completed the World Health Organisation five steps to safer surgery for all surgical procedures to monitor compliance with this standard.

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. We saw staff ensured patients could access fresh water at their bed side.

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

Specialist support from a dietitian was available to patients. The hospital had a dietitian that worked under practising privileges. Staff could signpost patients to the dietitian for additional dietary advice and support.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The hospital director told us that hospital catering staff tailored menus to meet patient needs. This included responding to food allergies or personal requests for favourite foods.

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. Staff asked patients about their pain during vital observations and at medicines rounds.

Patients received pain relief soon after requesting it. Records demonstrated administration of pain relieving medicines if patients had reported pain.

Staff prescribed, administered and recorded pain relief accurately. Medicine prescriptions records showed staff prescribed appropriate pain-relieving medicines at regular intervals during the day as well as additional pain medication as required by the patient if they experienced increased pain.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements for patients. The service had been accredited under the National Joint registry and was working towards Joint Advisory Group (JAG) accreditation.

The service participated in relevant national clinical audits. The service had a programme of local and national audits in place to benchmark the service against other hospitals in the provider group, local policy compliance and service improvements. Actions were required for any audits scoring less than 95% compliance. We looked at action plans and saw each item had associated evidence to improve compliance.

We reviewed the service patient safety and quality scorecard summary data for the period January to March 2022. There was a dashboard where staff collated safety information relating to standards that were in line with the care quality commission five domains; safe, effective, caring, responsive and well led. For example, under safe the goal was to reach 100% for pain trigger to action standard and this was achieved. In the effective section of the dashboard we saw participation in NHS Patient Reported Outcome Measures (PROMs) for hip and knee procedures. Their goal was 80% and their score was 48% which fell short of their target. There were other indicators where standards were not met, for example, the goal for recorded consent was 100%, however the score was 97%. We also saw discussions about monitoring improvements for PROMs in the minutes of clinical audit and effectiveness meetings.

Leadership staff attended monthly meetings to discuss patient outcomes. We saw good membership at monthly clinical audit and effectiveness meetings.

Managers and staff used the results to improve patients' outcomes. Managers shared and made sure staff understood information from the audits. Managers displayed audit results in staff areas and discussed the results within team meetings.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. We saw evidence of action plans from audit and saw that they were monitored and reviewed. Audits were repeated to improve compliance. Managers used information from the audits to improve care and treatment.

The service had been accredited under relevant clinical accreditation schemes. The hospital had been awarded the National Joint Registry quality data provider award and the hospital was working towards achieving JAG accreditation. Endoscopy services were Joint Advisory Group (JAG) registered but not accredited. The hospital had also applied for Venous thromboembolism (VTE) exemplar status and awaited the result. This was due to long backlogs in application reviews following the pandemic.

Inspected but not rated

Surgery

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers kept records of staff competence, and qualifications.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff received a hospital induction before they started work in their appointed role, and managers tailored a local induction to the clinical area. We reviewed staff records and saw that this was completed.

Managers supported staff to develop through yearly, constructive appraisals of their work. Clinical staff such as registered nurses, operating department practitioners and health care assistants participated in a meaningful appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. During the pandemic face to face meetings had been halted. Team and hospital meetings were conducted online. Staff told us that this had enabled better attendance as the meeting could be accessed from their clinical area.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff participated in a three-point appraisal process, each staff member met with their manager three times a year to monitor their progress and develop personal development plans. Data provided by the hospital showed that the appraisal rate for staff at December 2021 was 100% for the department.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff we spoke with had completed the appraisal process and had tailored individual development plans.

The hospital had 192 medical staff who worked under practising privileges. Consultants who did not comply with the conditions associated with the practising privileges had them removed. For example, consultants that did not supply copies of their annual practice appraisals, and indemnity insurance. Consultant practising privileges were monitored. The medical advisory committee (MAC) meeting minutes detailed where practising privileges had been suspended and conditions under which they would be removed.

Staff were 100% compliant with completion of revalidation with their professional body.

A clinical educator programme supported staff learning and development needs. This was a recent national initiative which had replaced individual clinical educator system. A leader for the roll out of the initiative informed us that this was work in progress aimed at standardising an effective system to develop staff competency and development.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw evidence of shared records from meetings in emails and displayed in paper format on staff notice boards.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff spoke to us of their study day commitment where the service closed and the time was protected to ensure all staff had the opportunity to attend.

Managers made sure staff received any specialist training for their role. Staff in leadership positions told us they were supported in achieving leadership qualifications. Staff at all levels were encouraged to develop their skills and take

advantage of professional growth opportunities. For example, the service had introduced progression opportunities for support staff to become recovery practitioners. Leaders told us they took a 'grow your own' approach to national staff shortages. We saw staff from other disciplines being developed, for example, staff from mental health backgrounds being supported in achieving appropriate skills to work in theatre.

