Medical Innovations Centre Ltd

Harley Street Specialist Hospital

Inspection report

18-22 Queen Anne Street
London
W1G 8HU
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Overall summary

We rated the service as good because:

The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks 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. They gave patients enough to eat and drink and gave them pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were skilled and experienced. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. Patients had access to good information and key services were available seven days a week.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

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

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated the service as good because: The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks 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. They gave patients enough to eat and drink and gave them pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were skilled and experienced. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. Patients had access to good information and key services were available seven days a week. Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment. Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities.

Summary of findings

Outpatients

Good

We rated it as good because:
The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, and had access to good information. Key services were available seven days a week.
Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients.
The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it.
Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Diagnostic imaging

Good

We rated it as good because:
The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks 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

Summary of findings

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, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to suit patients' needs.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.

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

Summary of findings

Contents

Summary of this inspection

Background to Harley Street Specialist Hospital

Harley Street Specialist Hospital (HSSH) is an independent acute hospital located in the Harley Street. It provides specialist treatment and surgical care to insured and self-pay patients aged 18 years and over with a range of conditions from the location hospital at 18-22 Queen Anne Street, London, W1G 8HU.

Consultants are granted practising privileges after scrutiny by the Medical Advisory Committee. The governance framework of the hospital ensures that performance of individual consultants is closely monitored to ensure the highest standards of care, that consultants are working within their scope of practice and consistent patient outcomes are delivered and maintained.

- The service is located at the corner of Harley Street and Queen Anne's Street. It is arranged over six floors:
- the lower ground floor houses a state-of-the-art ultraclean operating theatre, anaesthetic room, 2 recovery bays and 4 day-case pods. It also houses a small office space and instrument storage facilities.
- the ground floor contains the reception, one theatre, staff room, one patient room and a three bedded recovery bay. The theatre is managed and staffed by HSSH.
- the first floor contains the minor operations suite, two outpatient rooms, a dispensing pharmacy and x-ray imaging suite that incorporates an OPG and Cone-Beamed Computed Tomography CBCT machine.
- the second floor currently houses two temporary physiotherapy suites and storage areas but there are plans for a gym and patient ensuite rooms. This is currently planned for the second half of 2023.
- the third floor contains outpatient rooms that are used by the consultants.
- the fourth floor contains three consultation rooms used for cosmetic surgery and administrative spaces.

How we carried out this inspection

We inspected this surgical service using our comprehensive inspection methodology, carrying out an unannounced site visit on 28 February and 01 March 2023. During the inspection we visited reception areas, waiting areas, treatment rooms and consultation rooms. We spoke with staff members, including the registered manager and reviewed a range of information provided to us.

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.

Outstanding practice

The hospital had a number of innovations which included a novel nerve blocking drug that allowed up to 4 days of pain relief, virtual reality headsets for patients to watch films and allowing healthcare students from a neighbouring college to undertake work experience in the service.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust 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 SHOULD take to improve:

Surgery

The service should ensure that cosmetic damages to the walls in theatres were repaired.

Our findings

Overview of ratings

Our ratings for this location are:

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

Good

Surgery

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

Is the service safe?

Good

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training modules were a mixture of face to face and online training. At the time of our inspection mandatory training compliance levels for theatre and surgical wards was 100%, which exceeded the hospital's target of 95%.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included but were not limited to, manual handling; slips, trips and falls; infection control; immediate life support; basic life support; and equality, diversity and inclusion. The resident medical officer (RMO) was advanced life support trained.

Staff told us they had protected time to complete their mandatory training. Clinical nurse facilitators and ward managers were responsible for monitoring mandatory training completion.

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.

We reviewed the service's safeguarding adult's policy. The policy detailed individual responsibilities, processes for reporting and escalation of concerns and who to contact.

All clinical staff were trained to level 2 safeguarding adults training. All staff were at least level 1 trained in child safeguarding across the hospital, although there was strict exclusion criteria around not treating any patients under the age of 18. The outpatient lead, theatre manager and RMO were the deputy safeguarding leads trained to level 3 in adult safeguarding. The director of clinical services was the safeguarding lead and trained to level 4 in adult safeguarding. Compliance rates for all levels of safeguarding training was 100%.

Staff we spoke with had good awareness and knowledge of female genital mutilation (FGM) which was part of safeguarding training.

Good

Surgery

All staff we spoke with demonstrated a good understanding of safeguarding vulnerable adults and children. Staff were able to identify the potential signs of abuse, the process for raising concerns and what would prompt them to make a referral. Staff knew how to escalate concerns to their manager and safeguarding lead. We saw safeguarding posters in toilets with information on how to raise safeguarding concerns.

The service had not had to make any safeguarding referrals in the last 12 months.

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.

We observed all areas of the service to be visibly clean. Ward areas were clean and had suitable furnishings which were clean and well-maintained. Theatre areas were visibly clean and free of clutter. There was access to hand sanitisers throughout the hospital and we saw handwashing posters above sinks.

Staff cleaned equipment after patient contact. Cleaning checklists of clinical areas and equipment were completed on a daily and weekly basis and showed good compliance.

The clinical service director was the decontamination lead, and the theatre manager was the infection prevention control (IPC) lead. The hospital also had an external IPC and microbiologist advisor, who was responsible for assisting the hospital's management team with the development of the annual IPC programme and compliance with said programme.

The infection control policy was in date and accessible to staff. Infection control, and personal protective equipment was part of mandatory training for staff and compliance rates were 100%.

Hand hygiene audit compliance rates for theatres were between 96% and 100% from September 2022 to February 2023.

There was easy access to personal protective equipment (PPE) such as gloves and aprons and we saw that staff followed infection control principles and were bare below the elbow. We observed theatre staff wearing appropriate PPE in theatres.

Staff worked effectively to prevent, identify, and treat surgical site infections (SSIs). There had been one surgical site infection in the last 12 months. Investigations of the infection and evidence from a root cause analysis (RCA) showed that the patient had already been colonised from a previous operation in an NHS Hospital.

We reviewed the infection prevention and control meeting minutes for 3 March 2023. The meeting had representation including from the consultant microbiologist and the superintendent pharmacist. Topics discussed included: IPC audit results, SSIs, policies and facilities.

The hospital had an outbreak of infection policy. There had been no cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin-susceptible Staphylococcus aureus (MSSA) or C. Difficile in the last 12 months on the surgical wards.

Whilst most of the theatre equipment was single use, the hospital did have a service level agreement with a local NHS trust for the decontamination of sterile theatre equipment. The instruments coordinator at HSSH told us this worked well and they had not encountered any issues with the service.

We witnessed staff cleaning the theatres throughout the day and the hospital employed an external cleaning company to carry out additional deep cleans of the service areas every six months.

Staff kept substances which met the Control of Substances Hazardous to Health (COSHH) regulations in a locked cupboard in a room accessible by staff only. We saw these were stored appropriately.

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.

Harley Street Specialist Hospital is an 11,100 square foot, six floor hospital building located adjacent to Harley Street. The lower ground floor housed its operating theatre, anaesthetic room, two recovery bays, and 4 day-case pods. It also housed a small office space and instrument storage facilities. The service has been on a refurbishment journey since 2020. The ground floor theatre was refurbished in April 2020 and there had been completion of refurbishment works on common areas and the reception area.

In theatres room number 2, we found evidence of flaking paint on the walls above a pendulum arm lighting fixture. Although this was a cosmetic issue and the area of damage was away from the patient zone of treatment, it was an infection control risk, as the 25 air exchanges per hour could potentially float and land on a patient's wound. We raised the issue with leaders of the service, as well as the estates and operational supervisor and they confirmed that the issue needed addressing urgently. The morning following the inspection, we were sent a risk register entry for the issue raised, which provided a description of what needed to be completed to return to compliance. This included, adding white rock coving protection, an IPC assessment being completed by the consultant microbiologist, and repainting the area. The due date to complete these actions by was 3 March 2023. Following our inspection, we were sent evidence of the completion of the works and all actions from the risk register entry being addressed on 2 March 2023.

The three sharps' bins, we looked at were correctly labelled and were not filled above the maximum fill line. We found the sharps bin to be compliant with (HTM 07-01) Management and disposal of healthcare waste.

Waste management was handled appropriately, with different colour coding for general waste, and clinical waste. All clinical bins were seen to be operated with lids and were not overfilled. Waste management and removal including those for contaminated and hazardous waste was in line with national standards.

Oxygen tanks were stored securely and were in date. The fridge in theatres were temperature checked daily and warming cabinets were checked daily and signed and dated.

Checks on the anaesthetics machine were carried out by the operating department practitioner. We saw evidence of regular checks of resuscitation trolleys and were stocked with adequate supplies and equipment readily available in the event of an emergency.

The hospital kept an asset register which detailed when assets were last serviced and when assets were due for the next service. We saw the hospital's test results, asset management and certificate of testing. We noted 330 appliances had been portable appliance tested on 17 March 2022, with all appliances passing their test. The next retest date was scheduled for 17 March 2023.

The service had safe systems in place for water safety and were fully compliant with (HTM 04-01) Safe water in healthcare premises. An occupational and health organisation undertook the water sampling and offered records for inspection.

HSSH had environmental champions within the hospital to support recycling and good waste management. They had also partnered with a company who provided upcycled clothing, who in collaboration with HSSH's clinical expertise, had designed and manufactured clinical scrubs and workwear clothing made out of recycled plastic from the oceans.

HSSH were also planning a project looking to recycle clinical waste to produce medical products.

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

Due to the nature of the service, the hospital's patients tended to be fit and healthy (ASA 1 and 2 a normal healthy patient and a patient with mild systemic disease respectively). ASA is an American Society of Anaesthesiologists classification system for assessing the fitness of patients before surgery.

The service had a major haemorrhage policy and a major haemorrhage protocol in the event of an emergency where red blood cells were needed. HSSH had service level agreements (SLA) with an NHS hospital, who would supply blood products upon request in an emergency.

HSSH provided specialist treatment of orthopaedic, spine, and cosmetic procedures, accepting elective admissions for treatment of those conditions. The hospital operated a strict exclusion criterion which included: patients with diagnosed or suspected sepsis; patients with major psychiatric issues; patients currently receiving treatment for any psychiatric illness or alcohol/drug detoxification; patients considered morbidly obese or with a BMI over 45; and patients with notifiable diseases or infections.

The hospital had an SLA with a London hospital if they needed to transfer a patient to an intensive treatment unit (ITU), as HSSH were unable to provide intensive treatment services. The service had zero unplanned transfers of deteriorating patients in the last 12 months. The service also had zero reported cases of hospital acquired venous thromboembolism (VTE) or pulmonary embolism (PE) following surgery in the last 12 months. We observed a patient having surgery being provided with compression stockings to help with VTE.

We observed posters around the service about deteriorating patient training sessions for staff to attend. The next session had been scheduled for 17 March 2023.

