

The Harley Street Clinic

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Outstanding



Are services safe?

Good



Are services effective?

Good



Are services caring?

Outstanding



Are services responsive?

Good



Are services well-led?

Outstanding



Summary of findings

Letter from the Chief Inspector of Hospitals

The Harley Street clinic is part of HCA International group, who also provide care at five other hospitals in London.

We carried out this inspection as part of the CQC's ongoing programme of comprehensive, independent healthcare acute hospital inspections under the new methodology.

The Harley Street Clinic undertakes a range of surgical procedures and provides medical and critical care, to adults. The hospital also provides services to children and young people, carries out outpatient consultations and provides critical care services to children. The hospital has the largest independent healthcare paediatric intensive care unit (PICU). The hospital therefore provides five of the eight core services that are inspected by the Care Quality Commission as part of its new approach to hospital inspection.

The Harley Street Clinic has 103 beds, four operating theatres, three catheter laboratories and six treatment rooms. The hospital provides 93 inpatient and ten day case beds. Specialities treated include oncology, cardiac and neurosciences for both adults and paediatrics. At the time of the inspection the hospital was not providing any NHS funded care.

We inspected the Harley Street Clinic as part of our planned inspection programme, visiting 3-5 August 2016 followed by an unannounced visit 17 August 2016. This was a comprehensive inspection and we looked at five core services provided by the hospital: medical care, surgery, critical care, services for children and young people and outpatients and diagnostic imaging.

We rated the safety, effectiveness and responsiveness of this hospital as good. We found the leadership and caring aspects of this hospital to be outstanding. Overall, we have rated The Harley Street Clinic as 'outstanding'.

Are services safe at this hospital?

By safe, we mean that people are protected from abuse and avoidable harm.

- There was a hospital wide electronic incident reporting system and staff were aware of how to report incidents. Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed and staff clearly demonstrated examples of learning from these. Senior management understood and adhered to the duty of candour appropriately.
- Clinical areas were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.
- Staff had access to a range appropriate equipment to care for patients safely. Equipment was safety tested and well maintained, in line with manufacturer's guidance.
- Medicines were stored securely and managed safely. Pharmacy staff were actively involved in the pre-admission, admission, inpatient and discharge processes.
- Records were managed safely, securely stored on site and available when needed. The radiotherapy department had implemented a fully paperless system of working. This system mitigates the paper based system risks and is also better for the environment. The department has assisted other independent and NHS departments in the implementing the system.
- Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.
- Patients were appropriately risk assessed, their condition was monitored throughout their stay, and there were appropriate procedures and protocols for responding to any deteriorating condition.

Summary of findings

- We had concerns that staffing in the paediatric intensive care unit (PICU) did not meet Royal College of Nursing (RCN) guidance, as the majority of nurses were not trained specifically in paediatrics. In all other areas, staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.
- Staff received appropriate training to perform their role safely and were supported to keep their skills up to date.
- Plans and arrangements were in place to respond to emergency situations.

Are services effective at this hospital?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Patients care and treatment was planned and delivered in line with current best practice, evidence based guidance and legislation. Performance was monitored and improved in line with national guidance from organisations such as the National Institute for Clinical Excellence (NICE) and the Royal Colleges.
- Patients' pain was monitored and the effectiveness of pain management evaluated. Patients had access to different methods of pain relief.
- The hospital offered a range of meals and drinks and hospitality team were always available. Patients had comprehensive assessments of their needs, which included assessment of their clinical needs, physical health, nutrition and hydration needs.
- Oncology patient outcomes were monitored at cancer multi-disciplinary (MDT) meetings
- The hospital surgery participated in a range of national audits and benchmarking, including: the Public Health England (PHE) surgical site surveillance for benchmarking for coronary artery bypass grafting (CABG) and total abdominal hysterectomy (TAH). We found the hospital had performed better than the national average for CABG. For example, the PHE SSI audit from April 2015 to March 2016 indicated that there had been 0% infections compared to the five year average for all hospitals of 4.3%.
- The Adult intensive care unit (AITU) contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The hospital performed better than similar units in unplanned readmissions and non-clinical transfers out of the unit in 2015/16.
- The National Congenital Heart Disease Audit Report 2012 -15 demonstrated the hospital had a 98.8% survival rate for patients admitted with this condition. This was better than the expected predicted survival rate of 97.3%.
- The hospital published the Breast Quality Framework Report; containing outcome data collected as a retrospective audit of breast cancer patients treated in the period of 2010 to 2014. The hospital is working collaboratively with Public Health England to collate and publish patient survival rates.
- Consultants were granted practicing privileges after a lengthy application process supported and verified by the medical advisory committee (MAC). Those privileges were then reviewed once a year. The MAC also reviewed policies and guidance and advised on effective care and treatment.
- There was good communication between the MAC and hospital medical directors and this was maintained through coordinated consultant engagement.
- Practice facilitators and educators ensured that nursing staff were supported through the revalidation process.
- Staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.

Summary of findings

- The consent process for patients was well structured, audited and reviewed to improve how people are involved in making decisions about their care and treatment.
- Staff were trained in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs), although rarely used as the vast majority of patients treated had capacity to give their informed consent.

Are services caring at this hospital?

By caring, we mean that staff involve and treat patients with compassion, dignity and respect.

- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and were willing to go the extra mile to meet individuals' needs. We saw incidences of staff changing their shifts or working additional shifts in order to offer anxious patients continuity of care. We saw examples of pro-bono patient care to accommodate individual needs.
- Staff always took people's personal, cultural, social and religious needs into account. For example, care plans for patients observing Shabbat included instructions on how staff could support them to avoid use of technology such as call bells by increasing the frequency of checks. We saw examples of 'weddings' that had been organised on the ward to accommodate immobile patients' last wishes and hosting an event so one patient could fulfil their role as 'mother of the bride' at their daughter's wedding.
- People's emotional and social needs were highly valued by staff and are embedded in their care and treatment. For example, the 'rainbow beads' project provided an opportunity to recognise the courage and strength of children and young people who were accessing the hospital for long term treatments. Children and young people were rewarded with a bead for each treatment or intervention. We saw examples of patients supported to have visits from loved pets.
- Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care and treatment.
- The hospital used patient feedback to ensure they were addressing patients' needs.

Are services responsive at this hospital?

By responsive we mean that services are organised so they meet people's needs.

- The complex and differing needs of patients were central to the planning and delivery of the tailored service that the hospital provided. Pre-assessment nurses pro-actively provided individual patient-centred care before admission and after discharge.
- The provider approached care and treatment for their patients in a truly holistic and individualised way. We found excellent multidisciplinary team (MDT) working with close collaboration between all staff. National experts in their field with access to latest diagnostic and treatment methods attended regular MDT meetings. We saw the multidisciplinary team working together to provide the best care available and working to ensure all needs of patients were met.
- Patient admissions were arranged in a timely manner, with minimal delays. The outpatient service ensured that waiting times were kept at a minimum.
- There were allocated appointment slots for patients that wanted same day diagnostic procedures.
- All radiological imaging results were available within 24 hours or earlier if requested.
- There were facilities in place and readily available for patients from different cultural backgrounds and for whom their first language was not English.

Summary of findings

- The hospital did not treat many patients with dementia or complex mental health needs but staff were aware of who to escalate concerns to regarding these patients.
- Complaints were dealt with by the CNO and CEO and the service ensured that complaint responses were timely and well managed.
- Learning from complaints was assessed and shared with staff via both email and monthly ward meetings.

Are services well led at this hospital?

By well-led, we mean that the leadership, management and governance of the organisation, assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- We found approachable and motivational leadership that promoted staff development and career progression, teamwork and high-quality patient-centred care.
- Staff were aware of the corporate vision and all staff were aware of their unit vision and strategy. The vision and strategy of the service was embedded into practice by staff.
- The corporate governance structure ensured that there was a vast amount of cross over in-between key groups.
- The governance team had hired new members of staff to maintain the risk register and oversee other areas. The handover process was sound and the reporting mechanisms in place were of a high quality.
- Service managers had monthly meetings with the CEO where issues were actively discussed and best practice was encouraged to be implemented. Staff felt they could engage with the CEO and felt they managers could raise issues on their behalf and they would be listened to.
- All staff were able to name the CEO and reported that the senior management team were visible and accessible. Staff felt as though there was an open 'family'-like culture.
- We saw new leaders and managers in the paediatric services who were driving forward change to improve staff development and patient care. We saw and heard about the improvements to the working culture and how staff satisfaction had improved. New ways of working had been introduced to promote safe and effective patient care.
- A "Nurse in charge" work initiative was in place in the outpatients department specifically tailored to encourage junior staff nurses to develop leadership skills. This initiative contributed to the five new outpatient senior nurse roles and has allowed the department to promote internally.
- There were world class, first of their kind innovations taking place at the hospital and staff were proud to say they worked there.
- The radiotherapy department in collaboration with a London NHS trust has lead a unique scalp sparing technique study. The study is aimed at improving the quality of life of patients requiring whole brain radiotherapy treatment, by trying to remove the side effect of hair loss at such an emotional time in the patient's life. The study was the winner of the LangBuisson 2015 award for Innovation in Care.
- The cancer service offered innovative patient-centred care through access to latest diagnostic and therapeutic methods and by seeking out new treatment options and taking a holistic approach to patient care. This high quality care included psychological support and complementary therapies such as relaxation or aromatherapy for example. Patients were given access to early phase clinical trials for new cancer drugs through partnership with a cancer research institute.

However, there were also areas where the provider needs to make improvements.

Summary of findings

Importantly, the hospital must make the following improvements:

- The provider must take action to ensure the skill mix of staff in the paediatric intensive care reflects current recommendations.

In addition the hospital should:

- Ensure that the multi-faith rooms are appropriate to meet patients' spiritual needs.
- Provide more adequate storage space in theatres.
- Ensure that the theatre doors fully close and do not overlap one another.
- Ensure all staff that have contact with patients under the age of 18 are trained to a minimum of level 3 safeguarding training.
- Ensure all staff are up to date with mandatory training requirements.
- Ensure all department risk registers reflect the current risks to their service.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Rating Summary of each main service

Medical care

Outstanding



The leadership promoted an open and approachable culture with emphasis on integration and collaboration of all staff, driven to improve high quality patient care. Staff felt comfortable to express their views and approach managers with their concerns. The management actively encouraged staff to learn and improve. Staff satisfaction surveys showed that staff felt committed to give their best.

There was a clear governance structure and well executed quality management. The hospital's risk register was up-to-date and proactively managed. Patients were cared for compassionately and holistically and were kept informed of their treatment plan and progress. There was an ethos of staff going above and beyond their duty to support patients' emotional and social needs.

An in-house psychology team was available for patients, relatives and staff. Emotional support for patients was well considered and provided through the easily accessible psychology team, Macmillan Cancer Centre and support groups. Alternative therapies were offered to improve well-being. A make-up and skincare workshop was aimed to help women living with cancer improve their self-confidence and self-esteem.

There was an established process for reporting and investigation of clinical incidents. Staff were aware of their responsibilities to report incidents and be open with patients in the event that things went wrong. Learning from incidents and complaints were shared across the teams and the hospital.

We found excellent multidisciplinary team (MDT) working with close collaboration between all staff. National experts in their field with access to latest diagnostic and treatment methods attended regular MDT meetings.

The cancer service offered innovative patient-centred care by seeking out new treatment options and taking a holistic approach to patient care. Patients had access to latest diagnostic methods and new cancer drugs through early phase clinical trials.

Summary of findings

The complex and differing needs of individuals were central to the planning and delivery of the tailored service that the hospital provided. There was no evidence of any long waiting times or delays. Staff were aware of the processes to facilitate admissions and complex discharges. A pre-assessment nurse and a discharge liaison nurse provided individual patient-centred care.

Surgery

Good



Senior management were accessible to staff and were reported to be supportive in their approach. The governance processes in place ensured a vast amount of collaborative working.