Managers identified poor staff performance promptly and supported staff to improve. Managers gave us examples of when they have relieved staff of their duties as a result of recognised poor performance following use of support to improve practice if this was appropriate.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Surgeons, anaesthetists and operating department practitioners completed the World Health Organisation (WHO) five steps to safer surgery checklists at daily briefings and debriefed where appropriate.

Staff worked across health care disciplines and with external agencies to care for patients. For example, engaging with local NHS hospital staff when jointly working with a patient. Staff could access specialist support for patients, such as, the dementia lead and infection prevention and control lead. Staff communicated with local authority safeguarding teams, social workers, community services and GPs when they planned care for their patients.

Staff shared patient information with the patient's GP following surgery. GPs were sent a discharge letter clearly outlining outcomes and discharge detail to share appropriate medical information.

Seven-day services

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

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.

Patients could access support from the service following discharge. This was available 24 hours a day seven days a week.

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. The service had access to all key diagnostic services such as diagnostic imaging and laboratory services seven days a week to support clinical decision making.

The pharmacy was open Monday to Friday 8:30am to 5pm and on Saturday 9am to 1pm. Pharmacists were on an on-call rotation which provided pharmacy advice when the pharmacy on site was closed.

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/units.

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

Inspected but not rated

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. There was an accessible consent policy that was within the date of review and included guidance for staff to follow. The policy included guidance for patients assessed as lacking capacity to consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice. Staff told us they asked for consent before delivering routine daily care, for example assistance with washing and dressing. Staff gained written consent from patients for all surgical procedures and we saw consent recorded in all patient records.

Staff made decisions in their best interest, considering patients' wishes, culture and traditions when patients were not in a position to consent.

Staff made sure patients consented to treatment based on all the information available. Theatre staff checked that patients understood the procedure they were having. This was included in the World Health Organisation five steps to surgical safety checklist.

Staff clearly recorded consent in the patients' records. We reviewed six patient records where consent had taken place; all of the patient records contained correctly completed consent forms for their procedures. The hospital carried out an audit to monitor consent. We saw that 100% of patients had a fully completed consent recorded in their notes for audit completed January to June 2021.

There was an interpreter service available to support patients whose first language was not English during the consent process. Interpreters were pre-booked to provide either face to face or telephone support. Staff told us family members were not used for consent purposes.

Are Surgery well-led?

Inspected but not rated

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.

Management structures were clearly defined with lines of responsibility and accountability understood. At operational level, the theatre department was overseen by a theatre manager, who was supported by a deputy theatre manager. There were a number of team leaders, supported by specialist and theatre practitioners and theatre support workers. The ward manager was supported by ward sisters, nursing staff, specialist nurses, health care assistants and a resident medical officer. Staff worked well as a team to provide good care for patients and provide a supportive environment to colleagues.

Inspected but not rated

Surgery

Staff told us that hospital leaders were visible and approachable. Staff told us the leadership team were engaged, sincere and caring.

Leaders understood the department's priorities and worked with staff to achieve them. Leaders attended daily meetings attended by all departments using online video conferencing. Staff used these daily meetings to plan and co-ordinate business including capacity, patient acuity and staffing. Staff also used these meetings share information and risks and escalate concerns.

Leaders were passionate and worked with staff to deliver best possible outcomes for patients.

Leaders facilitated regular staff meetings and staff told us they had opportunities to share their views and feel valued.

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.

Leaders shared the hospital's vision and a strategy with staff. The shared strategy included 'to strive for an outstanding hospital' and 'exceed expectations'. The strategy outlined information regarding the hospital's finances, consistency in terms of standards of care, and specific reference to theatre and the preoperative environment. The vision and strategy referenced the hospital and the wider Spire group.

Culture

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

Staff reported a culture where they could raise concerns with their managers. Staff we spoke with confirmed that the needs and experience of their patients was at the centre of the service. Leaders were proud to share the patient forum work they did. This was a virtual process, where staff met with patients to seek feedback on how they could improve patient experience.

Staff worked well together as a team. Staff expressed support for each other across departments with a strong focus on safe and good quality patient experience.

Staff told us they could raise concerns without fear and were confident they would be heard with appropriate action taken. Staff were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process. Hospital leaders and medical staff demonstrated integrity, openness to challenge and working collaboratively.

Staff had access to independent freedom to speak up guardians to express any concerns outside of their immediate teams if they needed to. The hospital had a freedom to speak up guardian, who fed into the national corporate guardian.

Inspected but not rated

Surgery

Governance

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

The governance structure was headed up by the hospital director, supported by a medical advisory committee chair, a senior management team and hospital management team. The hospital committee structure included a medical advisory committee, health and safety/risk committee, clinical governance committee, hospital management team meetings, senior management team meetings and other committees. These structures supported systems and processes, including accountability for delivery of the service.