The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice. The service used an electronic WHO checklist that matched the same WHO checklist prompts and questions that had been designed and displayed on the walls within the procedural rooms to ensure maximum compliance and ease of use. Audits were carried out monthly and the latest audits from October 2022 to February 2023 showed between 99% and 100% compliance for WHO checklist completion.

In the hospital's 'Final recognition and sepsis policy', it stated that nursing staff would be responsible for the recognition of deteriorating patients. They would utilise the NEWS observation tool and escalation to ensure prompt medical review in line with the escalation process and identification of patients with potential sepsis. The service showed compliance with its monthly NEWS audit schedule. Measures looked at included: was respiratory rate entered on the NEWS template; was air and oxygen administered; was blood pressure entered on the chart; and was the patient alert.

The hospital's pre-assessment questionnaire captured the patient's past medical and surgical history, to ensure an informed decision was made surrounding a patient's appropriateness for the planned surgical techniques, type of

anaesthetic to be used and overall fitness for surgery. This also ensured all relevant risks were identified and the relevant staff had access to the reports prior to patients undergoing surgery to potentially avoid further complications pre, intra and post-operatively. Pre-operative tests and/or reports to acquire depending on the patients answers to the pre-assessment questionnaire were identified in line with NICE Routine Pre-Operative Tests for Elective Surgery (2016).

Falls assessments were undertaken and if an issue was identified then the preassessment nurse would work with the physiotherapist to overcome any issues and if necessary, arrange aids to help the patient.

As a day case elective hospital, all of the service's patients were either discharged to their home or alternate accommodation. The service did not accept acute admissions. They had a dedicated emergency number which was manned 24/7 and the primary consultant surgeon was always available, especially for the first night post-procedure. Any immediate clinical emergencies, that occurred outside the hospital, were directed to the local A&E where admission was arranged by the primary surgeon.

When the service did have very rare overnight stays, the primary consultant surgeon and anaesthetist were available within a 30-minutes of the call being made to them, as were the theatre and recovery staff.

Staffing

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

The service had enough medical staff to keep patients safe. The service was consultant led. Consultants and anaesthetists worked under practising privileges agreements. Under practising privileges, a medical practitioner was granted permission to work within an independent hospital. Practising privileges were granted to consultants by the medical advisory committee (MAC). Consultants with practising privileges had their appraisal, mandatory training and revalidation undertaken by the responsible officer. The MAC reviewed and advised upon the continued eligibility of consultants' practising privileges

There was always an RMO in the building when there was a patient on-site and were available until the last patient left the hospital. There was a different RMO for overnight stays, but the lead RMO was responsible for all of the RMO rotas. All RMOs were advanced life support (ALS) trained and most came from an accident and emergency (A&E) background. There was one full time RMO and two bank RMOs working in the service. The hospital were currently trying to recruit a second full time RMO.

During admission and post operative recovery, the hospital provided 1:1 nursing care to its patients. This allowed for the hospital to care for increased complexity day case procedures such as joint replacements of the hip and knee.

The service was fully staffed in most departments, although there were some vacancies in administration and theatres. There were three scrub nurse positions, one anaesthetics practitioner role, and one senior recovery practitioner role available. Interviews were scheduled for each of those roles.

Recruitment was described to be challenging due to the COVID-19 pandemic and local competition. The hospital had recently introduced a referral scheme for staff of £1,000 and signing on bonuses for new employees. The hospital had seen an uptake and interest in positions and had begun filling the long-term vacant posts.

Good

Surgery

Agency staff were used infrequently as the service had a large pool of bank staff. The director of clinical services described having a loyal pool of bank staff. Agency staff completed an induction and orientation programme on the first day of commencing work, with a copy being kept by the line manager and a copy sent to the employee compliance coordinator for filing. The orientation programme included local induction, fire procedures, clinical emergency procedures, patient identification, safe surgery, and point of care testing equipment.

The 'Staff Update Booklet' for November 2022 showed that there were two new permanent starters at HSSH (senior radiographer and medical receptionist/administrator) and one bank pharmacist starter. There were four new consultants that stated in the month with practicing privileges.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Practitioners used the hospital's electronic medical record system to maintain a complete set of medical records for all its patients under the care of the practitioner, including completion of medical history forms, operation notes, progress notes, discharge and clinic letters, or any other documentation relevant to the patient's care.

The hospital's patient administration system, was a cloud-based system that could be logged into remotely, enabling easy access for consultants and their secretaries. Appointments could be booked directly onto open clinics and all patients demographics could be viewed online.

The five sets of patient notes reviewed all contained assessments, discharge summaries and WHO checklists for each patient.

The medical records audit was undertaken monthly. Compliance with this audit had been variable, varying from 86% to 92% between October 2022 and February 2023. The director of clinical services told us that this variation had been occurring due to COVID-19 consent forms, with consent forms forming part of the medical records audit, not being systematically signed by consultants now that covid-19 restrictions had eased. The lack of completion to complete the covid-19 element of the consent form kept bringing down the audit results, although compliance was still good. The director for clinical services explained that the governance committee were in talks to remove the covid-19 consent off the medical form but until that had been approved, the medical records audit would keep failing. The hospital's software system for managing their quality and compliance processes, had an inbuilt system which detected that if an audit didn't reach 100%, then the service would have to devise an action plan for that audit that failed.

Medicines

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

The service had an in-house pharmacy located on the first floor with a superintendent pharmacist and pharmacy technician. The opening hours were from 8am to 5pm daily on weekdays and on Saturdays from 8am to 4pm, subject to availability for patients. The in-house pharmacist dispensed private prescriptions and oversaw ordering medication as well as conducting medicine management and controlled drug audits and providing medication and prescribing advice for the multidisciplinary team.

The RMO who was responsible for a patient's discharge, also wrote up prescriptions, and provided to-take-away (TTA) medicines for patients being discharged. TTA medicines were prepared in the pharmacy.

Good

Surgery

The service stored medicines safely and audited them each month. An external medicines management audit had been performed in October 2021 and the hospital had received 100% compliance. The hospital also had a controlled drugs (CDs) external audit in the same period and had been compliant across all measures, with no concerns identified, and with all processes and record keeping being compliant and accurate.

Controlled drugs audits for the theatres showed 100% compliance between October 2022 and February 2023.

The clinical director of services was the authorised witness for controlled drug (CDs) disposal and the CEO was the accountable officer for controlled drugs. CDs were retrieved from the on-site pharmacy and CDs were checked twice a day (morning and night) by nurses. Two nurses had to sign for and check CDs.

The hospital had recently been inspected by the home office drug licensing inspection team in August 2022 and been provided with a good audit report. The audit did however suggest some actions to initiate which included: amending its standard operating procedures (SOPs) to include a section which set out the requirements and arrangements for notifying the Home Office and the Police in the event of any theft, loss or unaccountable discrepancy of a CD; amending its SOPs to make it clear that all destruction/denaturing of unwanted, expired or damaged stocks of CDs must be undertaken in the presence of the authorised witness named on the Home Office license. We saw evidence of the changes having been made to the SOPs.

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.

Incidents and patient feedback were discussed at a daily meeting which was held at 10am. There had been 76 incidents across surgical services in the last 12 months. All incidents were logged on the hospital's incident reporting system. The electronic incident reporting system made it mandatory to state the incident, perform an investigation, communicate the incident, create action plans, and examine lessons learnt. All these discussion areas were then fed back to the teams involved to close the loop.

We saw evidence of incidents being investigated with actions plans and learning outcomes.

Staff understood the duty of candour and were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood their responsibilities and could give examples of when they would use duty of candour. Staff also described giving duty of candour over the telephone to patients and their families when things went wrong. 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. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

We saw 27 certificates of attendance for staff who had attended the Duty of Candour training session.

Is the service effective?

Good

Surgery

Good

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. All policies that we looked at were maintained in line with National Institute for Health and Care Excellence (NICE) and Association for Perioperative Practice (AfPP) guidelines. The pre-assessment information provided to patients made reference to 'Preoperative Assessment and Optimisation for Adult Surgery including consideration of COVID-19 and its implications – June 2021' NICE guidance.

Enhanced recovery is an evidence-based approach that helps patients recover without delay after undergoing elective surgery. Research has shown that the earlier a patient started mobilising, eating and drinking after having an operation, the shorter their recovery time will be. The service had an enhanced recovery programme for its patients undergoing surgery and set itself priorities in the pre-assessment and theatre process to ensure that patients were as healthy as possible prior to surgery and gave patients the best possible care from the theatre team whilst in the recovery process.

The service offered complementary therapies to patients as adjuncts to their physiotherapy treatment, to best support patients with their recovery. These included: soft tissue massage, acupuncture, and clinical Pilates.

Clinical staff regularly attended conferences and talks on the subject of enhanced recovery, which had led to the development of the service's day case joint replacement programme as well as the implementation of high carbohydrate drinks pre and post operatively for major cases.

Several of the pathways implemented in the service had been used by an NHS hospital in their day case recovery programme, including the use of a new drug (a long acting nerve blocker), of which HSSH were the first hospital in Europe to introduce into everyday practice.

Patients had access to the hospital's rapid orthopaedic walk-in centre and daily injection clinics, providing access to pain specialists and treatment within the same visit.

The service had an orthopaedic specialist group that worked at the hospital, with two consultants working together on all procedures.

Staff had access to an app on their mobile telephone which would allow them to access relevant policies and minutes for meetings.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. 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.

The hospital's policy on the management of pre-operative food and drink stated that no food of any sort must be consumed by the patient in the six hours prior to their surgery. The welcome pack letter that was sent to patients at the

time of their booking also explained that patients that were having a procedure under general anaesthetic or sedation, had to fast from food for a period of approximately six hours and two hours for water. To ensure that patients were compliant with the policy, monitoring processes were undertaken, which included the immediate logging of a incident when fasting times were not adhered to by patients.

The service had a nutritionally balanced menu which had been inspected and approved by an external nutritionist. Patients were given a choice of food and drink to meet their cultural and religious preferences. The service would take food orders for patients before their surgery. Food offerings were provided from salad menus, meat and fish menus, vegetarian and vegan menus. If a patient had to stay overnight, they would also be able to order from the breakfast menu.

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.

The service had a Rapid Pain unit, which operated from Monday to Friday. The rapid access and same day pain and injection service was led by consultant pain specialists and radiologists. The service followed up with all patients within 30 days of their procedure and were asked about their pain management as well as other parameters. The service also held a monthly patient forum attended by the director of clinical service, the head of outpatients and the CEO.

The service were using a novel nerve blocker drug which could decrease feeling in a specific area for up to 4 days and provide long-lasting pain relief. We were told by leaders in the service that this had revolutionised clinical pathways, leading to more complex surgery being undertaken as day surgery and increased patient satisfaction in terms of mobility and pain relief.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes such as, BTI Implants Accredited Centre and ASCA.

The service had an annual audit plan that included regular audits, which were broken down into a schedule of monthly, quarterly, bi-annually and annually. Monthly audits included: WHO checklist, NEWS score, hand hygiene, resuscitation bleep management, and health and safety. Quarterly audits were for medicines management and sharps bins. We found high levels of compliance in many of these audits. The only audits that had failed were the medical records audit, and this was being addressed by getting the governance committee to remove the covid-19 consent element off of the medical form.