The service were using outstanding cutting edge technology including non-invasive robotic radiosurgery, laser therapy and brachytherapy. There were processes in place to reduce the risks associated with surgical procedures.

Nurses monitored patients after their operation and medical staff were available if there were any concerns.

Automatic alerts were sent to the resident medical officers (RMOs) if a patient's observations were of concern. This was facilitated via the electronic National early warning scoring tool (NEWS).

Pre-operative assessment was undertaken by qualified staff in line with the NICE guidelines.

There were sufficient numbers of staff to care for patients.

Patients provided positive feedback about their care and treatment.

There were regular MDT meetings to discuss patients' care and treatment.

The pharmacy department provided support for ward staff.

Critical care

Good



There was a clear system of incident reporting in place and staff were aware of their responsibilities to report incidents.

Clinical areas throughout the hospital were visibly clean and patient risks were identified and acted upon swiftly.

Staffing in the unit was compliant with Intensive Care Society (ICS) guidance with a suitable number of qualified and registered staff.

Care was provided in accordance with national guidance including NICE guidelines.

Summary of findings

Services for children and young people

Good



The unit contributed to the Intensive Care National Audit & Research Centre (ICNARC) for critical care patients. The rates of early deaths on the unit was below the national average for similar units.

The unit participated in local and national audits to demonstrate patient outcomes.

Nurses received regular supervision and 100% of nurses had undergone an appraisal in the last year.

We observed good working relationships between all grades of staff and all professional disciplines. MDT meetings were well attended.

We reviewed comment slips and 'thank you' cards and spoke with patients who found the staff to be very caring and respectful.

The complaint handling process was clear and speedy.

There were arrangements in place for governance, risk management and quality measurement associated with intensive care patients.

There was a comprehensive audit programme and senior staff maintained the risk register.

We observed strong leadership and lines of accountability in the unit were coherent.

Staff took time to ensure that children and their parents understood their treatment and went above and beyond in caring for patients.

The emotional and social needs of patients were highly valued and excellently considered in terms of treatment planning.

The 'rainbow beads' project provided an opportunity to recognise the strength and courage of long term children and young people. Patients were also supported to have visits from beloved pets.

Staff were open and transparent, and fully committed to reporting incidents and 'near misses'. Learning from incidents was demonstrated to be a high priority within the service. We saw thorough analysis and investigations completed when things went wrong and saw that learning was shared appropriately amongst staff.

All clinical areas were clean and well organised. All equipment was safety tested and cleaned.

Medicines, including controlled drugs (CD's) were stored and managed appropriately. Fridge temperatures were monitored daily.

Summary of findings

Outpatients and diagnostic imaging

Good



The staffing ratios were better than most comparable units according to the paediatric intensive care audit data (PICANet). Data was also submitted to the National Congenital Heart Disease Audit (NCHDA). Not all nurses were paediatric nurses and this did not comply with Royal college of Nursing (RCN) standards. Nurses had a 26 month learning and development pathway and informed us that they had good opportunities for growth. There were daily RMO ward rounds and MDT safety huddles. Support groups were set up for families who had come abroad for treatment. These meetings were well attended by clinical psychologists to provide additional patient support. Staff were aware of the unit vision and strategy and there were clear governance arrangements in place.

Staff felt encouraged to move up the career ladder by their managers. All staff we spoke to confirmed this taking inspiration from the CEO and other colleagues who all progressed from junior roles within the hospital. All staff were aware of the corporate provider's vision and embedded the strategy into everyday work. The radiotherapy department in collaboration with a London NHS trust lead a unique scalp sparing technique study aiming to improve the quality of life of palliative brain patients preventing hair loss during such an emotional time. The study won the LangBuisson 2015 award for Innovation in Care. There were processes in place to investigate incidents and staff were aware of how to report incidents. All clinical areas were visibly clean and patient areas had enough seating. Staff complied with the hospital bare below the elbows (BBE) policy and we observed staff using personal protective equipment (PPE) where necessary. Diagnostic and imaging staff followed national guidance and equipment was appropriately cleaned, tested and maintained. Both radiology and radiotherapy used the Ionising Radiation (Medical Exposure) Regulations (IR(MER)(2000) where necessary. There were appropriate numbers of nursing staff and consultants. There was low use of agency staff.

Summary of findings

Performance and competence was continually assessed and staff we spoke with confirmed that they were encouraged to undertake continued professional development (CPD).

Complementary therapies were available free of charge to patients and we saw that staff were caring and maintained patients dignity and privacy at all times.

Delays to treatment were dealt with as efficiently as possible. This was confirmed by patients.

The radiotherapy department used a paperless system of working mitigating paper based risks whilst also being environmentally superior. The department has guided other independent and NHS departments who have then implemented the same system.

Summary of findings

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Outstanding

The Harley Street Clinic

Services we looked at

Medical care; Surgery; Critical care; Services for children and young people; Outpatients and diagnostic imaging.

Summary of this inspection

Background to The Harley Street Clinic

The Harley Street Clinic is a 103 bedded private hospital, based in Harley Street, London. The Harley Street clinic is part of the HCA International group who provide care at five other hospitals in London.

The hospital undertakes a range of surgical procedures and provides medical and critical care to adults. The hospital also provides services to children and young people and carries out outpatient consultations. The hospital therefore provide five of the eight core services that are inspected by the Care Quality Commission as part of its new approach to hospital inspection.

The hospital has four operating theatres, 78 consultation rooms, six treatment rooms, 93 inpatient and 10 day case beds all with en-suite facilities.

Specialities treated include oncology, cardiac and neurosciences for both adults and paediatrics.

The registered manager from the Harley Street is Ms Aida Yousefi (CEO).

The nominated individual is Mr Michael Neeb.

Our inspection team

Our inspection team was led by:

Inspection Lead: Michelle McCarthy, Inspection Manager, Hospitals Directorate, London.

The team included CQC inspectors and a variety of specialist advisors including; consultants, nurses, radiographers and a pharmacist inspector.

Why we carried out this inspection

We undertook a comprehensive inspection of the hospital as part of our planned inspection programme of independent acute hospitals.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before our inspection, we reviewed a range of information we held about the hospital and each core service.

We carried out an announced inspection on 3,4, 5 August 2016 and an unannounced inspection on 17 August 2016. We spoke with a range of staff in the hospital, including nurses, consultants, administrative and clerical staff.

During our inspection we spoke with 37 patients and 125 staff from all areas of the hospital. We observed how people were being cared for, talked with patients and reviewed treatment plans and patient records.

We received 20 comment cards from patients, relatives and members of staff before and during the inspection. All comments were positive about the service and the hospital as a whole.

Summary of this inspection

We conducted interviews and focus groups with staff members of all levels including clinical and non-clinical staff. We also interviewed the hospital's senior managers, including the registered manager, chief nurse and chair of the MAC.

We would like to thank all staff, patients and relatives for sharing their views and experiences of the quality of care and treatment at The Harley Street Clinic.

Information about The Harley Street Clinic

Context

- The hospital is registered for 93 inpatient and 10 day case beds.
- 868 doctors have practicing privileges. Their individual activity was monitored and in the period April 2015 to March 2016, this ranged from 1 to 624 patient episodes per consultant. Of the 868 consultants, 153 had seen over 100 patients per annum.
- The hospital employs 16 Resident Medical Officers (RMOs).
- There are currently 156.4 whole time equivalent nurses in post.

Activity

- Between April 2015 and March 2016, there were 6,948 inpatient and day case episodes. During the same period, there were 55,936 outpatient visits; of these 16 were NHS funded.
- During the same period there were 8,702 children's outpatient attendances.
- Around 3,074 adult inpatients and 588 children stayed overnight in the hospital between April 2015 and March 2016.
- Between April 2015 and March 2016, there were 2,184 adult day cases and 910 children's day cases.
- In the year before the inspection the hospital carried out 38 diagnostic endoscopy procedures in their theatres. The scopes were sent to another HCA hospital to be decontaminated.
- The top ten most common medical procedures were as follows:
 - Radiotherapy (1044)

- Chemotherapy (587)
- Cardiac Electrophysiology (590)
- Transeosophaseal Echo (261)
- Interventional Radiology Biopsy (252)
- Interventional Radiology Other (252)
- Interventional Radiology Drainage (238)
- Cardiac catheterisation (202)
- Photodynamic Therapy (55)
- MOHS (53)

- The top 10 most common surgical procedures were as follows:
 - Spine (508)
 - Thoracic (427)
 - Ear, Nose and Throat (320)
 - Head and Neck (266)
 - Breast (236)
 - Cardiac (219)
 - Vascular (211)
 - Colorectal (175)
 - Upper GI (173)
 - Bladder (108)

Inspection History

- The Harley Street Clinic has been inspected four times between 2012 and 2015. At the last inspection in February 2015 we issued requirement notices because the provider: did not have suitable arrangements to store and prescribe medications, did not have an up to date children's safeguarding policy in place that reflected national guidance and did not have an up to date 'do not attempt cardio pulmonary resuscitation' policy in place that reflected national guidance. The provider sent us a

Summary of this inspection

report telling us the action they intended to take to make improvement. During this inspection we found the provider had complied with the requirement notices.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

There was a hospital wide electronic incident reporting system and staff were aware of how to report incidents. Staff reported incidents and openness about safety was encouraged. Incidents were monitored and reviewed and staff clearly demonstrated examples of learning from these. Senior management understood and adhered to the Duty of Candour appropriately.

Clinical areas were visibly clean and tidy. Hospital infection prevention and control practices were followed and these were regularly monitored, to reduce the risk of spread of infections.

Staff had access to a range appropriate equipment to care for patients safely. Equipment was safety tested and well maintained, in line with manufacturer's guidance.

Medicines were stored securely and managed safely. Pharmacy staff were actively involved in the pre-admission, admission, inpatient and discharge processes.

Records were managed safely, securely stored on site and available when needed. The radiotherapy department had implemented a fully paperless system of working. This system mitigates the paper based system risks and is also better for the environment. The department has assisted other independent and NHS departments in the implementing the system.

Staff were knowledgeable about the hospital's safeguarding policy and clear about their responsibilities to report concerns.

Patients were appropriately risk assessed, their condition was monitored throughout their stay, and there were appropriate procedures and protocols for responding to any deteriorating condition.

We had concerns that staffing in the paediatric intensive care unit (PICU) did not meet Royal College of Nursing (RCN) guidance, as the majority of nurses were not trained specifically in paediatrics. In all other areas, staffing levels and skill mix were planned, implemented and reviewed to ensure patients received safe care and treatment at all times.

Staff received appropriate training to perform their role safely and were supported to keep their skills up to date.

Plans and arrangements were in place to respond to emergency situations.

Good



Summary of this inspection

Are services effective?

Good



Patients care and treatment was planned and delivered in line with current best practice, evidence based guidance and legislation. Performance was monitored and improved in line with national guidance from organisations such as the National Institute for Clinical Excellence (NICE) and the Royal Colleges.

Patients' pain was monitored and the effectiveness of pain management evaluated. Patients had access to different methods of pain relief.

The hospital offered a range of meals and drinks and hospitality team were always available. Patients had comprehensive assessments of their needs, which included assessment of their clinical needs, physical health, nutrition and hydration needs.

Oncology patient outcomes were monitored at cancer multi-disciplinary (MDT) meetings

The hospital surgery participated in a range of national audits and benchmarking, including: the Public Health England (PHE) surgical site surveillance for benchmarking for coronary artery bypass grafting (CABG) and total abdominal hysterectomy (TAH). We found the hospital had performed better than the national average for CABG. For example, the PHE SSI audit from April 2015 to March 2016 indicated that there had been 1.9% infections compared to the five year average for all hospitals of 4.3%.

The critical care unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The hospital performed better than similar units in unplanned readmissions and non-clinical transfers out of the unit in 2015/16.

The National Congenital Heart Disease Audit Report 2012 -15 demonstrated the hospital had a 98.8% survival rate for patients admitted with this condition. This was better than the expected predicted survival rate of 97.3%.