Data collection processes were robust to provide operational and clinical assurances. Staff attended wide ranging meetings that fed into committees for oversight. Leaders attended a range of meetings, including monthly managers meetings, theatre staff meetings, governance meetings all of which fed into committee meetings for oversight. Information from these meetings were shared in a variety of ways, including staff handovers and team meetings.

Leaders shared important information by email, staff bulletins, staff notice boards, and verbally during ward meetings. We saw recorded standard items in leadership meetings where important information was discussed. For example, there was a standard item for National Institute for Health and Care Excellence (NICE) guidance updates which referenced methods of escalation and updating staff on these updates.

The medical advisory committee (MAC) met quarterly with responsibility for performance and surgery matters. The medical advisory committee (MAC) had oversight of audit results, complaints and incidents which were standard agenda items.

Incidents and themes were reported and discussed at the team meetings, clinical governance meetings and monthly clinical effectiveness meetings, medical advisory and health and safety committees.

There was a programme for internal audit to monitor compliance with policies and processes. Audits were completed monthly, quarterly and annually as per the providers audit schedule. The local, regional and national management teams monitored results. Results were shared at relevant meetings including the clinical audit committee, hospital management team meetings and clinical governance meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Staff were committed to best practice. We saw this evidenced in performance monitoring, risk management systems and processes. Leaders met daily to plan ahead for all activity and this included managing risks.

Leaders managed risk using a risk management system. Staff were clear on how to identify, record and manage risks on the register. Staff used a red, amber, green risk rating system, to indicate the high, medium and low risks. Staff were allocated responsibility on an action plan to oversee and mitigate risks within a specified review date. We saw among the top risks staffing and adherence to clinical policy. Both risks had key controls and assurances in place. Leaders revisited each risk on a monthly basis and dynamically as risks evolved.

Heads of department meetings discussed departmental risks at weekly meetings, then escalated as required to monthly senior leadership meetings. We saw a range of risks highlighted for discussion at the monthly clinical governance committee meetings minutes. For example, in February 2022, we saw six hospital risks discussed; one of which was risk of receiving the wrong medication.

Managers monitored performance against internal key performance indicators. Managers shared and used the results to compare with other hospitals in the provider group.

The MAC discussed hospital risks during the meetings every three months. We reviewed the MAC meeting minutes which demonstrated these discussions had taken place.

Leaders encouraged reporting patient safety incidents to manage risk, issues and performance. Incidents were investigated by appropriate staff, including the commission of independent reviews to ensure management, learning and improvements following incidents.

Leaders demonstrated a commitment to health and safety risk management updates from regulatory bodies. Leaders used the learning from regulatory inspections, the Health and Safety Executive and Medicines and Healthcare products Regulatory Agency to update policy, make changes to practice and share with staff.

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.

Information systems used were accessible and secure. Data and notifications were submitted when necessary to external organisations. Staff could access information using the intranet, for example, policies and up to date national guidance.

Staff used a secure encrypted email service for sending confidential information. All consultants working under practising privileges who removed notes off site were registered with the Information Commissioner's Office. This was a requirement of their practising privileges.

The hospital used written patient records. Staff stored patient records and information securely. We saw staff secure patient records in locked offices or secure notes trolleys when they were not in use.

Managers used patient records to audit and monitor the completion of the World Health Organisation (WHO) five steps to surgical safety. Theatre staff held records with information about the use of implants and traceability. We observed an implant and saw staff document the implant in patient records and upload to the implant registry. They followed best practice and only opened once checked and when ready to use.

The hospital submitted data to The Private Healthcare Information Network (PHIN) as required by the Competition and Markets Authority.

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.

Inspected but not rated

Surgery

The hospital worked closely with local NHS providers and people who were stakeholders in the hospital, this included patients.

Staff expressed a preference for meetings that were held virtually. Staff told us this meant they could use their time more efficiently as a result.

The hospital's performance dashboard demonstrated patient satisfaction outcomes. All outcomes were positive and were improving. An exception to this was response range times where the score had reduced however was still above the hospital target.

Leaders supported a range of engagement initiatives. A patient engagement strategy has been completed and was awaiting final review before circulation Staff facilitated a virtual patient forum to gain feedback from patients about their experience. A patient experience and engagement committee maintained oversight of patient experience action plan, escalating to senior medical team, the medical advisory committee and clinical governance group as appropriate.

The service participated in the hospital's patient survey. Patients and their relatives could provide additional feedback through links on the hospital's public website. The public website also provided information and news about the hospital and the provider for service users.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The hospital had an effective co-ordinated electronic pre-operative assessment system. The system provided patients with choice and encouraged patients to be involved in the pre-assessment process.

The hospital introduced a new safer staffing tool to help them manage staffing based on patient acuity more effectively. A new training system was being implemented to help standardise the process across the Spire group. It meant that training access would improve and help manage additional support or training identified to help staff improve their competencies.