The service had an audit program which formed part of their quality and governance report. An audit result board was displayed in the staff areas with areas of focus and improvement.

All sub-committees discussed audit results that were relevant to those committees, which was fed up to the integrated governance and the quality committee.

Good

Surgery

The results from the WHO checklist audit between September 2022 and January 2023 showed 100% compliance. Audit compliance for February 2023 showed 99% compliance, with 100% WHO checklist completion for 19 patients in the month and 75% completion for one patient in that month. The measures assessed included: entering the procedure date, surgeon name and anaesthetist; the sign-in time was completed, the time-out was entered; and the sign-out was also completed.

In the last 12 months, there had only been one patient who returned to theatres, and this occurred in November 2022. The patient had a procedure in the minor operations theatre under local anaesthetic. Several hours later, the patient contacted the hospital advising that they were bleeding and that the blood was collecting in their cheeks causing pain and lumps. The patient returned to the hospital to see the consultant and resident medical officer (RMO), with the patient needing to be taken back to theatre to open the wound to drain and restitch, a pressure dressing was also applied. The service recorded the learning from this event as it being important to act quickly postoperatively if bleeding to reduce swelling and settle any bleeding. The event was also discussed as a team at the 10 at 10 meeting.

The service had a number of accreditation and memberships with various organisations. Accreditations included: Save Face, which was a national register of accredited practitioners who provided non-surgical cosmetic treatments such as anti-wrinkle injections and dermal fillers. BTI Implants Accredited Centre accredited the service for dental implants, which meant the service had to maintain a very high standard of care when it came to the assessment, insertion and management of dental and oral implants. Other accreditations included ASCA (Anaesthesia Clinical Services Accreditation, which the service stated was currently being reviewed.

Memberships included those with ISCAS (Independent Sector Complaints Adjudication Service), IHPN (Independent Healthcare Provider Network, and being a member with PHIN (private healthcare information network), which is a government-mandated organisation publishing performance and fees information about private consultants and hospitals. The service provided data to benchmark their outcomes to PHIN, NJR, the NHS breast registry and national ligament registry.

The service were participating in a bone study, entitled 'Identifying Regulators of Bone Homeostasis'. They study aimed to recruit patients undergoing elective and non-elective orthopaedic surgery and obtain surgical bone waste for analysis, capturing those with bone disorders like osteoporosis and osteoarthritis, in addition to patients without overt clinical bone disease.

The quarterly antimicrobial stewardship audits for September 2022 and January 2023, which looked at the prescribing practice for medical and non-medical prescribers for 10 patients per month demonstrated 90% compliance for the September 22 audit. There was general compliance with most measures for the January 23 audit but non-compliance for 5 patients under the measure 'was the choice of antimicrobial prophylaxis agent prescribed as per guideline'. The auditor's summary showed that a consultant anaesthetist continued to be a repeat offender. The summary also showed that the consultant had been spoken to by the superintendent pharmacist and the issue would be brought up at the next clinical governance meeting.

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.

Practising privileges were reviewed by the medical director and signed off by medical advisory committee (MAC). The pre-requisites for consultants joining Harley Street Specialist Hospital was meeting with the senior leadership team, and the senior leadership team could sign off on temporary practising privileges until they had been ratified at the MAC.

Good

Surgery

The hospital had withdrawn 43 practising privileges in the last six months with reasons ranging from non-compliance to lack of hospital utilisation.

The service kept a 'scope of practice' folder for all of its consultants, detailing information on which registries and hospitals the applicant consultant shared outcome data with, and how many sessions and the volume the applicant intended to bring to HSSH, the list and locations of where the applicant's procedures were carried out, in addition to the volume per annum being undertaken.

The consultant handbook detailed the hospital's values; names and emails of those who to contact for requesting an outpatient room, treatment room booking, sending clinic lists, requesting a theatre session, or updating consultant's practising privileges documentation.

There was a clinical services competency workbook for cannulation and venepuncture, which assessed theoretical knowledge for venepuncture and cannulation and clinical skills for venepuncture and cannulation, where staff being assessed were given a competency level of achievement and it was signed off by their mentor. The director of clinical services ran the cannulation and venepuncture workshop. The 'recognition and management of sepsis' workshop was run collaboratively by the director of clinical services, the RMO and the lead for theatres and IPC.

We saw a 'care and communication of the deteriorating patient' (CDDP) information and workbook, which was designed to support the CDDP course, providing information pre-course reading. Topics in this workbook covered NEWS.

Managers supported staff to develop through yearly, constructive appraisals of their work. The service had a 94% appraisal completion rate.

HSSH had provided mentors from external organisations to newly appointed heads of clinical department. The hospital had also employed a management and coaching consultant company to support the organisation with its need in terms of strategies and educational support.

The hospital offered and had rolled out an annual program of clinical education and resuscitation scenario training and support workshops, which were run by leading consultants and doctors. Courses included regional block syndrome workshops and difficult airway training.

The service had supported staff to complete further courses such as mental first aider, manual handling trainer and independent prescriber course.

The hospital provided access to internal CPD training courses (train the trainer courses) as well as external training courses such as surgical first assistant. All educational plans were discussed individually with the staff member at their annual appraisal.

The hospital operated a buddy system for its new starters until the new starter completed their probation.

Multidisciplinary working

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

Good

Surgery

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Speciality user groups and multidisciplinary team (MDT) meetings were set up for plastic surgery, orthopaedics and oral maxillofacial. The goals of the meetings were: to provide departmental updates, including the review of relevant serious incidents and the specific lessons learnt; HSSH's future plans and projects; service development, including the review of new procedures, policies and pathways; theatre and equipment update; and case discussion and shared learning.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service worked closely with allied health professionals e.g., physiotherapists and psychologists. The service held bi-monthly plastics MDTs and weekly orthopaedic and maxillofacial MDTs.

The daily 10 at 10 meeting that we attended on the inspection was chaired by the CEO. The theatre list for the day and following day was discussed and a 'shout out' was given to a recovery nurse who went over and beyond when dealing with a patient the previous day.

Seven-day services

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

The hospital was open from 06:30am – 8pm Monday to Friday. The first procedure for the day usually occurred from 7:30 and the last procedure could occur at 8pm, with doctors staying later if surgery overran. The hospital was also open on Saturdays, but opening hours were ad-hoc depending on if there were scheduled clinics and procedures for the day.

There was a duty manger on-call hours 24 hours a day. The director of clinical services was the duty manager for the week that we carried out our inspection. The duty manager role was shared between the director of clinical services and the CEO, with them both undertaking the role on a one week on one week off rota. The duty manager would be responsible for coordinating other staff to come into the service outside of operating hours if the circumstances arose.

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. The service had a range of information available to patients on smoking cessation, keeping healthy, directly aimed to maximise the result of their treatment. Stop smoking advice was sent with pre-assessment packs to patients.

On the day of inspection, we had been notified that a consultant had had to cancel a plastics patient because they failed a tobacco test. The procedure being carried out was a chin contouring. The procedure required no smoking for 2 weeks, with obvious access to the mouth needed and bacteria could affect the result. The patient was rebooked again later that month.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Good

Surgery

We saw completed consent in all the records we reviewed. Written consent was sought from patients and we observed consent being confirmed with patients prior to their surgery. Consent forms were signed by patients and their consultants. Written consent including anaesthetic and surgical consent was sought from the patient. Written consent was also sought prior to surgery and on the day of surgery. The service had a covid-19 consent form, which patients were required to sign, consenting that they did not have covid-19.

Patients undergoing any surgery were given a cooling off period of 14 days where they could change their mind about their decision.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) as part of their mandatory training within the consent module.

Staff were able to give clear explanations of their roles and responsibilities under the Mental Capacity Act 2005 (MCA) regarding mental capacity assessments and deprivation of liberty safeguards (DoLS).

Is the service caring?

Good

Compassionate care

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

Staff were discreet and responsive when caring for patients. We saw all staff taking the time to interact with patients in a respectful and considerate way. Patients we spoke with and feedback we reviewed consistently reported that staff treated them with kindness and compassion. We observed all staff to be caring and compassionate in their interactions with patients. Patients we spoke with told us care was 'brilliant' and staff were 'so caring'.

There was a strong, visible, patient centred culture within the service. Staff were passionate about their work and were focused on delivering patient centred care.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. Staff in pre-assessment were committed to ensuring patients felt at ease from the beginning of their journey.

The hospital's independent healthcare review platform report showed that the top word trends used by patients accessing the service was professional, excellent, good, friendly. Survey results from their review platform showed that patients consistently rated the service as "very good" or "excellent".

We were provided with an example from the provider following our inspection, of where an autistic patient who had been refused dental surgery at other private and NHS establishments was able to receive the required dental surgery they needed. A holistic approach was taken to manage the patient's care effectively, with the patient's parents also being supported within theatres to accompany and support the patient through their perioperative journey.

Good

Surgery

Emotional support

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The hospital provided access to psychological services for all plastic and orthopaedic patients and had partnered with leading sports psychologists and patient support companies. Some plastics surgery pathways required psychological assessment prior to surgery for added reassurance and safety. Transgender patients saw psychiatrists all throughout their pathway.

Staff we spoke with understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients we spoke with told us staff were 'extremely kind and considerate'. Patients told us call bells were answered quickly. We observed staff knocking before entering patient rooms and introducing themselves to patients and what they were there do to.

Patients told us staff supported them emotionally. They told us they felt safe and confident which in turn helped their family feel confident about their care as well. They told us staff supported them and were 'sweet and comforting' when they had a few tearful moments.

As part of the hospital's initiatives to support patient care and relieve anxiety due to surgery, they had introduced virtual reality (VR) headsets for all patients to use pre and post operatively so that they could watch films. The technology was being used extensively for patients undergoing surgery under local anaesthetic and for those patients who were awake during their procedures. The use of the technology had led to the hospital being nominated for the Laing Buisson Award 2022 for Nursing Practice.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff involved patients in decisions about their care and treatment. Patients told us they felt comfortable asking their consultant any questions they had and felt involved their treatment plan. Patients told us staff spent time explaining the procedure and were happy to repeat any details which they did not understand.

Patients told us they felt informed throughout their treatment and that staff also kept their family members informed as well. A patient's partner told us that they had been kept well informed about their partner's care and felt that they had left them in "the most capable hands".

For self-pay patients, the vast majority of these patients were referred to the hospital via consultant led practices, where the consultant's administration team or practice manager would be discussing the treatment pricing with the patient. As the hospital was only one element in the overall price that the patient paid, the hospital communicated with the consultant's administration team or practice manager to provide the hospital's element of the cost to the patient.

Good

Surgery

Is the service responsive?