The hospital published the Breast Quality Framework Report; containing outcome data collected as a retrospective audit of breast cancer patients treated in the period of 2010 to 2014. The hospital is working collaboratively with Public Health England to collate and publish patient survival rates.

Consultants were granted practicing privileges after a lengthy application process supported and verified by the medical advisory committee (MAC). Those privileges were then reviewed once a year. The MAC also reviewed policies and guidance and advised on effective care and treatment.

Summary of this inspection

There was good communication between the MAC and hospital medical directors and this was maintained through coordinated consultant engagement.

Practice facilitators and educators ensured that nursing staff were supported through the revalidation process.

Staff worked well within teams and across different services to plan and deliver patients' care and treatment in a coordinated way.

The consent process for patients was well structured, audited and reviewed to improve how people are involved in making decisions about their care and treatment.

Staff were trained in the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLs), although rarely used as the vast majority of patients treated had capacity to give their informed consent.

Are services caring?

Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and were willing to go the extra mile to meet individuals' needs.. We saw incidences of staff changing their shifts or working additional shifts in order to offer anxious patients continuity of care. We saw examples of pro-bono patient care to accommodate individual needs.

Staff always took people's personal, cultural, social and religious needs into account. For example, care plans for patients observing Shabbat included instructions on how staff could support them to avoid use of technology such as call bells by increasing the frequency of checks. We saw examples of 'weddings' that had been organised on the ward to accommodate immobile patients' last wishes and hosting an event so one patient could fulfil their role as 'mother of the bride' at their daughter's wedding.

People's emotional and social needs were highly valued by staff and are embedded in their care and treatment. For example, the 'rainbow beads' project provided an opportunity to recognise the courage and strength of children and young people who were accessing the hospital for long term treatments. Children and young people were rewarded with a bead for each treatment or intervention. We saw examples of patients supported to have visits from beloved pets.

Patients understood the care and treatment choices available to them and were given appropriate information and support regarding their care and treatment.

The hospital used patient feedback to ensure they were addressing patients' needs.

Outstanding



Summary of this inspection

Are services responsive?

Good



The complex and differing needs of patients were central to the planning and delivery of the tailored service that the hospital provided. Pre-assessment nurses pro-actively provided individual patient-centred care before admission and after discharge. Staff were aware of the processes to

The provider approached care and treatment for their patients in a truly holistic and individualised way. We found excellent multidisciplinary team (MDT) working with close collaboration between all staff. National experts in their field with access to latest diagnostic and treatment methods attended regular MDT meetings. We saw the multidisciplinary team working together to provide the best care available and working to ensure all needs of patients were met.

Patient admissions were arranged in a timely manner, with minimal delays. The outpatient service ensured that waiting times were kept at a minimum.

There were allocated appointment slots for patients that wanted same day diagnostic procedures.

All radiological imaging results were available within 24 hours or earlier if requested.

There were facilities in place and readily available for patients from different cultural backgrounds and for whom their first language was not English.

The hospital did not treat many patients with dementia or complex mental health needs but staff were aware of who to escalate concerns to regarding these patients.

Complaints were dealt with by the CNO and CEO and the service ensured that complaint responses were timely and well managed.

Learning from complaints was assessed and shared with staff via both email and monthly ward meetings.

Are services well-led?

Outstanding



We found approachable and motivational leadership that promoted staff development and career progression, teamwork and high-quality patient-centred care.

Staff were aware of the corporate vision and all staff were aware of their unit vision and strategy. Staff embedded the vision and strategy of their services into practice.

The corporate governance structure ensured that there was a vast amount of cross over in-between key groups.

Summary of this inspection

The governance team had hired new members of staff to maintain the risk register and oversee other areas. The handover process was sound and the reporting mechanisms in place were of a high quality.

Service managers had monthly meetings with the CEO where issues were actively discussed and best practice was encouraged to be implemented. Staff felt they could engage with the CEO and felt their managers could raise issues on their behalf and they would be listened to.

All staff were able to name the CEO and reported that the senior management team were visible and accessible. Staff felt as though there was an open 'family'-like culture.

We saw new leaders and managers in the paediatric services who were driving forward change to improve staff development and patient care. We saw and heard about the improvements to the working culture and how staff satisfaction had improved. New ways of working had been introduced to promote safe and effective patient care.

A "Nurse in charge" work initiative was in place in the outpatients department specifically tailored to encourage junior staff nurses to develop leadership skills. This initiative contributed to the five new outpatient senior nurse roles and has allowed the department to promote internally.

There were world class, first of their kind innovations taking place at the hospital and staff were proud to say they worked there.

The radiotherapy department in collaboration with a London NHS trust has lead a unique scalp sparing technique study. The study is aimed at improving the quality of life of patients requiring whole brain radiotherapy treatment, by trying to remove the side effect of hair loss at such an emotional time in the patient's life. The study was the winner of the LangBuisson 2015 award for Innovation in Care.

The cancer service offered innovative patient-centred care through access to latest diagnostic and therapeutic methods and by seeking out new treatment options and taking a holistic approach to patient care. This high quality care included psychological support and complementary therapies such as relaxation or aromatherapy for example. Patients were given access to early phase clinical trials for new cancer drugs through partnership with a cancer research institute.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	 Outstanding	Good	 Outstanding	 Outstanding
Surgery	Good	Good	Good	Good	 Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	 Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	 Outstanding	Good
Overall	Good	Good	 Outstanding	Good	 Outstanding	 Outstanding

Notes



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

Information about the service

Inpatient and day care medical services at the Harley Street Clinic were delivered on two wards and the Day Care Unit (DCU). The oncology ward had 16 beds in single room accommodation, including four isolation beds on a separate haematology oncology unit. The cardiology, general medicine and cardiothoracic surgery ward on the third floor had 15 single rooms and a five-bedded bay. The DCU comprised a single four-bedded bay on the ground floor of the hospital. In the last year the service performed 38 diagnostic endoscopy procedures in their theatres.

Inpatients were accommodated in single rooms with an en-suite toilet and shower. Day case patients stayed in the DCU or in the five-bedded bay on the third floor.

The Harley Street Clinic had an agreement of professional clinical services with two neighbouring NHS trusts for provision of palliative care services. A specialist team of palliative medicine consultants and clinical nurse specialists worked together with other health service staff to provide care for patients in the final phase of life.

During our inspection we visited the two wards, the cardiac catheter laboratories (cath labs) and the DCU.

We spoke with four patients and four relatives, as well as 33 members of staff including doctors, nurses, allied health professionals, clinical service managers, governance managers and support staff.

We observed interactions between patients and staff. In addition, we considered the environment and looked at records, including eight patient care records and ten prescription charts. Prior to, and during the course of our inspection, we also reviewed performance information and data about the service.

Summary of findings

We rated the service as 'outstanding' because:

- Patients were cared for compassionately and holistically and were kept informed of their treatment plan and progress. There was an ethos of staff going above and beyond their duty to support patients' emotional and social needs. Psychological and emotional support for patients was well considered and easily accessible. There was also a variety of therapies and workshops for patients to make use of.
- We saw evidence of detailed and thoughtful consideration of patient and family wishes and circumstances. Staff organised family meetings and discussed important topics in multidisciplinary meetings.
- Staff understood the hospital's vision and strategy, which were embedded in daily delivery of care. The governance structure was clear and quality management was well executed.
- Staff were motivated to provide the best possible care for patients. There was a high degree of collaboration across the service. We spoke with managers, doctors, nurses, allied health care professionals and support staff and we found there was a culture of mutual respect at all levels.
- The leadership promoted an open and approachable culture with emphasis on integration and collaboration of all staff, driven to improve high quality patient care. Staff felt comfortable to express



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their views and approach managers with their concerns. The management actively encouraged staff to learn and improve. Staff satisfaction surveys showed that staff felt committed to give their best.

- There was an established process for reporting and investigation of clinical incidents. Staff were aware of their responsibilities to report incidents and be open with patients in the event that things went wrong. Learning from incidents and complaints were shared across the teams and the hospital.
- We found excellent multidisciplinary team (MDT) working with close collaboration between all staff. National experts in their field with access to latest diagnostic and treatment methods attended regular MDT meetings.
- The cancer service offered innovative patient-centred care by seeking out new treatment options and taking a holistic approach to patient care. Patients had access to latest diagnostic methods and new cancer drugs through early phase clinical trials.
- The complex and differing needs of individuals were central to the planning and delivery of the tailored service that the hospital provided. There was no evidence of any long waiting times or delays. Staff were aware of the processes to facilitate admissions and complex discharges. A pre-assessment nurse and a discharge liaison nurse provided individual patient-centred care.

However:

- Not all written entries in the medical records were clearly legible or conformed to professional standards.
- Not all staff were aware of the meaning of the Mental Capacity Act (MCA) and had little knowledge of Deprivation of Liberty Safeguards (DoLS).
- We did not see any formal outcome data in oncology.

Are medical care services safe?

Good



We rated medical care services as good for safe because:

- There was an established process for reporting and investigation of clinical incidents. Staff were aware of their responsibilities to report incidents and be open with patients in the event that things went wrong.
- There were sufficient numbers of medical and nursing staff with appropriate training to deliver safe care.
- Infection prevention and control processes were in place to protect patients from the risk of infection.

However:

- Not all written entries in the medical records were clearly legible or conformed to professional standards.
- We saw indications of high nursing staff turnover.

Incidents

- The medical department reported 406 clinical incidents in between April 2015 to March 2016. Of these, 397 incidents were rated as 'low' or 'no harm', and a further eight were rated as 'moderate' harm. In cases we reviewed, appropriate action had been taken at the time to prevent similar incidents happening again.
- Staff were aware of their responsibilities to raise concerns, record and report safety incidents on the electronic system. There was a hospital incident policy which staff knew how to access. Feedback and learning from incidents were discussed regularly in both ward and wider hospital meetings. We were shown evidence of incident investigations and how outcomes were shared via departmental meetings.
- The hospital had recently arranged an incident reporting training day, which staff found very useful. According to staff, the volume of reported incidents had increased as a result but they were filled out better or they were reporting all incidents they should. The ward manager informed her team about incidents in a weekly ward newsletter.
- The hospital reported one unexpected death for the medical department between April 2015 and March



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2016. Monthly Morbidity and Mortality meetings were held, where both expected and unexpected deaths were discussed. Unexpected deaths were referred to the coroner who would decide about a post-mortem or inquest to be held. We saw documentation of these meetings on a standardised form which included clinical details with time line of events leading to death, cause of death and review details including points of discussion and identified learning or areas for improvement.

Safety thermometer

- The hospital did not use the NHS safety thermometer, this is a tool to measure harm to patients which may be associated with their care. However, the hospital had developed their own dashboard which monitored pressure ulcers, falls, catheter-associated urinary tract infections and venous thromboembolism (VTE).
- The hospital gathered patient information such as hospital acquired infections. This information was displayed on staff notice boards, within clinical areas and on the hospital website. There had been no incidents of hospital acquired VTE or pulmonary embolism (PE) in the reporting period (April 2015 to March 2016).
- The nursing notes included mandatory assessments, for example falls and VTE assessments. Between April 2015 and March 2016, an average of 95% of patients were screened for the risk of VTE.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour. Supporting information was available to staff for reference.
- We saw examples in incident documentation where the duty of candour regulations were applied correctly.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean. Cleaning schedules were on display in the nursing station. Clinical equipment was appropriately labeled with green "I am clean" stickers to show when it had last been cleaned.
- Staff adhered to the bare below elbow (BBE) dress code and we observed staff cleaning their hands regularly. We observed staff using personal protective equipment (PPE) such as gloves and aprons appropriately when indicated, such as whilst administering intravenous chemotherapy.
- There were sufficient hand washing facilities and hand sanitisers throughout the department. Red hand hygiene signs enhanced their visibility and hand hygiene notices encouraged staff to clean their hands. A corporate hand hygiene policy and audit schedule monitored staff compliance.
- The results of the monthly hand hygiene audit between January and March 2016 averaged 94% for the oncology ward and 91% for the cardiology and general surgery ward.
- The haemato-oncology unit was equipped with negative pressure rooms to isolate infectious patients.
- Doors to single patient rooms on the wards had built-in sliders to indicate whether isolation precautions were in place. We observed staff putting on gloves and an apron before entering an isolation room.
- The hospital had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. There was a named infection control lead nurse and infection control link nurses. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice.
- We saw that clinical waste, including chemotherapy waste, cytotoxic waste and sharp objects, were disposed of safely. Waste was separated in different coloured bags to signify different categories of waste. All containers were labelled correctly.
- There were no incidents of Meticillin resistant staphylococcus aureus (MRSA) or MSSA in the reporting



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period April 15 to March 2016. A corporate MRSA screening and management policy was in place. An infection control audit for May to June 2016 demonstrated 100% MRSA screening of admissions.