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the needs of those accessing its services. The hospital used local hotels as part of its patient pathway to enhance the experience from the patient's perspective. Through the use of its front desk service, the hospital had been able to only bring patients to the hospital when they were ready to go for their operation. Following on from their procedure, once it was appropriate to discharge the patient, the front desk team were able to ensure that patients were able to return safely to their local hotels. Consultants would visit the patient at the hotel to check that everything went well following their surgery, by ensuring the patients were in close proximity to the hospital the service was able to support the patients' emotional needs. Dependant on the level of clinical input, staff would visit the patients at the hotel the following morning and assist with their dressings, or the concierge would escort the patients back into the hospital to get this done.

Managers monitored and took action to minimise missed appointments. All procedures undertaken at the hospital were elective, so the service planned the date and time of the procedure around the patient. Between March 2022 and March 2023, there had been 102 cancellations in total. The reason for the cancellations fell under the categories of: unwell; covid-19 positive; needing to reschedule, payment and insurances; and other reasons not specified.

The hospital provided transgender surgery. To ensure the needs of these patients were met the service had introduced initiatives such as reviewing their signage so that it was genderless, and providing dedicated training to the hospital's staff in what would make a transgender patient feel safe, the use of pronouns during the patient's pre-operative stage, endeavouring to create an environment that felt secure and safe for this community to undertake their surgery.

HSSH were keen to explore ways of integrating more proactively with their local community. This had involved the director of clinical services undertaking talks at the local girls' school to encourage them to have a future interest in medicine. The hospital's front of house team had also attended local community police talks on security and safety within the local community.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

A television screen in the reception area, broadcasted rolling information about the organisation relating to its people working in the organisation, its governance, accreditations and broadcasted reviews from other patients. WIFI access was available across three different networks and patients could access up to 6000 magazines across 2 tablet devices made available in the reception area.

The service collaborated with an organisation to provide psychological support to patients who were having cosmetic surgery. Consultants could triage and refer patients to the organisation for body dysmorphia disorder and a range of other metrics that could impact on the perceived success of having surgery. Assessments were delivered remotely, and reports would be sent to the referrer within 48 hours of the appointment.

The service also had a sports psychologist available who specialised in clinical sports psychology having worked with elite athletes and sports people. The consultant psychologist was also able to see patients remotely.

The hospital had devised its own autism passports and commented that this initiative which was part of the pre-assessment process in the patient's journey, was crucial for the hospital to tailor the needs for its patients. The passport included information about the patient such as: how I like to communicate; how I would like people to communicate with me; things I do not like in hospital and may find challenging; what I do when I am in pain; what I do if I am anxious and worried; things that I do not like that people should know; and things that I do like that people should know.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had a service level agreement with Language Line to fulfil its interpreting needs, offering an over the phone and video interpreting service.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The hospital's website was embedded with software compliant with accessible information standards. Their new reception area was fitted with an induction loop for those that were hard of hearing.

We service provided wheelchairs by the main visitors lift and toilets were wheelchair accessible, with grab rails and emergency pull cords.

The hospital had information leaflets available in languages spoken by the patients accessing their services. The service provided post-operative instructions and advice leaflets with varied answers to frequently asked questions depending on the type of surgery that was being had. Answers provided to general frequently asked questions were: when can I leave hospital; bleeding; pain management and smoking and alcohol.

A 'Surgical Wound Care at Home' leaflet had been provided to patients giving information and advice on caring for their surgical wounds once they got home. The leaflet included key information about: bathing and showering; taking care of stitches: and changing the dressing.

The pre-assessment leaflet provided to patients informed patients on what they could expect, what they could do to prepare for pre-assessment.

The concierge style receptionist support organised transportation to and from the hospital for patients who were staying in nearby hotels. As a complimentary service, the hospital provided extra beds for chaperones of patients who were travelling from greater distances.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

There were booking meetings every day at 3pm to discuss patient's needs in advance. Consultants worked very closely with the service so that the service could filter information to the consultant team quickly. The pre-assessment nurse chaired the booking meetings, which was also attended by physiotherapist, the anaesthetic lead, CEO, the theatre manager, booking coordinator and director of clinical services.

The resident medical officer (RMO) was responsible for leading the doctor led discharge. The director of clinical services told us that the service had changed from a nurse led discharge to a doctor led discharge and in doing this, complaints had so far amounted to zero. We were told that this change occurred in part because of complaints but also because of the psychology of patients wanting to see a doctor before they were discharged. The doctor led discharge still had to meet the same discharge criteria as it was when it was nurse led.

There were 14 items on the discharge checklist, which included a series of questions and observations with prompts such as: has the patient fully regained consciousness; are the patients' vital signs stable and respiration rate within normal parameters; is the patient able to mobilise independently with or without the use of walking aids; no postural hypotension or syncopal events (fainting on mobilisation or standing; has the patient passed urine; and has the operative site been checked, and any surgical or anaesthetic related complications been ruled out. We looked at 4 discharge summaries and found that they had been completed appropriately and followed the criteria for the proper planning of discharging a patient.

One person had been re-admitted back into the service within the last 12 months, as they had fallen over and split their wound open. All patients were seen within 1 to 2 weeks for wound checks and between 1 to 2 weeks for post operation follow up. Patients could contact the RMO if they were having issues with their wounds.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. Information was signposted around the service about how patients could make a complaint. The hospital's complaints procedure aimed to resolve complaints quickly and effectively and encouraged all complainants to approach staff in person in the first instance. The hospital operated a three-stage formal complaint procedure after an informal complaint. Under the stage one process, a complainant's complaint would be registered on the corporate complaints register; a letter or email would be sent to the complainant within 3 days confirming receipt of their complaint; the service would then initiate an investigation; and the complainant would receive a reply of the investigation's outcome no later than 21 days from the letter confirming receipt of their correspondence.

Staff understood the policy on complaints and knew how to handle them. The service had a complaints policy, which was effective from 26 March 2022 and had a review date of 26 March 2025. The author of the policy was the governance and compliance officer and the compliance reviewer was the CEO. The director of clinical services responsibilities with regards to complaints were: to investigate and respond to patients' complaints that were escalated to stage 2; to provide support and training for the overall patient experience for all staff when deemed appropriate; to support managers drafting the response letters to ensure consistency; and to prepare reports as required on complaints and patient feedback which would then be provided to the integrated governance committee, as appropriate.

The hospital were a member of Independent Sector Complaints Adjudication Service (ISCAS) who reviewed and approved the hospital's complaints policy. We saw evidence that HSSH had agreed to conform to ISCAS's code of practice for resolving complaints. If patients were unhappy with the hospital's response to their complaint they could contact ISCAS.

Good

Surgery

Managers shared feedback from complaints with staff and learning was used to improve the service. There were 5 complaints relating to theatres in the last 12 months. There were no real themes to the complaints, but reasons included: wait times, issues with nurses, compression socks not received post-surgery and the wrong name on medication. In the 10@10 meeting that we attended, we observed complaints being discussed.

The hospital set up a waiting time improvement group to learn from its complaints, as a weakness in its satisfaction scores were waiting times.

Is the service well-led?

Good

Leadership

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

The CEO was the responsible person for the hospital and the director of clinical services was the registered manager for Harley Street Specialist Hospital. All clinical teams fed up to the director of clinical services, who had oversight of theatres, outpatients, imaging, pharmacy, physiotherapy and governance. The director of clinical services reported up to the CEO.

There were 3 leads for each of the service areas – anaesthetic, surgery, and recovery and they reported to the director of clinical services.

The senior leadership team for the hospital, were: a president and chairman; a CEO, a medical director, director of clinical services; a director of communication and new business; and a director of commercial finance.

The senior team had the skills and experience to run the service. The director of clinical services had been a theatre manager for 13 years before becoming a director for clinical services and the CEO had run other hospitals in and around Harley Street. The medical director also worked in the service 3 to 4 days a week as an anaesthetist.

The director of clinical service described the medical director as being one of the best medical directors to work with who had a wealth of knowledge and was very approachable.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. The vision and strategy were focused on sustainability of services.

The hospital's mission was to provide rapid access to the most advanced day-case surgery, achieving the best possible clinical outcomes for their patients, doing so in a safe, caring, and effective environment. The hospital's vision was to become a leading healthcare provider through their commitment to innovation, compassionate care, and pursuit of excellence in day-case surgery.

Good

Surgery

Leaders told us that staff were involved in the development of its hospital strategy, helping to ensure that the strategy was well informed and practical, as staff members had a good understanding of the challenges and opportunities within their particular areas of expertise. Leaders stated that this had led to increased motivation and productivity, and helped to create a positive and collaborative organisational structure.

The hospital's values of compassion, innovation, collaboration and boldness were dotted across the walls of the hospital. All staff had the values of the hospital in the signature of their email.

The consultant base at the hospital had grown over the last 6 months, as surgeons had been identified and recruited as part of the growth strategy. The hospital were also looking at the development of inpatient facilities, that would allow a greater mix of cases with increased complexity. There would also be a focus on developing a highly efficient joint replacement pathway, with specific patients being suitable for day case discharge.

The hospital were currently in discussions with a healthcare insurance organisation to work with them on a back-pain pathway. This would enable HSSH to become a triage site with the potential for direct bookings from that healthcare insurance organisation.

Culture

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

Staff commented that the hospital team prided itself on having an open culture where staff could approach senior leaders if they had any worries or concerns. There were drop-in sessions for staff to speak with speak up guardians and champions. The hospital had an employee assurance programme, where they would continue to pay their staff, if they had to self-isolate.

There was a lead physiotherapist working in the service who provided mindfulness sessions for staff.

Governance

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

The medical advisory committee (MAC) met every quarter. The speciality leads representing at the MAC were for: orthopaedics, plastics, oral, maxillofacial and radiology. Minutes from this meeting were shared in the monthly consultant newsletter.

Integrated governance and quality committee meeting minutes from 16 January 2023 discussed updates to external guidelines, best practice, regulations, and patient safety alerts; policy reviews and approval; and discussed its integrated governance and quality committee report. He committee received reports from its clinical subcommittees, which were for infection prevention and control, health and safety and resuscitation.

Both the hospital's MAC and Integrated Governance and Quality Committee took place quarterly and were chaired by a nominated consultant. Each committee had its own terms of reference.

Good

Surgery

Minutes from the monthly theatres meeting in January 2023 discussed agenda items: governance, staff changes, and learning and development. Under the agenda item, 'what do we feel is working and what is not in the hospital', the minutes showed that there were ongoing issues with procurement and supply, and setting up and stocking up theatres and anaesthetics can be inconsistent making it difficult at weekends and on busy mornings. Both concerns had a named person to follow up on those actions.

The consultant newsletter that was sent out for January 2023, started with a new year's message from the CEO. Other items on the newsletter welcomed the new superintendent pharmacist, the announcement of the forthcoming consultant satisfaction survey for the year and statistics from prospective patients enquiring into the different specialities about the hospital.

Management of risk, issues and performance

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

The service had a risk register which was reviewed at the governance committee, heads of department meetings and the senior leadership team (SLT) meeting as well as medical advisory committee (MAC). There were 11 risks related to theatres recorded on the hospital risk register. All risks had an owner, last and next review date and were red, amber green RAG rated, based on severity of the risk. On the inspection we escalated an observation about the integrity of the theatre flooring to the senior leaders. This was quickly followed up on, with an entry for this being made on the risk register. The risk related to two minor dents (less than 2cm) in theatre two's flooring. There was no tear present, or, penetration of membrane beneath the coated surface.