- Between April 2015 and March 2016, there was one incident of *Clostridium difficile* and six incidents of *Escherichia coli*.
- All endoscopy scopes were sent to another HCA hospital cleaning unit for decontamination.

Environment and equipment

- Resuscitation equipment was stored securely in designated trolleys and was available in all areas. We saw records of daily checks. All drawers and shelves were fully stocked with consumables and medicines that were in date. Drugs about to expire were marked with “do not use after” stickers. Emergency equipment was clean and ready for use. Staff were trained in its use as part of their mandatory training.
- Electrical equipment we saw was marked as having undergone safety testing.
- Sharps boxes were appropriately assembled, labelled and not overfilled. We witnessed a nurse correctly assembling and signing a sharps bin.
- The third floor ward had two dirty utility rooms. One of the macerators for disposal of bedpans and urine bottles was unserviceable and awaiting replacement. However, staff told us that most patients on the ward were mobile and this was not an issue.
- Environmental and equipment audits were completed monthly. These audits looked at general appearance, labelling of sharps bins, storage, linen management and equipment. Results for January to March 2016 showed compliance between 68% and 82% for the wards and 100% and 94% for the cath labs.

Medicines

- Medicines were stored safely and available for patients when they needed them, including controlled drugs. Medicine keys in both units were under the control of a qualified nurse. All medicine stock items we checked were in date. Staff we spoke with were aware of how to access medicines out-of-hours. Emergency medicines

were available and checked daily by a registered nurse. Chemotherapy drugs were stored outside the ward and collected individually. This reduced the risk of error in this high risk category of medicines.

- A departmental audit of the storage and administration of controlled drugs (CD) between January and March 2016 identified several issues. Errors in log books were not managed correctly, log books contained incomplete entries and missing signatures, cupboards contained expired stock and patients own controlled drugs were not returned on discharge. The audit contained a detailed action plan. The CD log books and cupboards we saw during inspection did not show any irregularities.
- A hospital wide audit of treatment rooms in the same period identified several issues across departments including: fridge temperatures not being checked daily, drugs not being appropriately stored in locked cabinets/ fridges, expired drugs still present in active stock, medical notes not being stored correctly and IV fluids not kept in the correct location. Action plans were put into place to address these topics. During our visit we found significant improvements: Fridge and room temperatures in ward treatment rooms were all checked daily in line with hospital guidelines, drugs and medical records were stored appropriately and IV fluids were kept in locked cupboards.
- A pharmacist was available seven days a week, during normal working hours on weekdays and in the mornings on weekends. The hospital had access to pharmacists out-of-hours, including specialist oncology pharmacists. The duty manager and RMO had access to the pharmacy at all times to obtain medications for inpatient use only.
- Pharmacists and technicians spent time on the wards and were involved in decisions about patient care.
- Medicines were reconciled on admission, meaning the process of obtaining an accurate list of each patient's current medications. Recent audits showed that in February 2016 93% of patients had had their medicines reconciled within 24 hours of admission. In March 2016, this fell to 82%. However, these figures had improved since 2015.
- The hospital aimed to dispense discharge medications in one hour. Audits between January and May 2016



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indicated that only 8% of prescriptions did not reach this target. A checklist was used to ensure patients went home with all medications and information required. This checklist was developed as the result of historical incidents where some patients had not received all medicines on discharge.

- A specialist oncology pharmacist was involved in the screening, prescribing and preparation of chemotherapy. Nurses told us that chemotherapy doses were always ready when patients needed them. The consultants prescribed chemotherapy preparations electronically. Patients received blood tests prior to receiving each cycle of chemotherapy, which were reviewed by a consultant, to determine whether it was appropriate to proceed. We observed the correct administration of chemotherapy intravenously by nursing staff.
- Patients were able to store and administer their own medicines if appropriate. A thorough risk assessment and review was completed for each patient on admission. Although safe storage was available, we saw some medicines in patients' rooms that were not secure.
- We reviewed ten prescription charts during the course of the inspection. All were legible and filled out correctly. Patient allergies were clearly recorded on each chart. Missed doses were audited regularly and any that could not be accounted for by a valid reason (for example clinical need) were investigated. Actions had been taken to improve the rate of omission, such as providing more information to staff about how to access medicines out-of-hours.

Records

- Hospital staff used both electronic and paper based patient records to record patients' needs and care plans, medical decision making and reviews, and risk assessments. Paper based notes were stored appropriately in the nursing stations on the wards that we visited. Information Governance was part of the annual mandatory training programme, which all staff were required to attend.
- We looked at eight sets of patient notes. The majority of notes were dated, signed and followed the hospital's note writing protocol. However, we noted that

handwritten entries in the medical records were not always clearly legible and some medical entries did not include a stamp with the doctor's name and GMC number.

- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. We reviewed two DNACPR forms during the course of inspection and both detailed full discussion with patients and their relatives. All forms had been signed by a consultant, as per policy.
- The hospital undertook quarterly audits against the standards within the 'Nursing care process, including documentation, admission and discharge policy' of the NMC. Audit results from May 2016 showed an overall compliance of 92.5% across all 17 standards.

Safeguarding

- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Although no safeguarding incidents had been reported in the last year, staff at all levels knew who to contact if they wanted further advice. Staff had access to the safeguarding policy on the intranet. Flow charts for the necessary escalation procedures regarding adult safeguarding concerns were seen within both units and staff knew how to escalate any concerns.
- The Chief Nursing Officer (CNO) was the lead for safeguarding for the hospital and there were safeguarding link nurses for the wards. The catheter (cath) labs had their own safeguarding lead within the department as a significant number of paediatric patients coming to the cath lab had been identified as patients with learning disability.
- Safeguarding was part of annual mandatory training. Safeguarding children level 1 & 2 training was mandatory for all nursing staff. Records indicated that 84% of staff across the hospital had completed this training. All senior staff had level 3 safeguarding training. The CNO and head of clinical services were trained up to level 4. A member of senior staff was required to be available at all times for advice to ensure appropriate cover.

Mandatory training



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- Mandatory training courses for all staff included: health and safety, manual handling, infection control, safeguarding adults (level 1 and 2), fire safety, ethics and code of conduct, information governance, equality and diversity, and basic life support. Training was available to staff through a combination of face-to-face training and e-learning modules. The hospital target for mandatory training was 95%. Compliance with this training varied between 77% and 87% between April 2015 and March 2016. Senior staff had a responsibility to monitor training compliance and send staff reminders to complete this if necessary. All staff we spoke to felt they had sufficient opportunities to access mandatory training.
- Nursing staff on the wards had additional mandatory training requirements in a variety of areas such as caring for those living with dementia, use of appropriate risk assessment tools and the Mental Capacity Act (MCA). Staff in specialist areas had access to mandatory training specific to their departments.
- There was a mentorship programme for nursing staff in accordance with the corporate clinical support: clinical supervision, preceptorship, mentorship and revalidation reflection policy. A full time clinical practice nurse facilitator (CPF) helped to train new staff and oversee mandatory training.

Assessing and responding to patient risk

- The hospital used the National Early Warning Score (NEWS) to identify deteriorating patients. This is a basic set of observations such as blood pressure, respiratory rate, oxygen saturation, temperature and pulse rate. This was monitored in line with National Institute for Health and Care Excellence (NICE) guidance CG50 'Acutely ill-patients in Hospital'. Staff recorded observations on an electronic system which automatically calculated the level of risk. When a certain level was reached, the on call RMO was automatically informed and he would review the patient. Staff knew how to escalate any concerns regarding deteriorating patients, by contacting the ward's resident medical officer (RMO). Intensive therapy unit (ITU) outreach was readily available if required.
- The nurse in charge of each ward monitored the completion of venous thromboembolism (VTE) risk assessments and ensured follow-up with RMOs when

required. Duty Managers monitored all new admissions and ensured that VTE assessments were completed. VTE link nurses monitored 'high risk' patients on each ward and supported nursing staff where required.

- Adult basic life support (BLS) was part of mandatory training for all staff. Records showed that 78% of all staff had completed BLS training. There was a hospital wide cardiac arrest team, as well as a resuscitation officer, to support ward staff.
- The members of the resuscitation team were assigned specific roles daily and this was reviewed at the start of the day and evening shift. All members of the emergency team were trained in advanced life support and were contactable by emergency bleep.
- The cath lab staff all had up to date intermediate life support (ILS) or advanced life support (ALS) training. There were paediatric and adult resuscitation trolleys in each cath lab. Staff would contact a senior manager immediately if a patient deteriorated. The cath lab had 24/7 consultant surgical cover to ensure that deteriorating patients were properly managed.
- Staff in cath labs utilised the WHO safety checklist that involves briefing, sign-in, timeout, sign-out and debriefing. The use is to ensure patient safety throughout the perioperative journey. The National Patient Safety Agency (NPSA) advocates it for all patients in England and Wales undergoing surgical procedures.
- Falls risk assessments were undertaken in patients with impaired mobility. Management plans involving physiotherapists and mobility aids were put into place. Staff were encouraged to communicate the 'Call, don't fall' message to all patients.
- There was an emergency call bell in every room.

Nursing staffing

- Staffing was in line with national guidance of the Royal College of Nursing for sufficient nursing staff on both wards. One nurse would be allocated to a maximum of three patients (oncology) and four patients (cardiology). In addition to these core nursing staff, there was a ward manager, a nurse in charge and a health care assistant (HCA) on each ward. Senior sisters, clinical nurse specialists (CNS) and clinical practice facilitators (CPF) were based supernumerary on the wards as well.



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- Between April 2015 and March 2016, there were high rates of bank and agency nurses (between 25% and 37%) and HCAs (between 30% and 63%) reported for the hospital, compared to other similar independent acute hospitals. The bank to agency ratio was 2:1 for nurses and 10:1 for HCAs. The Chief Nursing Officer (CNO) was aware of this and had initiated a recruitment drive and improved training opportunities for nurses.
- Seven new nursing staff had recently been appointed on the third floor cardiac and general surgery ward, indicating a high turnover. Staff we spoke to confirmed this. Management was aware of the situation and had made staff recruitment and retention a top priority. During a recruitment drive, the hospital hired seven new international staff, from Spain and Portugal, for the cardiology ward. Training, courses and education had been improved, with the aim of increasing staff retention.
- There was no acuity tool in use on either ward. An acuity tool gives guidance for staffing and skill mix by assessment of severity of the status of the patient and intensity of nursing care required. We were told that additional nursing staff or senior staff would be allocated to a ward, if required.
- The staff sickness rate for the hospital was around 4% between October 2015 and March 2016, conforming with NHS England average. Staff sickness rates for the medical wards was not provided.

Medical staffing

- Medical staff worked under a practicing privileges arrangement. The granting of practicing privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.
- The medical advisory committee (MAC) reviewed each application for practicing privileges and advised the hospital chief executive officer (CEO). The advisory function covered granting, renewal, restriction, suspension and withdrawal of practicing privileges. Consultant credentials were reviewed via a report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials

were provided. There was an annual review of practicing privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via local Decision Making Group and then the Corporate DMG if required.

- All patients were admitted under the care of a named consultant. Lead consultants were available on admission and were there to be reached on-call at all other times. They reviewed their patients regularly and communicated any changes or concerns with the Resident Medical Officer (RMO). Patients told us they saw their consultant once or twice daily and once on weekends.
- During normal working hours, there were two RMOs present on the oncology ward and one RMO on the cardiac ward. They were responsible for reviewing patients on a daily basis and communicating with the patients' lead consultant.
- Both the oncology and the cardiology ward were covered by one RMO per ward at night. The cardiology RMOs occasionally worked 24 hour shifts.
- Permanent core and bank staff mostly covered the RMO rota. Few shifts were covered by agency RMOs. Nursing staff told us that they felt well supported by RMOs and consultants, and that cover was sufficient to ensure patient safety.
- A physician and an interventional radiologist provided further on-call cover for the medical department throughout the week, including weekends.

Major incident awareness and training

- There was an emergency preparedness, resilience & response (EPRR) policy in place and staff were aware of it. Major incident boxes on the wards contained instructions for staff in their roles and actions in case of a major incident.
- The business continuity management system (BCMS) policy gave guidance to ensure the continued safe and effective delivery and management of healthcare during short or long term service disruptions

Are medical care services effective?



Medical care

Good



We rated medical care services as good for effective because:

- We found excellent multidisciplinary team (MDT) working with close collaboration between all staff. National experts in their field with access to latest diagnostic and treatment methods attended regular MDT meetings.
- Staff were qualified to carry out their roles effectively and were supported in their further development.
- We saw formal outcome data in cardiology that showed that the hospital performed in line or better than predicted rates or national average.

However,

- Not all nursing staff we spoke to were aware of the meaning or implications of the MCA or DoLS.

Evidence-based care and treatment

- The cardiology department submitted data to the National Institute for Cardiovascular Outcomes Research (NICOR). NICOR is a research partnership of clinicians, IT experts, statisticians, academics and managers which analyses and disseminates information about clinical practice. The hospital contributed to the National Cardiac Rhythm Management Ablation Audit 2013-2014 with 423 procedures and showed excellent data quality, however the audit report did not include outcomes for ablation success or complication rates.
- Research has identified a relationship between the number of procedures performed in a centre and its complication rates. In 2013, the British Heart Rhythm Society published recommendations for a minimum of 70 new pacemaker implants and 60 new complex device (CRT/ICD) procedures. The Harley Street Clinic fulfilled the requirements and performed sufficient procedures according to the National Audit of Cardiac Rhythm Management Devices 2014-15.
- We reviewed six guidelines and policies on the hospital intranet. All listed the responsible officer, date of acceptance and review date. All were within the next due date for review.

- There was a Corporate Care of the Dying Adult in the Last Days of Life Guideline in use, based on NICE guidance. The hospital had responded to the report of the independent review of the Liverpool Care Pathway and introduced a replacement document based on the five priorities of care (One Chance To Get It Right, 2014), called 'Excellent Care in Last Days of Life'. The document included holistic prompts for staff to consider in the review of the patient, flowcharts to help managing symptom control, symptom observation chart for the dying patient and documentation of the medical plan and conversations held.

Pain relief

- The hospital staff used the numeric rating scale (NRS) to assess pain and the effectiveness of pain relief. Appropriate actions were taken in relation to pain triggers. We saw examples in the records of pain control managed with PRN ('pro re nata' or 'as required') pain relief medication and witnessed staff reacting promptly to requests for pain relief.
- Pain management and symptom control of oncology patients were discussed daily in the team's handover and any queries were feedback to the consultant. The oncology and palliative care specialist nurses regularly reviewed the drug charts and spoke to ward staff about whether patients' pain and symptoms were adequately controlled and managed. Background doses of pain medication were increased where necessary.
- In place of a designated pain team, the oncology or palliative care specialist nurses would regularly review pain management and discuss with the RMO and the treating consultant. Pain link nurses offered further guidance and support to ward staff.
- We saw evidence that the service strived to meet the needs of those suffering from symptoms in the dying phase of life or because of their illness. The specialist team encouraged the use and regular review of both PRN and regular medication in view of changing symptoms. Complementary therapies such as reflexology or hypnotherapy were also available to patients to help manage symptoms.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The MUST (malnutrition



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universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we saw. Training in the use of MUST was mandatory for all nursing staff.

- Patients we spoke with were generally happy with the standard of the food provided to them.
- Dietitians reviewed patients on the wards if required and attended multidisciplinary team (MDT) meetings. A dietitian was on-call at weekends.
- Every private room had a refrigerator and the hospital allowed relatives to bring in food.
- For patients that were not eating at the end stage of life, staff ensured regular mouth care was carried out to ensure patient comfort and hydration.

Patient outcomes

- The National Audit of Percutaneous Coronary Interventions, conducted between 2012 and 2014, showed that the hospital performed in line with predicted rates and better than the national average in relation to major post procedural complications and mortality. The data looked at 296 procedures.
- The National Congenital Heart Disease Audit Report 2012 -15 showed a 98.8% survival rate for the hospital, which was better than the expected predicted rate of 97.3%. The data set included 695 patients.
- We spoke with the head of clinical informatics who informed us about data submission for breast, colorectal and prostate cancer audits. However, we only saw data from the Breast Quality Framework Report 2010-2014. The report contained provider wide data and did not include 1- or 5-year survival outcome results.
- Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the specialist team. Throughout all provider locations, there were 274 referrals to the specialist team between April 2014 and April 2015.
- Medical or nursing staff on the oncology unit would make a referral to the palliative care (PC) team if appropriate. The PC consultant and PC CNS would then review patients accordingly. We saw related documentation in medical records. There was a Corporate Care of the Dying Adult in the Last Days of Life Guideline in place to support staff.

- There were 41 expected adult deaths across both the cardiac and oncology wards in the year April 2015 to March 2016. Of these patients, 30 had been managed by the palliative care team on the wards.
- Monthly Morbidity and Mortality meetings were held where both expected and unexpected deaths were discussed. We saw examples of well-documented mortality review sheets with named attendance of each member of the multidisciplinary team (MDT), including the admitting consultant.

Competent staff

- All nurses received annual appraisals, which looked at their development needs and set achievable and realistic targets to measure progress against. Appraisal rates for staff were reported to be 100% last year.
- Clinical Practice Facilitator (CPF) nurses were on hand to provide clinical supervision to both new nurses and nurses who required additional assistance.
- New nursing staff had one week of general induction. After that they were placed as supernumerary on the ward for two weeks to start working at their own pace, gradually looking after own patients.
- Every member of nursing staff had a competency book, which varied depending on the clinical area they worked in. For example, every nurse on the cardiac ward had to pass a competency test in ECG recognition.
- Across all departments, 100% of nursing staff had been trained in the use of syringe drivers for patients nearing end of life. We also saw evidence that all oncology nursing staff had completed departmental training for 'Excellence in End of Life Care'. This training comprised of training on EOLC policy/protocol, DNAR CPR, patient information leaflets.
- RMOs received revalidation at the Harley Street Clinic if required. The RMOs felt supported in their education and were provided with funding to attend conferences, for example. The RMOs we spoke to had a high level of training (mostly just below consultant level), and worked whilst also undertaking research. Most RMOs had a designated mentor.
- Consultant credentials were reviewed via a report provided to the CEO through the Centralised



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Credentialing and Registration Service based within the Corporate Office. There was an annual review of practising privileges, including scope of practice and activity.

- Staff told us about debriefings after stressful situations and psychological support if required.

Multidisciplinary working

- A broad range of MDT meetings were held regularly. For example, oncology and cardiology MDTs took place on a weekly basis, whereas cath lab MDT meetings took place every two to three weeks, with high consultant presence (between six to 20 consultants attended each cath lab meeting). The nurses within the department told us that the meetings were 'a fantastic learning tool'. Consultants that we spoke with were proud of MDT working across the department and of the collaborative nature of the department.
- We witnessed an urology MDT meeting that was attended by a variety of allied health professionals, including lead consultants. Discussion of each of the patients was holistic and sensitive. The team contained national experts in their field who had access to diagnostic tools with increased accuracy that improved patient care and lowered patient morbidity.

Seven-day services

- The wards had access to a full range of allied health professionals on weekdays, between 9am and 5pm. Dieticians and physiotherapists offered an on-call service on weekends.
- The hospital had access to on-call pharmacists out-of-hours, including specialist oncology pharmacists.
- Consultants would undertake ward rounds on weekends if required. Otherwise, they would contact the RMO on duty for updates on patients. A physician and an interventional radiologist provided further on-call cover for the medical department during the week and on weekends.
- The multi-faith chaplaincy service was available every day of the year, 24 hours a day. The team had arrangements with local faith leaders to provide an on-call out-of-hours service.

Access to information

- Medical and nursing staff felt they had easy access to the relevant information in order to provide effective care and treat patients in an individualised and timely manner.
- Before leaving the hospital, patients received two copies of their discharge letter, one for provision of the GP.
- Staff had access to patient and hospital information via the computers on the wards. The number of computers we saw on the wards we visited evidenced this
- Staff had access to an online learning management system and hospital policies via the intranet

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent was obtained before proceeding with invasive cardiac procedures and chemotherapy regimens. All of the notes we looked at included signed consent forms. Staff were aware of their duties in relation to obtaining consent. The hospital had an up-to-date consent to treatment policy.
- The consultant reviewed and obtained consent from cardiac patients, on the ward or the day care unit (DCU), before procedures took place in the cath labs.
- Senior staff knew about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), but they had never been involved in the process and told us that they would seek advice should the need ever arise. They were able to give examples of when they had referred patients to clinicians for situation-specific capacity assessments.
- MCA and DoLS was part of mandatory training for nursing staff. There was a DoLS policy available for staff on the intranet and each ward had access to a DoLS link nurse. However, not all nursing staff we spoke to were aware of the meaning or implications of the MCA or DoLS.
- There was a corporate CPR/DNACPR policy in place in accordance with current Resuscitation Council (UK) guidelines.
- The annual report of the DNACPR audit 2015 identified training needs to improve documentation after review of 44 DNACPR forms. Further training and discussion in



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relation to DNACPR forms were implemented as a result. Audit results of January to April 2016 and May to July 2016 showed improved medical and nursing documentation.

Are medical care services caring?

Outstanding



We rated medical care services as 'outstanding' for caring because:

- There was an ethos of staff going above and beyond their duty to support patients' emotional and social needs. There were many examples of health professionals who went that extra mile: birthday parties for inpatients organised by nurses, weddings, ambulance and health care assistant to accompany a patient so he could attend an important family event.
- We saw evidence of detailed and thoughtful consideration of patient and family wishes and circumstances. Staff organised family meetings and discussed important topics in multidisciplinary meetings.
- The Friends and Family Test scores were consistently high for both wards and the Patient Satisfaction Survey Report showed high scores for quality of care.
- Staff ensured that patients and their families were always informed about their care and were fully involved in any treatment decisions.
- An in-house psychology team was available for patients, relatives and staff. Emotional support for patients was well considered and provided through the easily accessible psychology team, Macmillan Cancer Centre and support groups. Alternative therapies were offered to improve well-being. A make-up and skincare workshop was aimed to help women living with cancer improve their self-confidence and self-esteem.
- The patients we spoke with felt safe in their environment.
- We observed interactions between nursing staff and patients. Staff were professional, kind and friendly.
- There were many examples of health professionals who went that extra mile. An inpatient told us that ward nurses organised a party with cake and balloons for his birthday. He and his relatives were very happy about this. Staff had also made arrangements for patients' personal pets to visit them at the hospital if they had been inpatients for a long period. We were given examples of weddings that had been organised on the ward to accommodate immobile patients' last wishes and hosting an event so one patient could fulfil their role as 'mother of the bride' at their daughter's wedding.
- The hospital provided a health care assistant and an ambulance to enable a patient who was an inpatient to attend his grandson's Barmizvah for a few hours.
- We spoke with four patients and four relatives. Everyone spoke very positively about the care they or their relative had received. Some of the positive comments from patients included: "Everybody cares and listens to what I say.", "I am very happy with the way I am being treated", and the ward staff "feels like [a] family".
- The Friends and Family Test (FFT) results were overwhelmingly positive for each of the wards. The test asks patients how likely they are to recommend a hospital to others after they have received treatment there. Between April 2015 and March 2016, the oncology ward scored averaged 93.9 % and the cardiac ward averaged 97.4% in this measure. However, it is difficult to know how meaningful these scores are as the response rate was not disclosed to us. Similarly, the Patient Satisfaction Survey Report showed that 95% of patients felt that quality of care was 'excellent' or 'very good'. Between April 2015 and March 2016 the data of 1748 patients was analysed.
- The Macmillan Accredited Information and Support Services Department Patients Audit May/June 2016 showed that 100% of 45 respondents would recommend the Harley Street Cancer Centre to family or friends, with 83% of people giving it a '10 out of 10' rating.