The hospital received both The Medicines and Healthcare products Regulatory Agency (MHRA) and National Institute for Health and Care Excellence (NICE) medical alerts weekly, to ensure the service remained compliant.

The quarterly board meeting discussed all performance issues relating to the hospital's finances, human resources, investment and plans for the hospital.

The service had a business continuity plan, which included a flow chart of what to do in the event of a incident or business continuity scenario, with the CEO or senior manager on duty activating the business continuity plan.

Information Management

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

The hospital used a bespoke quality management system and an electronic patient record system. The hospital had a plan to be paperless by quarter 3 of 2023. The director for clinical services told us that staff had a lot if input in the design and testing of the systems, so they were quite unique to the hospital.

Results from an information security audit for February 2023 showed 100% compliance. Some of the measures looked at were: are all PCs positioned to avoid overlooking of screens in public areas and/or are screen filters applied when needed; are all work areas cleared of sensitive information when not staffed; and are all printers located in suitable secure (non-public) areas.

Good

Surgery

The hospital had three policies relating to information management, these were: confidentiality and data, information and governance, and medical records and archive policy.

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.

A consultant survey was undertaken every year. 84% of consultants agreed or strongly agreed that Harley Street Specialist Hospital (HSSH) was better than other facilities that they worked at. 96% of consultants agreed or strongly agreed that their patients spoke very highly of their time at HSSH. Comments from consultants ranged from, "proud to be part of HSSH" and "it is my pleasure to work in HSSH. The theatre team is very keen and enthusiastic."

Feedback from the staff forum showed that staff: would find it useful if they had more training on the hospital's quality management system and would like the opportunity to speak with other senior leadership team members. This had been addressed by providing multiple training sessions on the hospital's quality management system and hosting a CEO hour and a member of the SLT attending the last 15 minutes of each forum.

The hospital had created links with two organisations to participate in mental health teaching and support sessions. HSSH also had mental health and mindfulness champions on site, who ran regular mindfulness sessions and sessions to support staff's mental health. They were also available for informal discussions and to give advice.

The hospital operated a 'Shout Out Recognition', 'Shout Out Monthly Star', and 'employee of the quarter'. A senior recovery practitioner received 'employee of the quarter' for August 2022 having been recognised for the significant praise she received from patients.

HSSH had an external speak up guardian who was also the hospital's external medical advisory committee (MAC) chair. They were available by telephone and email at any time and held regular drop-in sessions within the hospital for confidential discussions and support, also facilitating open-door sessions on a quarterly basis to address any concerns staff may have. HSSH also had two staff members acting as speak up champions who were available on site every day during the week.

The provider also had champions that supported other functions within the hospital, these included champions for: equality and diversity; education and development; and infection control.

The hospital had introduced a CEO hour, which was an opportunity for any staff member who wished to speak with the CEO about anything in confidence. The last CEO hour was held on 22 March 2023. Staff also had their own forum once a month where the senior leadership team were not invited. A newsletter went out to staff and consultants once a month.

Throughout the calendar year the hospital supported and arranged staff social events for a mixture of different occasions. Leaders told us that this has been vital to support staff well-being and increase morale.

The hospital also had an employee assistance programme, a scheme designed to help staff through difficult times outside of the workplace.

Good

Surgery

The electronic patient feedback system was the main source for the hospital to receive feedback about the service. There were electronic patient feedback system tablets in theatres and the service commented that they had good uptake within the building. An email was also sent to patients 24 hours after a procedure to seek their feedback on their experience of using the service.

Ninety-eight percent of all patients reviewed the overall service provided by the hospital as good or better with an overwhelming 85% rating them as excellent. The hospital's score for friendliness out of 5 was 4.87.

As well as asking patients to complete a discharge questionnaire, the service made an effort to call patients within 30 days of their procedure and follow up where required.

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.

A core part of HSSH's values were to be innovative and bold, with HSSH having aspirations, to showcase the work of their world-class surgeons and specialist teams.

HSSH has already taken its first steps in its research and development offering by recruiting an experienced project manager and were also in discussions with a clinical director with many years' involvement in projects. The hospital felt that these two roles would be critical to the success of their research and development venture. All clinical activity and/or new procedures (including research and development) were overseen by a MAC and an integrated governance and quality committee. Both were chaired by external consultants to maximise scrutiny and patient safety.

HSSH was the first hospital to deliver samples for bones, a five-year project which was externally funded. The global project is to study the reasons for bone changes and create a bone atlas.

The hospital stated that as they were not a very old hospital, they were committed to continuous improvement and learning and to their mission of 'providing rapid access to the most advanced day case surgery, achieving the best possible clinical outcomes for our patients and doing so in a safe, caring and effective environment.'

The hospital's clinical improvement plan for 2023 and 2024 listed a number of project names with a description of those project aims. Three of the projects on that plan were to: introduce a clinical training expansion programme; the expansion of its existing complementary therapy offering; and the introduction of a physicians associate programme, which looked to explore the use of physician associates in all clinical specialities as part of the hospital's further education programme.

The hospital were supporting a neighbouring college with work experience and teaching sessions on anatomy, nursing and medical careers. The hospital also had the same relationship with the South East London Schools alliance supporting secondary schools in Bromley and Bexley.

The Doctify award for Transparency recognised HSSH for delivering exceptional patient experiences, striving to ensure the service left no patient unheard and ultimately promoting greater transparency within the sector for the sake of better patient care.

The seventh Annual Healthcare and Pharmaceutical Awards 2022 awarded the hospital the best day case hospital for Surgery in London.

Good

Surgery

The hospital were also finalists for Laing Buisson Awards 2022, providing excellence in the provision of acute or mental health services with a focus on innovation and differentiation as a result of an individual hospital initiative or investment. Under its nursing practice, they were finalists in providing excellence in the delivery of nursing services with a focus on innovation, patient management and engagement in the acute or mental health hospital setting across both the NHS and Independent Hospital providers.

Good

Outpatients

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

Is the service safe?

Good

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training compliance was 100% at the time of inspection. Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities and autism.

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 including female genital mutilation. All clinical staff were trained to a minimum of safeguarding level 2 and were up to date with training. The service had a safeguarding lead who was trained to safeguarding level 4 who was available to all staff.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and knew how to make a referral. Staff told us of a recent safeguarding incident involving vulnerable women that had been escalated and actioned.

The service clearly displayed their safeguarding procedure and chaperone policy in all patient areas with information on who to contact if needed.

Good

Outpatients

Cleanliness, infection control and hygiene

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

Clinical areas were visibly clean and had suitable furnishings, which were clean and well-maintained. Cleaning records for the past 3 months were up-to-date and showed that all areas were cleaned regularly. The service conducted bi-annual deep cleans of the entire building.

Hand washing facilities were available in each room and hand sanitiser was available throughout the location. The service scored 100% in their latest hand hygiene audit.

The service held quarterly infection prevention control (IPC) meetings. This was led by a consultant microbiologist who gave specialist advice on matters such as antibiotic prescribing, IPC training and information on circulating organisms. Staff had access to the consultant outside of these meetings if they had queries or concerns related to IPC.

The service had up to date policies on IPC and infection outbreaks.

Staff followed infection control principles including the use of personal protective equipment (PPE) and being bare below the elbows.

Environment and equipment

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

The service had suitable facilities to meet the needs of patients' including areas where they could sit comfortably and wait for their procedure.

Staff carried out safety checks of specialist equipment. Annual maintenance of equipment was carried out by an external company who recorded when checks were due. Managers were able to access this log if needed. Tests of emergency buzzers were completed daily.

The service had enough suitable equipment to help them to safely care for patients. They kept an up to date log of all clinical and non-clinical equipment with details on the last service date and when equipment was due to be next serviced.

Each room had colour coded waste bins so staff could dispose of clinical waste safely. The service had an up to date waste management policy that reflected national guidelines.

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 completed risk assessments for each patient on arrival using a pre assessment tool based on national guidance.

Good

Outpatients

Staff told us they knew how to respond promptly to any sudden deterioration in a patient's health. Staff received training on managing deteriorating patients appropriate for their role. Senior staff were trained in immediate life support (ILS). The service highlighted every morning in the team meeting who was trained in ILS for that day. Emergency buzzers activated the response team. The service audited the response to emergency buzzers and scored 100% in the previous three months.

Staff received training in identifying and dealing with specific risk issues including sepsis. We saw up to date policies on assessing and managing this.

The service had an agreement with another local hospital for the transfer and management of deteriorating patients who became unwell.

The service had access to mental health liaison and specialist mental health support. The service displayed information on how to refer to specialist mental health support in clinical rooms.

Staffing

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

The service had enough nursing and support staff to keep patients safe and the managers could adjust staffing levels daily according to the needs of patients. Managers were able to use suitably trained staff from other departments when needed in an emergency.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift. On the day of inspection, the number of nurses and healthcare assistants matched the planned numbers, which was 2 nurses and 1 health care assistant. Staff told us there was always enough staff to safely care for patients.

Consultants were employed through practicing privileges. The service completed employment checks, background checks and practicing credentials on all consultants .which were reviewed regularly by medical advisory committee (MAC).

The service employed a resident medical officer who was always present on site when a patient was in the building.

The service had low sickness and turnover rates and no vacancy rates in outpatient services.

The service used regular bank staff when needed and limited their use of agency staff. They requested staff familiar with the service.

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

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Good

Outpatients

Patient notes were comprehensive, and all staff could access them easily. We reviewed four patient records and found these had been completed to the required standard.

There were no delays in staff accessing patient records. Consultants and their secretaries could access easily records of their patients when providing clinics in the hospital.

Records were stored securely on computers. Electronic records were shared with other health care professionals if needed through encrypted emails.

Medicines

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

Staff followed systems and processes to prescribe, record and administer medicines safely. The service had an in house pharmacy where they dispensed medications off of private prescriptions.

They were available between the hours of 9am and 5pm. The service had a system for accessing common medications outside these hours.

We saw staff completed medicines records accurately and kept them up to date. They reviewed each patient's medicines regularly and provided advice to patients about their medicines. The service provided information packs about patient's treatments and medicines. These were emailed to them after each consultation.

The service employed a pharmacist who stored and managed all medicines and prescribing documents safely. Prescription pads were numbered and recorded before being sent to consultants to ensure prescription pads were not misused.

We saw logs of medicine safety alerts with actions detailed.

The service completed regular quarterly controlled drug audits but did not complete regular non controlled drug medicine audits. However, we were shown a schedule of medicine audits developed by the pharmacist which started in March 2023.

Incidents

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

Staff knew what incidents to report and how to report them. They reported incidents, including serious matters, and raised concerns in line with the services policy. The service reported 25 incidents in January 2023 with 22 being no harm and 3 being low harm.