Compassionate care

- There was a corporate privacy and dignity policy in place.
- Patient consultations, treatment and personal care took place in private rooms that ensured privacy and dignity.



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Understanding and involvement of patients and those close to them

- Patients we spoke to felt involved in their care. They had frequent opportunities to speak with their consultant and other members of the multidisciplinary team (MDT) in charge of their care. This enabled patients to make informed treatment decisions and be meaningfully involved in their care.
- Relatives we spoke with were happy with the care their family member received and that they felt well informed about the treatment plans. In their opinion, there was good communication with the medical and nursing staff and information and results were shared promptly. Staff provided them with sufficient information and regular updates about the treatment progress.
- Life expectancy was discussed with the oncology patients and the family. We saw documentation of this in medical records of patients nearing end of life.
- We saw detailed and thoughtful consideration of patient and family wishes and circumstances in the patient care records that we examined. A family member did not feel comfortable with the initial plan of the patient to spend the last days at home. This was made topic in a family meeting and the patient decided to be transferred to a hospice. Staff documented plans and outcomes of family discussions fully. We witnessed multiple discussions relating to family and social circumstances in both handovers and MDTs that we attended.
- We were given examples of staff organising to bring patients' beloved pets to the hospital for emotional support.
- The Macmillan centre on site offered extensive information and support for patients diagnosed with cancer and their relatives. Macmillan volunteers offered emotional support through visits and talks.
- 'Look Good, Feel Better' Workshops offered skincare and make-up workshops for women living with cancer, free of charge. The aim of the initiative was to help combat the visible (and often psychological) effects of treatment by teaching women practical tips to help increase their self-confidence and self-esteem.
- The hospital provided in house psychological supportive services, including counselling and alternative therapies, to patients and their relatives. Alternative therapies offered included: aromatherapy, relaxation, reflexology, chair massage, reiki and hypnotherapy.
- The hospital held a support group for patients receiving treatment for head and neck cancer. The support group meetings took place every six weeks. These groups were specifically for patients, rather than relatives, so as to encourage openness amongst the group and give patients the opportunity to express their feelings without worrying how their carer or partner would feel.

Emotional support

- The hospital chaplaincy service was multi-faith and provided 24/7 spiritual support. Staff were aware of how to contact spiritual, pastoral or psychological advisors to meet the needs of patients and their families. In the previous 12 months, 14 patients had been referred to the multi-faith chaplaincy service
- Patients and relatives told us that they felt staff was approachable and that staff did their best to reduce anxieties or fears. They described how the staff had helped them through difficult times during the course of their respective treatments. For example, one piece of patient feedback we saw stated, "I don't really know where to start as I feel overwhelmed with the level of support that my breast cancer nurse has provided me."

Are medical care services responsive?

Good



We rated medical care services as 'good' for responsive because:

- The complex and differing needs of individuals were central to the planning and delivery of the tailored service that the hospital provided.
- There was a holistic approach to treatment in order to provide truly patient-centred care.
- We saw examples of non-profitable patient care to accommodate individual needs.
- Staff were aware of the processes to facilitate complex discharges and a dedicated discharge liaison nurse helped to facilitate this.



Medical care

- Weekly patient satisfaction and experience meetings discussed recent complaints and comments with learning shared across the teams.

Service planning and delivery to meet the needs of local people

- The corporate provider's overseas office managed all aspects of care of international patients. This service was designed to meet the needs of the large demographic of international patients the hospital received. They oversaw the full referral process from pre-admission, obtained visas and organised follow-up care, amongst other duties.
- An in house Arabic liaison coordinator helped facilitate admission and discharge procedures for international patients.
- The hospital was aware of expected times of reduced admissions, for example during Ramadan period. Staff were given the option of flexible annualised hours to accommodate for busier and less busy times.
- The pre-admission procedure would be offered over the phone to facilitate the process for patients travelling from a distance for treatment or those with impaired mobility.
- The cardiac ward had 15 single rooms with an additional five bedded bay for occasional day cases. One of the side rooms was just outside the general ward area and was used for isolation of infectious patients when necessary. Every bed had built-in ECG monitoring and there was a central monitor in the nursing station. We were told that there was always a senior nurse in the nursing station watching the central monitor. Bed occupancy was between 70 – 80%, with a high numbers of day cases.
- The oncology ward had 16 single rooms, including four single rooms in a separate haemato-oncology unit. Oncology patients would be admitted as outliers on the cardiology ward if there were no oncology beds.
- There was an agreement of professional clinical services in place with neighbouring NHS trusts to provide specialist palliative care. Staff could refer patients if appropriate and the palliative care team was available 24/7.
- A pre-admission nurse for cardiac and cardiothoracic patients called patients two days before any planned admission for an initial assessment. An online web portal assessment was also available, but only a small minority of patients only used this. The pre-assessment process included a full explanation of the planned operative procedure to the patient and advice about activities, for example driving, after discharge. The pre-assessment nurse would contact the consultant prior to admission if they had any concerns.
- The pre-assessment nurses would also call every patient 48 hours after discharge and ask about any complications or concerns. The nurse would seek advice from the relevant consultant if necessary. For example, a patient with faintness after pacemaker implantation might be an indication that urgent checks of the pacemaker should be carried out.
- An audit of the pre-assessment and follow-up process demonstrated that 70% of patients were contacted. Attempts to contact the remaining 30% of patients were not successful, reasons for this were not provided.
- Senior staff told us there were no waiting lists for procedures in the cath lab or the oncology department, however, we did not see any formal data.
- The average length of stay for medical patients was 4.88 days between April 2015 and March 2016.
- Cardiac rehabilitation was offered to all cardiac and cardiothoracic patients either by referral to an NHS service close to their homes, or to a private rehabilitation service in central London close to the Harley Street Clinic.
- A discharge liaison nurse was appointed in June 2016 in order to coordinate all necessary discharge arrangements for oncology patients. The role had been created to reduce delays for patients with complex discharge needs. The discharge liaison nurse attended the daily ward round and began discharge planning straight away upon admission of a patient.
- On discharge, all patients were given a telephone number that allowed them to contact an assessment nurse, or nurse in charge of the relevant ward directly.
- An Arabic liaison coordinator worked closely with the relevant embassy to facilitate the admission and discharge of international patients.

Access and flow



Medical care

- Provider wide data showed that 100% of patients nearing end of life were discharged to their preferred place of care between April 2015 and March 2016. The exception was in August 2015, where this figure was only 40%, a reason for this was not provided.
- Mortuary services were outsourced to a local undertaker, who could be accessed 24 hours a day.

Meeting people's individual needs

- The ward managers undertook their own ward rounds to talk to patients individually, suggest additional support and to ensure their needs were met. Nursing staff told us that the adequate nurse/patient ratio meant that they could spend sufficient time with patients to cater for their individual needs. For example, an inpatient told us how his lunch meal was adjusted after developing diarrhoea in the morning. He was impressed by the quick response of the team.
- Staff were proud to always make patient's needs a priority. For example, staff told us about a patient whose routine cardiac echocardiogram was performed during their hospital stay, as their insurance policy did not cover it as an outpatient examination.
- A corporate policy outlined how to support people living with dementia. The hospital provided all staff with mandatory training in this area.
- Patients living with dementia were offered 1:1 nursing care and family members and carers were encouraged to be involved in their care as possible. The same nursing staff would care for people living with dementia where possible to foster a degree of familiarity. Hospital passports, designed by the Alzheimer's Society, were used if required. These were designed to give hospital staff helpful information about the patient such as likes or dislikes and their interests. This helped all the hospital staff know how to make patients with communication difficulties feel comfortable.
- Relatives we spoke with were happy about the open visiting hours on the wards. On request, an extra bed would be set up in the patient room to enable a relative to stay.
- Staff allowed late night visitations, during Ramadan, for example.
- There were in-house interpreters for Arabic, Russian and Greek international patients. If possible, staff would arrange in advance for an interpreter to join medical consultations or family meetings. Staff had access to telephone interpretation services out-of-hours. Staff told us they would only use family members for translation for informal day-to-day communication with patients.
- A multi-faith chaplaincy service was available 24/7 to support religious or spiritual wellbeing. Staff knew how to contact leaders of different religions. A multi-faith room was available for patients, visitors and staff.
- There was a quiet room on the oncology ward for family discussions or meetings.
- Staff told us that they would leave the patient room door open or check more frequently on Jewish patients on Saturdays, as religious custom dictated that they could not use the call button.
- We were given the example of a psychiatrist who came to see a patient who had struggled with pain issues. He immediately set up both changes in medication and arranged psychology input for the patient. He taught the attending RMOs by way of the discussion.
- Psychological counselling services were available for oncology patients suffering from anxiety, stress or pain. Other complimentary therapies like massage, reflexology, aromatherapy and reiki were also offered.
- We saw a variety of leaflets on information related to cancer and cardiac diseases on the wards. Additional cancer information was available through the Macmillan centre in the hospital.
- An on-site Macmillan information centre provided support to patients diagnosed with cancer and their relatives. Macmillan volunteers would visit inpatients on the ward to offer further support, if requested.
- The palliative care consultants and the discharge liaison nurse would manage referrals to local hospices or the community palliative care team in order to facilitate rapid discharge at the end of life. If patients wished to stay in hospital to die, the hospital accommodated this, despite this not being covered routinely by insurance companies.

Learning from complaints and concerns



Medical care

- There was a corporate patient complaints policy in place and information on how to raise concerns or make complaints was available in each patient room. We also saw comment boxes on each ward, which patients were encouraged to use to share feedback.
- There were systems and processes in place to acknowledge, investigate and respond to complaints within a defined period of 20 days. The performance of the Hospital for all formal complaints in 2015 was 99% for acknowledgement within 2 working days and 90% for a full response letter within 20 working days. Formal complaints were directed to the office of the chief executive officer (CEO) and chief nursing officer (CNO). Complaints were discussed and learning points shared in meetings such as hospital clinical governance and medical advisory committees. There was also a weekly patient satisfaction and experience meeting where patient comments and complaints were collated and presented. Immediate action plans were devised if necessary. All learning from these meeting were shared with wider groups of staff.
- Between April 2015 and March 2016 the medical department received seven formal complaints. Complaints were about care, treatment and communication.
- We saw complaints logs with description, outcome and action. Training or learning was implemented when required. A patient complained about the lack of rails or ledges for soap in the shower. As consequence all showers across the site were reviewed by an engineer to ensure all safety measures were in place and soap dispensers were available in all bathrooms.
- The leadership promoted an open and approachable culture with emphasis on integration and collaboration of all staff. Staff felt comfortable to express their views and approach managers with their concerns. The management actively encouraged staff to learn and improve.
- Staff appeared motivated to provide the best possible care for patients. There was a high degree of collaboration across the service. We spoke with managers, doctors, nurses, allied health care professionals and support staff and we found there was a culture of mutual respect at all levels for each other.
- There was a clear governance structure and the hospital's risk register was up-to-date and proactively managed.
- Staff satisfaction surveys showed that staff felt committed to give their best.
- The cancer service offered innovative patient-centred care by seeking out new treatment options and taking a holistic approach to patient care.