Staff received feedback from investigation of incidents and discussed the detail at daily and monthly team meetings. We reviewed incidents which had occurred in the previous 3 months and saw managers had investigated them thoroughly. Patients and their families were involved in these investigations and the service was open and honest with them where it was necessary.

Good

Outpatients

Staff told us managers debriefed and supported them after any serious incident when they occurred.

Is the service 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.

We reviewed various policies and saw they were up-to-date and based on national guidelines.

Managers completed audits to ensure staff were following policies. This included for example, medical record audits and risk assessment audits. Results of audits were displayed in the staff areas. The service performed well in most audits scoring 97% or above. We saw actions created as a result of previous audits that did not meet the services target.

Pain relief

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

Staff assessed patients' pain using a recognised tool from the British Pain Society and gave pain relief in line with individual needs. Managers monitored documentation of pain scores through medical record audits. No issues related to pain score recording were identified in the latest audit.

Pain relief medicines given to patients were recorded in the patient record.

Patient outcomes

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

The service monitored the outcome of patients with 30 day follow up calls. Outcomes for patients were positive and consistent.

Regular daily and monthly meetings were held to ensure staff understood the information from audits and how to improve future care. Audits included IPC, health and safety and fire safety. We saw actions plans created when scores fell below target to ensure service improvement.

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 gave all new staff a full induction tailored to their role before they started work. Staff told us they were supported by leaders when in their induction and beyond. We saw completed competency checklists for new staff.

Good

Outpatients

Managers supported staff to develop through yearly, constructive appraisals of their work. Training needs were discussed, and staff were supported to develop their skills and knowledge. The service funded external training, where it met the staff's developments needs and the service's needs. Appraisal rates for outpatient staff at the time of inspection was 100%.

Managers identified poor staff performance promptly and supported staff to improve. The service monitored the competencies of medical staff they employed through practicing privileges on a quarterly basis. The service held a Medical Advisory Committee (MAC) to assess competencies of existing consultants and approve new applications.

The clinical educators supported the learning and development needs of staff. Experienced leaders held sessions on relevant topics that staff were encouraged to attend. For example, the service had recently held a training session on managing deteriorating patients.

Managers made sure staff attended team meetings or emailed them minutes of the meetings when they could not attend. Senior leaders produced a monthly newsletter for staff and consultants with information and learning from the previous month.

Multidisciplinary working

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

The service held regular and effective multidisciplinary team (MDT) meetings in their speciality to discuss patients and improve their care. Consultants we spoke to told us the MDT meetings hosted by the service allowed them to share learning and good practice. We saw examples of cases and learning discussed at these meetings.

Patients could see all the health professionals involved in their care at one-stop clinics. The service was able to order diagnostic tests for patients on the same day or the next convenient day for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health. Staff were able to refer patients to a psychologist if patients were identified of needing mental health support.

Seven-day services

Key services were available to support timely patient care.

The hospital was open from 06:30am – 8pm Monday to Friday. The hospital was also open on Saturdays, but opening hours were ad-hoc depending on if there were scheduled clinics and procedures for the day.

The service had an out of hours contact number for patients to call if they needed help or advice. Patients told us they could easily access their consultant when needed.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support in patient areas including information on mental health.

Good

Outpatients

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle including information on smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff received and kept up to date with training in the Mental Capacity Act. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Staff made sure patients consented to treatment based on all the information available. We saw staff clearly recorded consent in all patients' records we reviewed. The service audited consent and scored 100% in their latest audit.

Is the service caring?

Good

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients in a respectful and considerate way. Patients told us staff treated them well and with kindness.

We observed staff following policy to keep patient care and treatment confidential.

Patients that we spoke to told us that staff understood and respected their needs including personal cultural, social and religious needs. One patient told us of how the service supported them in their sports recovery and made sure that medicines prescribed to them were not banned by their sporting association.

Emotional support

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

Patients told us staff gave them and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We reviewed patient feedback to the service and saw that patients continually commented that staff were understanding and supportive of their needs.

Understanding and involvement of patients and those close to them.

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Good

Outpatients

Staff made sure patients and those close to them understood their care and treatment. The service had access to translation services and information available in various languages.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service contacted patients 30 days after receiving treatment for feedback. We saw evidence of feedback given being distributed to staff in the monthly newsletter and actions taken as a result of the feedback.

Staff supported patients to make informed decisions about their care. Patients were sent information packs about proposed treatments after initial consultations either via email or through the post allowing them to make informed decisions. The service was upfront about treatment costs and patients told us they never paid more than they expected to.

We saw patients gave consistent positive feedback about the service through online surveys and post appointment follow up calls.

Is the service responsive?

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services so they met the changing needs of the local population. The service had in house pharmacy, physio and imaging services which minimised the number of times patients needed to attend the hospital, by ensuring patients had access to the required staff and tests on one occasion. Doctors were able to order diagnostic tests on the day if required during the consultation.

The facilities and premises including the consultation and treatment rooms were appropriate for the services being delivered. The service had waiting rooms on each floor so patients for each service could wait separately. The service had portable ramps for wheelchair access into the building and had lifts for wheelchair access to each floor.

The service a daily rapid pain unit that was available five days a week from 4pm. This was led by consultant radiologists and offered a variety of pain relieving therapies including platelet rich plasma injections, physiotherapy and acupuncture.

Managers monitored missed appointments and ensured that patients who did not attend appointments were contacted. The service had 27 patients that did not attend in the past year.

Patients told us when they missed their appointments the service worked to rebook them as soon as possible at a time that suited them.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences.

Good

Outpatients

We saw staff supporting patients with learning disabilities by using 'this is me' passports for patients who were autistic. The passports had an overview of the patients' conditions and information on the patients' preferences for communication.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

Managers made sure staff and patients could get help from interpreters or signers when needed through a translation service. Leaflets were available to patients at the clinic which were available in English and Arabic. The registered manager informed us that they responded to patient's needs, as a large population attending the service spoke either English or Arabic.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed. Appointments were organised by consultant and patient availability. The service currently had no waiting time to access the service. Patients told us they were able to get appointments at times that suited them.

Patients told us they could access information from the hospital or consultant when they needed. We were told examples of the service responding to queries quickly, including at unsociable hours.

Learning from complaints and concerns

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

Patients told us they knew how to give feedback, complain or raise concerns. The service sent out feedback forms via email after every appointment and identified themes from feedback and created action plans. The service had recently had a complaint about the cleanliness of the toilets, and we saw the service created a new cleaning schedule to ensure cleanliness. Staff told us the theme of feedback they received the most was waiting times on the day of appointments. We saw evidence of discussion in team meetings about actions to reduce these waiting times.

The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Managers shared feedback from complaints with staff at daily team meetings.

Managers investigated complaints and identified themes. The service had 3 complaints in the outpatient department in the past 12 months. We reviewed complaints and saw the service responded to and actioned complaints as per their policy. One complaint about the hospital in the past 12 months had been referred to the external reviewer, ISCAS (Independent Sector Complaints Adjudication Service).

Good

Outpatients

Is the service well-led?

Good

Leadership

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

The service had a clear management structure in place where staff knew their responsibilities. The outpatient service was led by a nursing manager and supporting manager. They were visible and approachable. Staff told us they would check in on them on every shift to see if they needed additional support.

The senior leadership team was made up of experience staff from both clinical and non-clinical backgrounds. It included a chairperson, chief executive, medical director, director of clinical services, director of finance and a director of communication.

Staff told us they were comfortable approaching senior leaders with any concerns or queries that they had. We observed the daily meeting on the day of inspection and saw input from both senior leaders and clinical staff.

Staff had the opportunity to discuss training needs with their line manager and leaders supported them to develop their skills and knowledge. We saw recent examples of staff being promoted from within the service.

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.

The service had a clear vision and strategy for the service. They had hospital and clinical care improvement plans for 2023 and 2024, which detailed objectives and the timelines they were to be carried out in. Clinical care objectives included the creation of a clinical training expansion programme to help further develop staff and creation of a wait time action group as a result of patient feedback. In the staff survey (May 2022), 88% of staff agreed with the hospitals vision and strategy and 93% of staff knew what the services values were.

The service had clear core values which they displayed around the service. They were 'compassionate, innovators, collaborative and bold'.

Culture

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

The service had a freedom to speak up guardian, who staff were able to approach if they had any concerns that they did not feel comfortable taking to their managers.

Good

Outpatients

In the latest staff survey, (May 2022) only 70% of staff felt valued and appreciated for the work they did, which was a reduction from the previous year. Furthermore, 24% of staff said they had been harassed or bullied by their managers or other staff. However, on the day of inspection, all staff we spoke to told us they felt valued and respected and felt comfortable approaching senior leaders to raise concerns.

Governance

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

Staff at all levels were clear about their roles and understood what they were accountable for. The service had a clear organisational structure chart that all staff could access.

The outpatients service held monthly team meetings that discussed, but was not limited to, audits, training, incidents and infection prevention and control. We reviewed minutes of the past 3 meetings and saw they were well attended from staff in the department.

The service held a monthly quality and governance meeting for leaders and senior staff which covered all departments. Topics that were discussed included incidents, updates on IPC, performance, audits and details of compliments and complaints. They produced a quarterly report for all staff which detailed key information from the meetings. Actions from audits were included in these reports. In January 2023, actions were creating a new cleaning schedule, monitoring the use of extension cables and ensuring there were enough recycling bags.

Clinical incidents and updates were discussed at the quarterly Medical Advisory Committee (MAC) which was attended by directors and consultants.

Management of risk, issues and performance

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

The service maintained an up to date risk register which detailed risks and their potential impact. Risks were scored on their likelihood and potential impact and each risk had an owner responsible for ensuring any actions for the risks were completed. We saw evidence of risks being discussed in governance meeting minutes.

The service used audits to monitor quality and identify risks. The service completed a range of audits across the department including an external health and safety audit and we saw that any issues identified were shared with the staff and actions were taken. The service had an up to date business continuity plan.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The service used electronic medical records and systems that designated staff had access to. Staff were able to access information on audits and performance in the service easily. If paper records were used, they were stored securely.

The service had introduced a bespoke app for the hospital which contained information for staff to easily access. They could see key contacts, the latest information, policies and performance of the service.

The service used encryption when sending personal data via email to protect patients' personal information.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had a yearly staff survey to gather feedback from staff. In the latest staff survey (May 2022) staff gave mostly positive reviews of the service. The service had identified areas for improvement and developed actions for this. The service also hosted staff forums where staff could speak to senior leaders of the service. We saw the service set up an environmental sustainability group as this was a concern raised by staff at previous staff forums.

The service engaged with staff regularly at daily and monthly team meetings to improve care. The services chief executive held monthly drop in sessions for all staff to raise any concerns or issues directly. Other senior leaders were also available to staff at staff forums.

The service told us they hosted monthly patient forums to gather feedback on how to improve care. However, we were not able to see any data from these forums due to cancellations in the previous 3 months.