Vision and strategy for this core service

- The hospital's vision statement was, "Together we consistently deliver exceptional care". This aimed to link high quality care, operational excellence and exceptional patient experience. The hospital stated that it strived to deliver high quality, cost-effective healthcare in the communities that it served. This was underpinned by the hospital's values, which were based around patient-centred care, compassion, integrity and team work
- Priorities for improvement in 2016 were to enhance operational excellence by considering new ideas and initiatives and to improve the patient experience through focusing on individual patient needs. For example, 'Project World Class' was launched this year, which was a hospital-wide approach to developing and embedding first-class service that aligned with excellent standards of clinical and nursing expertise. It focused on the hospitality side of service and involved people attending services pretending to be patients and feeding back to staff about how the service could be improved.
- The hospital had developed a C.Diff. reduction strategy with a clear timeline for 2016.

Are medical care services well-led?

Outstanding



We rated the service as 'outstanding' for well-led because:

- The hospital's vision and values were present on posters throughout the service. Staff understood the hospital's vision and strategy, which were embedded in daily delivery of care. Staff informed us that senior leaders were not only visible but very approachable.



Medical care

- The hospital's vision and values were present on posters throughout the core service. Staff were aware of the aims of the hospital's strategy and were able to discuss current developments that would progress to be made.

Governance, risk management and quality measurement for this core service

- The Medical Advisory Committee (MAC) worked as an advisory body that provided impartial advice regarding strategic and medical matters and admitting practicing privileges. The MAC met every two months. Consultants from each speciality service attended the meetings. They discussed issues relating to regulatory compliance, practicing privileges, quality assurance and also proposed new clinical services and techniques. The MAC carried out checks before granting new consultants practicing privileges, including checks on their scope of practice to ensure they were only undertaking treatment that they were competent to perform. The MAC chair worked closely with the medical director and the CEO.
- Consultant credentials were reviewed via a report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials were provided. There was an annual review of practicing privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via Decision Making Group and then the Corporate DMG if required.
- The risk register was maintained and kept up-to-date by the risk management committee. The majority of identified risks related to pharmacy services. There was a hospital risk strategy and policy that guided the identification and management of risk. Aims of the strategy included openness and transparency, risk awareness, provision of accurate risk information, thorough reporting and investigation of incidents and the sharing of any learning or improvements.
- Senior staff were aware of the risk register and ward managers and sisters were able to tell us what the key risks for their clinical area were.
- Clinical governance committee meetings took place every month. We observed meeting minutes and found

the discussion points to include: action points from previous meetings, feedback from subcommittees and MAC, incidents, issues regarding medical equipment and accreditation.

- The hospital also ran a variety of other regular governance meetings, such as: the quality and risk committee, the ethics and compliance committee, safeguarding meetings, radiation protection meetings and standards committee meetings. Quarterly Morbidity and Mortality meetings were headed by the medical director.
- The medical department undertook quality measurements with 36 regular audits and patient and staff satisfaction surveys. We spoke to the head of clinical informatics who showed us as an example the standardised process for cardiac audit data collection. This process ensured that every patient's data was collected and that data was accurate.
- A representative of the CEO and the lead consultant clinical psychologist of the hospital both attended the corporate 'supportive and palliative care and survivorship board'. The purpose of this board was to provide a supportive forum to develop recommendations to help establish HCA international as a network of excellence in supportive, palliative care and survivorship services for cancer patients.

Leadership and culture of service

- All staff knew about the local management structure of their department. Nursing staff felt well supported on the unit and felt they were part of a good team. They praised the good working relationship with RMOs. The nurses and RMOs on the wards told us that they had a good working relationship with consultants who they called 'approachable'. There were no problems with communication or access.
- All staff we met appeared motivated to provide the best possible care for patients. There was a high degree of collaboration across the service. This was evident in our talks with consultants, ward managers, nursing and medical staff who all spoke highly of the multidisciplinary working between their colleagues.
- Staff we spoke to were also familiar with the CEO and CNO and praised their accessibility and "open door" strategy. The senior management team visited the



Medical care

wards regularly and staff felt they were very visible and very approachable. Staff felt well supported by the executive team and many had the CEO's mobile number to contact them directly. There was an executive team on-call out-of-hours.

- The senior management team held bi-monthly meetings to discuss projects, incidents and other issues.
- Staff told us that the hospital offered vast opportunities for further education and career progression. There were time protected study days "as many as needed" and opportunities to develop professionally. A member of staff informed us that after an application, the hospital had agreed to fund her Masters course.

Public and staff engagement






- The Harley Street Clinic published a monthly newsletter for staff which included hospital news, patient satisfaction results, information about training courses, new staff announcements and staff birthdays.
- The hospital published a booklet called "bedtime stories" which contained patients' experience testimonies who had received treatment in different areas of the hospital.
- We saw patient comment boxes on the wards and patients were encouraged to leave feedback. Questionnaires were available in each patient room. Patients' comments were discussed in weekly patient experience and satisfaction meetings.
- There was access to participate in the Patient Survey through the hospital's website together with guidance about the complaints procedure and further contact details.
- The hospital gave staff employee recognition awards every five years. We spoke to a member of staff who had been employed by the service for 13 years and had received two gifts.

- Staff could nominate any colleague for 'Employee of the Month' and 'Employee of the Quarter' Awards.
- Minutes from Senior Management Team monthly meeting indicated that staff engagement was not as high as would be expected according to the staff satisfaction survey. In 2016, welcome cards and information about the hospital were sent to new employees, which improved staff engagement. Line managers would contact the candidates who would be able to ask any questions prior to commencement of duty.
- The latest staff survey from 2016 showed improvement in most areas compared to the previous survey 2014. About 75% of staff felt proud to work for the hospital and would recommend their employer. According to the survey, 97% felt committed to do their very best for the hospital. Staff engagement and overall staff satisfaction had also improved.
- The Harley Street Clinic is present on social media and the public are able to leave comments.

Innovation, improvement and sustainability

- The Cancer Centre offered psychological services and complementary therapy in conjunction with conventional medicine to all cancer patients receiving treatment.
- The lead clinical nurse specialist (CNS) for cancer had a good understanding of care packages for patients, including new treatments they may qualify for and which were not yet available to NHS patients. Her knowledge based on the newest information from the annual conferences that the hospital paid for her to attend. This suggested a forward-looking management team who strived to promote best practice for patients.

Surgery

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

Information about the service

The Harley Street Clinic provides day surgery and inpatient care for adults requiring a variety of surgical procedures. This includes complex cardiathoracic surgery, neurospinal surgery, cancer surgery and some general surgery. The hospital provides surgical treatment for private patients from the UK as well as from overseas.

There was one surgical ward with fifteen private single occupancy rooms and a mixed medical-surgical cardiac ward with fifteen private single occupancy rooms. These wards provide 24 hour, seven day a week care with 30 private single occupancy rooms. The hospital has four main operating theatres available Monday–Friday 8am to 9pm, Saturday 08am to 4pm and Sunday if required.

The day surgery surgical unit comprises of four beds. The service employs nurses, operation department practitioners (ODPs), physiotherapists, occupational therapists (OTs) and radiographers to care for surgical patients. Resident medical officers (RMOs) are employed to provide medical cover. The consultant surgeons and anaesthetists have practising privileges to carry out consultations, admit and treat patients having surgical procedures at the hospital.

We spoke with six patients and relatives and 16 members of staff during the inspection, including medical, nursing, administrative and managerial staff within the surgical team.

Summary of findings

We rated the service as good because:

- There were processes in place to reduce the risks associated with surgical procedures.
- Nurses monitored patients after their operation and medical staff were available if there were any concerns.
- Automatic alerts were sent to the resident medical officers (RMOs) if a patient's observations were of concern via the electronic National early warning scoring tool (NEWS).
- Pre-operative assessment was undertaken by qualified staff in line with the National Institute of Clinical Excellence (NICE) guidelines.
- There were sufficient numbers of staff to care for patients.
- Patients provided positive feedback about their care and treatment.
- There were regular multi-disciplinary team (MDT) meetings to discuss patients care and treatment.
- The pharmacy department provided support for ward staff.
- Senior management were accessible to staff and were reported to be supportive
- There were robust governance processes in place.
- The service were using outstanding cutting edge technology including non-invasive robotic radiosurgery, laser therapy and brachytherapy.

Surgery

However, we also found:

- There was inadequate storage space in theatres.
- The multi-faith room environment was not appropriate to meet patients' spiritual needs.

Are surgery services safe?

Good 

We rated the service good for safe because:

- There was a service wide vision and strategy that was embedded by staff in both inpatient wards and in the theatre setting. Staff were very proud of their service and felt as though their managers and members of the executive team were very approachable and caring.
- There were robust governance structures and reporting mechanism in place where performance and the quality of the service was reviewed. The surgical services risk register documented risks and assigned a manager responsible.
- Consultants felt that senior management were approachable and reported good working relationships. There was a consensus that senior management were very responsive to the needs of both staff and patients.
- Staff knew how to report incidents and the hospital encouraged incident reporting, and unexpected patient deaths were reviewed
- There were sufficient numbers of staff, who received appropriate training for their role.
- There were processes in place to identify and reduce the risks associated with surgical procedures, such as undertaking appropriate pre-assessment checks.
- Staff also ensured safe perioperative checks such as the five steps to safe surgery were embedded in everyday practice.
- Nurses monitored patients after their operation and medical staff were available if there were any concerns,
- Infection prevention and control processes were in
- The hospital benchmarks site specific information (SSI) for coronary artery bypass grafting (CABG), spinal surgery, total hysterectomy and neurosurgery; for the reporting period the rate of SSI was comparatively low in all areas, however not all surgeries were benchmarked.
- There were sufficient amounts of equipment available. Equipment was serviced in accordance with manufacturers' instructions and national standards.

Surgery

- Records were legible and patients were seen daily by the consultant responsible for their care.

However, we also found:

- There was a lack of storage space in theatres.
- One set of theatre doors were overlapping and not closing fully.

Incidents

- The hospital used an electronic incident reporting system and all staff we spoke with were familiar with how to report incidents on the system. Incident reporting training was included in the staff induction programme which all staff attended when they commenced employment at the hospital.
- The hospital reported 766 clinical incidents between April 2015 and March 2016. Out of these 71% (543 incidents) occurred in surgery or inpatients and 10% (80 incidents) occurred in other services. 19% (143 incidents) occurred in outpatients, diagnostics and imaging departments. The hospital reported 1% of incidents as severe or death incidents.
- Surgery reported 238 incidents between April 2015 and March 2016; 221 of these resulted in no harm or low levels of harm to patients; 14 resulted in moderate harm; one resulted in serious harm; and there were two unexpected deaths in the period. The hospital reported that there were no incidents that met the SI framework. However, the governance risk lead told us there were processes in place for any SI's to be reviewed by the chief medical officer and clinical governance committee.
- The incident reports as percentages for surgery, inpatients and other departments from April 2015 to March 2016 were: 53% occurred in surgery or inpatients and 47% occurred in other services. However, we found the rate of clinical incidents in surgery was not high when compared to other independent acute hospitals which CQC hold this type of data for.
- The interim theatre manager told us that all serious incidents were investigated. Data submitted relating to the occurrence of serious incidents (SI) in the hospital demonstrated that a root cause analysis (RCA) investigation was undertaken and recommendations

were made following each investigation. The RCA's explored the factors that contributed to the incident, such as signage, the escalation processes and service delivery.

- We were told all patients who had to return to theatre, were discussed in the Medical Advisory Committee (MAC). The minutes of the MAC we reviewed demonstrated that these discussions took place.
- All expected deaths were reviewed by the team involved in the patient's care.
- Staff told us that all unexpected deaths that occurred either in theatres or on the surgical wards were reviewed by the medical director. The hospital had a mortality and morbidity committee who reviewed deaths and identified learning and reported to the hospital's quality and risk board.
- The hospital produced a quarterly clinical operating report (QCOR). The report reviewed and monitored key performance indicators (KPI) on quarterly basis such as mortality and incidents. We viewed the report for quarter 1, January to April 2016.