Learning, continuous improvement and innovation

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

The service was accredited with SaveFace, the national register of accredited practitioners who provide non-surgical cosmetic treatments and BTI implants accredited centre, an accreditation for the high standard of care in assessment, insertion and management of dental and oral implants.

Leaders encouraged innovation and participation in research in the service. We saw consultants in the service recently being approved by the NHS ethics committee to create a study investigating the efficacy of a new treatments for back pain.

Good

Diagnostic imaging

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

Is the service safe?

Good

Mandatory training

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

At the time of inspection all staff were 100% compliant in mandatory training, this was evidenced on the providers internal matrix system. The mandatory training was concise and met the needs of patients and staff. Subjects contained within the mandatory training included; safeguarding, basic life support, mental health and dementia awareness, infection control prevention and data protection. Training was available both online and face-to-face and staff reported it was easily accessible. The registered manager informed us that training was regularly monitored and they were alerted electronically when training needed to be completed or updated.

Consultants at the clinic worked under practising privileges, which were reviewed regularly by medical advisory committee (MAC) to ensure suitability to their role within the clinic. We viewed 10 consultant portfolios on the day of inspection which contained their credentials, training, background checks, DBS, references, identification and clear evidence of an appraisal process completed by a responsible officer.

The range of mandatory training available to staff was varied and tailored to the provider supporting the needs of patients and staff.

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.

The service had a safeguarding policy, which was detailed and specific to the service. It included topics such as responding to adult and children safeguarding, female genital mutilation, modern slavery and human trafficking and detailed the mental health act 1983.

Good

Diagnostic imaging

All staff were compliant with safeguarding training. The registered manager was the safeguarding lead and was trained at level 4 safeguarding. Posters were clearly placed in every room of the clinic which explained how to report a safeguarding including contact numbers and named individuals to report to. Staff had a clear understanding of what safeguarding vulnerable people was and were able to give examples. Staff spoken to were aware of the appointed safeguarding lead and how to report using the referral process.

Staff were able to access policies easily via their internal intranet system and also via an app, which they can download securely onto their mobile phones. Staff spoke highly of the app used for employees within the clinic as it gave them secure instant access when needed.

Although the service only saw patients over the age of 18 years staff were able to evidence safe procedures for children visiting the service.

Cleanliness, infection control and hygiene

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

All areas of the service were visibly clean and had suitable furnishings which were well maintained. On the day of inspection cleaning schedules were up-to-date and demonstrated that all areas were regularly cleaned. The service employed its own housekeepers and were able to evidence signed and dated daily cleaning logs.

The service provided levels of cleanliness specified in the Royal College of Radiologists professional standards. For example, the correct use of personal protective equipment (PPE) including facemasks, hand sanitiser and gloves to maintain patient safety. Infection prevention control (IPC) policies and guidance were up to date and accessible to staff. Hand sanitiser stations were accessible throughout the clinic with clear signage encouraging patients and staff use.

Clinical and domestic waste bins were labelled correctly with the correct colour coded bin liners in place. Infection prevention and control guidance posters were visible in clinical areas detailing management of waste products. Sharps bin containers were signed and dated in accordance with IPC policy. The registered manager was able to evidence signed and dated contracts with clinical waste disposal company.

Cleaning schedules for the diagnostic and imaging suites were up to date, detailing when staff had cleaned equipment after patient use. The service completed audits including IPC and hand hygiene, which were 100% compliant. Staff were ‘bare below the elbow’ as per national IPC guidelines and we observed staff washing their hands in between patient contact.

Environment and equipment

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

The service had maintenance and service contracts in place with manufacturers and was able to evidence testing for all equipment. The service contracts included access to medical physics support, maintenance of machinery including breakdown services. The registered manager was able to evidence a signed radiation protection services contract with a local NHS trust. The service was able to provide evidence of radiation risk assessments; these were clear, concise and within date.

Good

Diagnostic imaging

Radiography staff had access to protective equipment to carry out diagnostic imaging such as x-rays and scans including lead vests, screens and dosimeters to reduce and monitor exposure. Dosimeters are used to monitor staff exposure to radiation. The radiographer was able to provide monthly records and audits during our inspection.

The service was compliant with local rules relating to x-ray safety procedures. There was clear signage outside the room indicating an x-ray procedure was taking place. The radiographer demonstrated the use of the signs were in working order.

The service had suitable facilities to meet the needs of patients and visitors. These included lifts to each floor, ramps for the main entrance steps and accessible toilets, which were fitted with fully functioning call bells. Resuscitation trolley was available on three floors along with grab bags containing resuscitation equipment. Staff had documented daily checks within a folder attached to the resuscitation equipment.

Fire testing was conducted once a week by the maintenance team. This included ensuring fire exits were not blocked, smoke detectors working correctly, and fire extinguishers were full and in date. Fire exits had clear signage including evacuation meeting point in the event of a fire. Fire evacuation sledges were available to transport patients safely out of the building in the event of an evacuation.

Staff disposed and tagged clinical waste safely via an external provider. Electrical equipment had undergone safety testing, which was evidenced by stickers containing dates and signatures. The service was well stocked with suitable equipment to support patients safe care and we saw evidence that equipment maintenance was up to date.

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

Risk assessments and questionnaires were completed and reviewed by the radiographer before receiving treatment to ensure patient suitability. Staff confirmed they carried out checks of patient identity, discussed and confirmed location area being scanned and obtained patients verbal and written consent.

Pregnancy status was discussed with patients and documentation was given highlighting the radiation risks to pregnant women. Posters were visible within the imaging suite containing local rules, abnormal findings escalation process, radiation incident escalation, and ‘paused and checked’ guidance supported by the society of radiographers.

The service had a deteriorating patient policy and staff spoken to understood how to respond to any sudden deteriorating patient and how to escalate if required. The service had a service level agreement with a local hospital. This detailed the level of support offered to patients at Harley Street specialist clinic if required.

The service had a copy of their ionising radiation local rules, which was in date and not due to be reviewed until 2025. This specified what was expected of staff and details of the medical physics expert (MPE), the radiation protection supervisor (RPS) and the radiation protection advisor (RPA). The local rules stated procedures for using PPE and shielding; controlled area entry; use of the radiation equipment; use of personal monitoring devices such as dosimeter and quality assurance testing.

Good

Diagnostic imaging

The service was able to demonstrate good documentation relating to radiation safety. This included instructions to both clinical and non-clinical staff entering the x-ray rooms. There was a clear diagnostic imaging standard operating procedures (SOP's) to guide staff. Policies relating to radiography were tailored to the service, all had signatures, authors, dates, reference to national guidelines and were version controlled.

Staffing

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

The service had enough staff to keep patients safe. They did use bank staff when required; however, these were regular staff to maintain continuity. Management were able to adjust staffing levels based on the number of clinics due to run on the day. The service offered pre-booked appointments to patients, which allowed for effective planning of staffing to meet clinical needs.

The service employed 3 radiographers, 2 of which were permanent staff with 1 vacancy. They used regular bank staff to fill this position. The service had an induction process for newly employed staff.

Medical staff worked at the service under practising privileges. The granting of practising privileges is a well-established process within independent healthcare whereby a medical practitioner is granted permission to work in an independent hospital or clinic. The Medical Advisory Committee (MAC) regularly reviewed practicing privileges to ensure suitability of the individual for their role within the clinic. We reviewed 10 medical staff portfolios, which showed what mandatory training they had completed; employment checks; practising credentials; background checks, indemnity insurance and appraisals.

All clinical staff were trained in basic life support (BLS) training and there was a resident medical officer (RMO) on site who had advanced life support (ALS) training. Prior to employment, staff had their training credentials and background checks completed. On inspection 10 personal files were chosen at random. These contained evidence of appraisals and background checks such as the Disclosure and Barring Service (DBS).

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.

Records were stored securely on both paper and electronic records. Records were kept in line with the Records Management Code of Practice 2021. Staff could access records easily and securely using individual pass code logins which gained them access to the internal database system. Paper records were scanned then stored in a lockable cabinet. Records could be electronically transferred to external healthcare professionals via a secure internal system. The service used a secure electronic picture archiving and communication system (PACS) to transfer images between healthcare professionals and locations.

We reviewed 10 patient notes, all of which were clear and complete. They included referral letters, consent forms, clinic letters and risk assessments. Staff followed internal policy to keep patient records safe and confidential.

Medicines

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

Good

Diagnostic imaging

Staff followed systems and processes to prescribe, administer medicines and dispose of waste medicines safely in accordance with their policy. Monthly medicine audits were evidenced on the day of inspection.

Only staff with the required competencies could give medicines, and they had attended a medicines management course. Oxygen cylinders were properly and securely stored on the resuscitation trolley.

Intravenous (IV) contrast was used for some imaging procedures. These were stored in a lockable store cupboard with an assigned key holder per shift.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the service's policy. All incidents were reviewed by the registered manager and senior management at a Clinical Governance Committee (CGC).

All staff were aware of how to use the incident database and all staff had access to the information they required. The registered manager encouraged staff to report anything they felt might be an incident, staff corroborated this.

The service had no reported never events or serious incidents within the last 12 months. We requested incidents over the past 12 months relating to diagnostics and were told there had not been any. The annual schedule of clinical audits was described in the corporate policy and oversight was maintained corporately and locally. Staff told us that if an incidents occurred, it would be discussed with staff to ensure lessons and recommendations were addressed. If additional training was needed, this would be arranged.

Is the service 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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service was able to evidence use of national guidelines within their policies such as the National Institute for health and care excellence (NICE) and The Society of Radiographers (SOR). All policies were tailored to the provider and were accessible via a secure app or the internal electronic system.

The service's physics expert calculated local dose reference levels for machines which used X-rays. They were all below the national dose reference levels.

Nutrition and hydration

Staff gave patients food and drink when needed. Patients could access specialist dietary advice and support.

Good

Diagnostic imaging

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients were given menus where they could select items of food from; this included dietary and religious requirements. The service did not provide catering on-site, however, had an arrangement with a local catering company who could provide same day delivery requests. Fridges were stocked with the bottles of water to allow staff and patients to remain hydrated.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes

The service carried out clinical audits to monitor care, treatment and implement improvements. Care records, hand hygiene, consent and compliance with Ionising Radiation (Medical Exposure) regulations (IR(ME)R) were examples of clinical audits used. The service was able to evidence regular scheduling of clinical audits including appropriate actions put in place to monitor and review the quality of the service.

The service had a record of patients who returned for further treatment and who had been recommended to use the service.

The service used a picture archiving and communication system (PACS). This is a computerised means of replacing the roles of conventional radiological film: images were acquired, stored, transmitted, and displayed digitally.

Patients were offered an opportunity to fill out a questionnaire on their satisfaction of the service provided. Staff also contacted patients' post-treatment using a 30 day call back system to gain patient feedback.

The service reported to various external services enabling them to benchmark their patient treatments and outcomes against local and national level data within the radiology sector.

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 the patients. The service was able to demonstrate appropriate recruitment checks on its staff. Checks included evidence of disclosure and barring service (DBS), references, photo identification, and professional registration where required.

The service ensured that all new employed staff members had a full induction specific to their role as part of their employment. Specific qualifications relating to the job role was evidenced in staff's portfolios, for example certificates detailing Nursing and Midwifery Council (NMC) membership and General Medical Practice (GMC) memberships.

Medical staff worked at the service under practising privileges. On inspection the service was able to provide 10 portfolios evidencing mandatory training, employment checks, practising credentials, background checks, indemnity insurance and appraisals.

We saw evidence of staff supervision and appraisal. Records showed all staff had received an appraisal within the last twelve months. Staff identified learning and development needs and agreed an action plan of how to achieve these.

Good

Diagnostic imaging

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 spoken to, reported that team working was well established within the service and they were encouraged to discuss any issues or concerns with their colleagues.

The service employed resident medical officers (RMOs) to support the with care of patients. The RMO worked closely within the imaging and diagnostic team and supported other services within the building.

The service worked closely together across various multidisciplinary teams (MTD), regular meetings were held for example fortnightly heads of departments meetings and monthly Chief Executive Officer (CEO) update meetings to ensure patients received safe treatment.

Seven-day services

Key services were available to support timely patient care.

The service was open Monday to Friday from 8am to 5pm. If a patient needed urgent support outside of these working hours, they were advised to attend their local NHS emergency department. If patients needed non-urgent support, they were provided email addresses and telephone numbers of their care team who would provide advice as soon as possible. The service had a service level agreement with a local independent health hospital for emergencies or complications that may arise during treatment.

Health promotion

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

The service provided health questionnaires for patients to complete as part of their consultation process. If health promotion was identified, then patients were signposted where they could receive further advice and support. Posters and leaflets were available throughout the clinic for patients to view.

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 received and kept up to date with training on the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS).

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. We saw evidence of this during our inspection process. Staff gained consent from patients for their care and treatment in line with legislation and guidance.

We were able to observe the interaction between clinician and patient regarding consent. All relevant information was given to the patient to enable them to make an informed decision regarding their care and treatment.

The service was able to evidence their most recent consent audit, which was 100% compliant.

Good

Diagnostic imaging

Is the service caring?

Good

Compassionate care

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

We were able to view 1 patient on inspection receiving diagnostic imaging services. We witnessed staff being discreet and responsive when caring for this patient. Staff understood and respected their personal, cultural, social and religious needs and how they related to their individual care needs.

Post inspection we contacted patients who had received treatment at the service. All 10 patients who spoke with us gave positive feedback and reported they were very happy with their treatment and care from staff and that they would recommend to friends and family.

The service collected data from patient surveys which we were able to view from the past month.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. The service offered mental health support via counselling sessions which could be arranged through the clinic. Clear visible posters detailing support were observed around the clinic and in patient waiting areas.

Nervous and anxious patients were encouraged to bring family members or friends to accompany them to maximise patient experience.

Staff had received chaperone training so they could further support patients. Posters were visible in all areas of the clinic detailing how to request a chaperone. The service provided a 30 day call back service to all patients which involved a wellbeing questioner.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment to enable them to make an informed decision regarding their care. Staff were able to use a translation service for patients and families to ensure effective communication was maintained throughout their care and treatment at the clinic. The use of hearing loops within areas of the service were used to support clinically impaired patients and visitors.

Patients and their families could give feedback on the service and their treatment via questionnaires and feedback forms. Feedback was positive from both search engine reviews and from surveys given directly to patients. All of the 10 patients reported that the staff were understanding and that information was clear including financial costs.

Good

Diagnostic imaging

Is the service responsive?

Good

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Facilities and premises were appropriate for the services being delivered. The service had individual lockable patient changing rooms, which included lockers meaning patients could leave any valuables whilst they had treatment.

Toilets services were clean and accessible with clear signage on the doors. Wheelchair access was available via ramps and internal lifts. The service provided patient toilets including a disabled toilet with supporting equipment and call bell in situ.

Medical staff maintained their own caseload and allocated enough time for each individual patient's needs, which meant not many patients in the waiting room at one time. Appointments were made to suit individuals, for example accommodating patients that needed to arrange travel and accommodation. The service offered tailored packages to patients receiving treatment including hotel stays and travel arrangements, as they provided care for patients across the country and also patients from abroad.

Meeting people's individual needs

The service took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Lifts were available within the clinic which were large enough to facilitate wheelchair access and treatment beds/ trolleys.

Leaflets were available to patients at the clinic which were available in English and Arabic. The registered manager informed us that they responded to patient's needs, as a large population attending the service spoke either English or Arabic. The service had access to a language line to support with communication if English was not their preferred language. The service provided treatment for patients with learning disabilities by using 'this is me' passports for patients who were autistic. The passports had an overview of the patients' conditions and information on the patients' preferences for communication.

The registered manager was able to evidence their exclusion criteria for patient treatments for example this service did not provide any services for children or patients living with dementia.

The service coordinated care with other services and providers using the system (PACS). This enabled radiologists to share with other healthcare providers such as GPs.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times for treatment were in line with national standards.

Good

Diagnostic imaging

The registered manager reported that there were no patient wait times or delays in treatment and that patients could access diagnostic testing with short notice. Consultants held their own diaries and were responsible for booking their own patients, which meant they could be flexible and prioritise based on the patient's individual needs. Patients were self-funders or covered under insurance policies that used the service.

Learning from complaints and concerns

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

There was clear policy for dealing with complaints, detailing written response times. The service employed an external company to assist with the complaints process. All complaints raised would be discussed at senior meetings including clinical governance committee. Staff were then informed of the complaints via daily meetings and emails for feedback and learning purposes.

The registered manager explained that complaints were reviewed on an individual basis, trends and themes identified would be discussed with staff during patient feedback groups and huddles. Complaint leaflets were available in waiting areas and in consultation clinics. The 10 patients spoken with explained that they were given clear instructions how to complain if needed and that a 30 day call back service was given by staff, which gave opportunity to raise concerns if required. Patients were also able to access the complaints team via the company website.

Is the service well-led?

Good

Leadership

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

There was a clear management structure which identified lines of responsibility and accountability. Staff told us they felt they could approach immediate managers and senior managers with concerns or queries. Staff reported feeling supported, respected and listened to within the clinic. This was evidenced on the day of inspection where a daily meeting was held with all staff, which was led by the CEO.

All staff understood the leadership structure and reported how approachable and understanding senior management were. The CEO knew every staff member by name as the inspection team was shown around the building, and they appeared comfortable around him. The service had established priorities based around providing a high-quality service. These were outlined within their business strategy and future growth plans.

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

Good

Diagnostic imaging

There was clear vision and strategy within the service specifying their vision, mission and values. The service was able to evidence clear branding positioning and communication strategy showing future growth plans. Staff we spoke with understood the goals and values of the service and how it had set out to achieve them.

There was clear vision and strategy relating to diagnostic screening services. An example of this was an innovating garment design that had been developed to protect the privacy and dignity of the patient receiving treatment. The registered manager was able to provide evidence of positive clinical outcome from recent case studies of the new garment.

Culture

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

Managers supported an open and honest culture by leading by example and promoting the service's values. There were opportunities to discuss training and development needs for current roles along with future career development.

Staff reported feeling able to raise concerns and were well supported from the service to do this. The service was focused on the needs of the patients, this was managed by regularly reviewing patient feedback and assessing and responding to incidents and complaints.

Staff we spoke with said they felt empowered to raise concerns and address any issues the service faced, openly and honestly. Staff told us they were proud to work for the service and that they felt part of a 'family' working for the service. Staff spoke highly of the positive impact they had on their patients care and experience, which was reflected in patient feedback viewed on site.

Staff told us there was a no blame culture when incidents happened, and the team supported each other at team meetings.

Senior staff worked hard to create a positive place to work, this was evidenced by the various schemes and incentives put in place for staff, such as employee of the week, month and year.

The service provides staff mindfulness sessions to promote staff wellbeing and mental health. These sessions were advertised on posters in staff communal areas and also on digital monthly newsletters.

Governance

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

The service had a clear organisational structure, with information on this available on the internal system for staff to access. Clinical governance committee (CGC) and Medical Advisory Committee meetings (MAC) were held quarterly, the service was able to provide minutes of these meetings on our visit. Information discussed at these meetings included incidents, updates on IPC, performance, audits and details of compliments and complaints. Any reported incidents would be discussed and reviewed at these meetings and an action plan would be put in place if necessary.

Good

Diagnostic imaging

The CGC meetings included the attendance of the medical director, clinical services director and radiologist to assist with discussions and reporting There was a clear process relating to escalation of incidents to executive level if required.

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.

The service had an up to date risk register, which identified specific risks and the potential impact on the service patient. Risks were regularly discussed at all governance meetings and actioned appropriately. These included relevant clinical and corporate risks to the organisation and action plans to address them.

There was a clear policy for unexpected events and how to address these including contact names and numbers. This was available on the internal system for staff to access. There was a service level agreement with a local hospital to support with unexpected events.

Regular audits were completed to maintain quality of care, for example some audits we viewed were infection prevention control, consent, clinical waste, Ionising Radiation (Medical Exposure) (IR(ME)R) were examples of clinical audits used. Performance data was collected to identify any trends and themes.

Information Management

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

The service used electronic platforms where staff had individual log in to gain access. If the service needed to send confidential emails documents; these were sent through an encrypted software which was suitable for purpose. Staff spoken to understood the storage of personal data was set out in the General Data Protection Regulation (GDPR). All staff were compliant with their GDPR training which we saw evidence of during inspection.

Data including policies and daily meeting minutes were accessible via a company app which staff had their own unique log in passwords to access.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service encouraged feedback from patients in various ways for example telephone questionnaires, online and paper form to maximise patient response. These were then collated and any areas for improvement, as well as areas of excellence were highlighted to all staff at monthly team meetings. The service provided staff meetings and feedback sessions to assist with improving treatment and care. During these meetings patient feedback was discussed, and any learning was identified and implemented.

The feedback collected was also used within the services Patient Experience Committee meeting, identifying themes and trends. Staff told us they felt listened to when they had suggestions related to service delivery.

Good

Diagnostic imaging

The service supports a local charity which they arrange events to raise money for the local community, for example staff completing cycling challenges and volunteering outside of working hours.

The registered manager informed us that they provide educational services to local medical colleges and secondary schools such as lecturing on various subjects and information on job opportunities.

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 service held monthly team meetings identified opportunities for staff members to contribute towards ideas for improvement within the clinic.

The service regularly checked and updated policies in line with national guidelines and evidence-based practice.

The service were finalists for the LaingBuisson Awards 2022 highlighting the 'excellence in provision of acute or mental health services with focus on innovation' and 'excellence in the delivery of nursing services with focus on innovation'.

The service also received an award for the best day case hospital in London from the '7th Annual Healthcare and Pharmaceutical Awards 2022'.

During our inspection we saw evidence of improvement and innovation. The service was able to evidence innovating technology with positive patient outcome such as virtual reality headsets, state of the art 3D printers and privacy garments all centred around individualist patient care.