Duty of Candour

- The hospital had used the 'duty of candour' (DoC) on four occasions in this period, three of which related to surgery. Root cause analysis (RCA) were being completed for two of the (DoC) incidents and the other incident involved a faulty piece of equipment, which had been returned to the manufacturer.

Safety thermometer

- The hospital did not use the NHS Safety Thermometer (a tool which measures harm to patients which may be associated with their care). However, the hospital had developed a dashboard which monitored pressure ulcers; falls; catheters and UTIs; VTE. These were monitored and benchmarked with NHS providers via the 'board report'.

Mandatory Training

- Mandatory training included health and safety, fire, manual handling practice, infection control, customer care and control. All staff were expected to complete life support training annually. Depending on their role staff completed training at either basic, intermediate and advanced level. However, the mandatory training

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spreadsheet recorded that six out of 27 staff had not updated their basic life support training (BLS) in accordance with the provider's training policy and was out of date.

- Managers were responsible for ensuring all staff were up to date with their mandatory training and completion was linked to salary increments. Mandatory training records provided and maintained by the individual departments showed that the overall compliance for the theatre and the wards was over 90%. For example, 100% of staff had up to date fire training.
- Bank and agency staff were expected to complete the hospital's mandatory training, and were provided with access to the hospital's training programme.
- Staff told us the hospital had introduced a 'learning academy' and mandatory e-learning could be completed either at home or at the hospital. Staff told us they were paid to complete training if completed at home.

Safeguarding

- Staff we spoke with were aware of how to access the safeguarding policies on the hospital's intranet. Most staff we spoke with were able to identify the different types of abuse and were aware of how to escalate concerns.
- There was information on the hospitals safeguarding procedure displayed on the notice boards in the staff room corridor in theatres for staff to refer to, including the contact details for the safeguarding leads.
- The nominated lead for safeguarding was the chief nursing officer and in their absence the clinical service manager for the hospital site. The provider also employed an organizational level safeguarding lead and named doctor. There had not been any safeguarding concerns raised within surgery in the previous 12 months.
- Safeguarding adults training was mandatory for all staff. Non-clinical staff were required to complete level one training; clinical staff were required to complete level 2 training. Clinical managers and matrons were required to complete level 3 training. Training records demonstrated 100% of theatre staff had completed

children's safeguarding level one and two training. Training records for surgery showed that 96% of clinical staff had completed level two adult safeguarding training. 83% of staff had completed training in 'prevent'.

- There had been no reported safeguarding to CQC in the reporting period of April 2015 to March 2016.

Cleanliness, infection control and hygiene

- The provider developed an infection control dashboard in 2014 which included mandatory reporting statistics to Public Health England (PHE) for bacteraemia, C.diff and surgical site infection (SSI).
- All the patient rooms were single occupancy on the wards we visited and therefore additional isolation areas were not required.
- Staff in all areas had access to personal protective equipment (PPE) such as gloves and aprons. We observed that theatre staff wore the appropriate PPE during surgical procedures.
- Staff were appropriately dressed and adhered to the bare below the elbow policy.
- The decontamination processes for surgical instruments included all instruments being coded and traceable.
- The surgical wards and theatres had cleaning schedules in place for the wards and the theatre area which were audited on a daily and weekly basis. The cleaning audits we saw confirmed there were no areas of concern.
- The theatre complex was cleaned by health care assistants (HCA) during the day and deep cleaned by cleaners at night in accordance with NHS cleaning standards. All equipment seen had 'I am clean' stickers to identify the date and time cleaning had taken place and to inform staff that the equipment they were using was clean.
- We saw a certificate confirming the theatre department had undergone a deep clean by a specialist surgical services cleaning provider in January 2016.
- Waste management practices were observed and complied with the hospital policy and good practice guidelines for segregation of waste. Sharps bins were labelled and dated and bed linen was bagged appropriately.

Surgery

- There were hand wash basins in all patients' rooms and hand gel was available throughout the surgical wards and theatre department. There were 'five moments of hand hygiene' posters on display across the wards and clinical areas we visited.
- The audit results for hand hygiene were included in the infection prevention and control dashboard. Monthly electronic dissemination of the dashboard included the senior sisters, Head of Departments for the clinical areas, the chief nursing officer and director for infection prevention and control. The surgery hand hygiene and scrub procedures audits had between 81% and 100% compliance between January and June 2016. The drop from 100% to 81% compliance rate in February 2016 had been discussed at the infection control committee in June 2016. Staff were informed that the hospital had a zero tolerance policy in regards to non-compliance with procedures. There was no audit in March 2016 due to the link infection control nurse having left their post. However, the hospital took prompt action to address this and established a new link practitioner in April 2016. The hospital were also trialling a new hand hygiene audit tool, commencing in August 2016. The tool had been developed by University College Hospital in London.
- The evidence seen demonstrated that 100% of inpatients in quarter 2, 1 April to 30 June 2016, were screened for MRSA on admission.
- There were no reported cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) blood stream infections in quarter 2, 1 April to 30 June 2016.
- There were six reported surgical site infections (SSI) between April 2015 and March 2016. Two in upper gastrointestinal (GI) in April 2015 to June 2015; two in upper GI from July 2015 to September 2015, one in cardiothoracic, relating to the heart, chest or lungs, from October 2015 to December 2015; and one in cranial surgery, relating to the brain, in July to September 2015. The rate of SSI's for cranial surgery was low compared to the average for NHS hospitals in the reporting period April 2015 to March 2016. However, there was no benchmarking for upper GI and colorectal, bowel, or cardiothoracic, heart and lung, surgery for the same reporting period.
- Staff told us the age of the hospital building posed challenges. For example, the floor was uneven in places, but risk had been mitigated by anti-slip strips and flooring.
- The theatre's reception had a large VDU screen that carried information and learning from across the hospital. For example, we saw case studies on display. The screens did not compromise patients' privacy as patients names were not identified on the screen.
- Theatres had three anaesthetic rooms and four theatres. The theatre and ward areas were well equipped. Theatre staff told us they checked in advance to ensure equipment was available and met the surgical procedures scheduled. Staff told us there were sufficient supplies of equipment and spares were available.
- Theatres used a bespoke 'rollastore' equipment storage system in the instrument room to enable staff in storing and locating equipment in a timely way.
- The four theatres varied in size and used for different procedures. Theatre one, one of the smallest theatres and used for major complex surgery such as breast and cardiac surgery had been risk assessed to ensure it was compliant with the minimum space of 55 square metres recommended by Department of Health (HBN 26).
- Theatre number two had glass doors which were overlapping and not closing fully. However, following our visit the hospital informed us they had taken action to address this, and the doors had been repaired.
- The recovery room had four adult bays and a paediatric bay. However, the paediatric bay was not child friendly.
- Staff told us storage space was an issue across surgery. A lack of storage space was identified on the surgical services risk register. Theatre four was being used to store a range of equipment. Staff told us the theatre was used approximately three times a week for dental or laser surgery. Staff said the equipment would be removed when the theatre was in use and pulled into the anaesthetic room or corridor. However, there was a risk that equipment in corridors could have obstructed the fire exit. The interim clinical manage showed us proposals the hospital had drawn up to redesign the theatres area. These included conversion of the staff room into a further storage area, and the creation of a new staff room and staff changing room.

Environment and Equipment

Surgery

- There were daily checks recorded as being carried out on all equipment prior to use and an annual service programme for all equipment.
- Staff told us instruments were autoclaved, sterilised, off site by a private provider.
- All patient rooms had en-suite facilities, as well as oxygen and suction in place in the room.
- The day care unit did not have any single rooms. However, staff told us they would try to move patients to single rooms post-operatively where possible.
- Pressure relieving equipment was available and staff reported that this was delivered to the ward without delay when necessary.
- There was a new lift that could be used to transfer patient to and from theatre post operatively
- The resuscitation trolleys in the theatre, the recovery area and the wards were recorded as being checked daily.
- Staff told us there were sufficient computers available to access patient information and consumables were readily available to support them in their clinical roles.

Medicines

- Medicines were stored safely and available for patients when they needed them, including controlled drugs. Staff we spoke with were aware of how to access medicines out of hours. Emergency medicines and equipment was available on both wards and were checked daily.
- Pharmacists and technicians spent time on the wards and were involved in decisions about patient care. We were told that the time they were on the wards depended on need and was not dictated by the service.
- All discharge medicines were dispensed with appropriate information and a check list was used to make sure patients went home with everything they needed. To enable some patients to leave more quickly the ward kept a small supply of pre-packed medicines which were dispensed by nurses following a safe procedure.
- Medicines were reconciled on admission and audits showed that in February 2016 93% of patients had had their medicines reconciled within 24 hours of admission

and in March 2016 the number was 82%. This showed an increase since 2015. Medicines were also checked at pre-admission clinics and patients advised as to what they should bring with them. Any medicines that patients brought in that were not used were kept separately and securely until discharge when pharmacists or nurses discussed with them whether they were still required.

- Prescriptions we saw were written clearly and administrations were signed for or coded and recorded as to why they were not given. Allergies were clearly recorded. Missed doses were audited regularly and any that could not be accounted for by a valid reason (for example patient refusal) were investigated. Patients received pain relief when they needed it.
- Nurses did not take verbal orders for prescription changes. They followed a newly introduced procedure whereby the consultant relayed information to a doctor on site who amended the prescription.
- Nurses told us how they were involved in learning from incidents and we saw one example that had been rolled out to the whole hospital team. Penicillin allergy alerts in the form of posters and cards were being used; these listed all the medicines that were liable to cause a reaction in a penicillin allergic patient.

Records

- All eight sets of patient paper and electronic records we looked at were legible, dated and all contained a plan of care which was reviewed on a daily basis by the consultant. All paper records containing medical documentation of the inpatient episode were scanned into the computer system and confidential records were destroyed after one month to six weeks.
- Risk assessment were complete and entered on the electronic care planning system. Staff were prompted to enter information by the system, and patients were given a specific care plan relevant to their condition and the procedure they were undergoing.
- Daily observations of patients were recorded. There were prompts on the electronic patient record (EPR) to remind nurses if these were not carried out regularly. Hourly comfort rounds were recorded and up to date.
- The anaesthetist documented discussions with patients prior to surgery.

Surgery

- Patient notes contained a copy of patients consent forms. The consent forms we saw were legible and included the risks and benefits of the procedure the patient was undergoing.
- Patient records were stored appropriately and electronic records were not left on screens. Access to the computers and patient confidential information was password protected, with staff having access via passwords.
- Copies of perioperative treatment were recorded in patient notes. These included the five step surgical safety check list and details of any implants or prosthesis used.
- The theatre registers included details of patient procedures and consultant operations.
- International patients' notes were photocopied and sent with patients on discharge.
- We viewed a records audit baseline report dated October 2015. The report had lessons learned from the audit. The interim theatre manager told us results and learning from records audits were disseminated to managers and discussed at team meetings.
- The hospital's compliance report recorded that 93.3% of patients had been assessed for the risk of VTE between May 2015 and June 2016. VTE risk assessments were analysed by the quality matron, conclusions were drawn and an action plan was in place to address any areas of non-compliance. For example, there was a dip in compliance in April to June 2016 (90%). The report recorded the reasons for the dip as "vacancy impacted on leadership monitoring of monthly compliance. RMO performance not closely monitored." In response the action plan recorded there would be "regular monitoring of RMO compliance in documenting VTE risk assessments and prophylaxis." The action plan recorded the work in progress to address this as, "spot checks on drug charts to identify the RMO's who are not completing VTE assessments."
- The hospital had identified prevention measures for those patients at risk of falls. There were posters to remind staff of falls risks to patients such as the environment, call bells to hand and foot wear. Patients were provided with yellow non-slip socks to wear and signs in their room to remind them to call for assistance.
- The hospital used a falls assessment tool to identify patients at risk. The falls dashboard recorded the number of reported falls had decreased from approximately 33 reported from July 2015 to June 2016.
- Consultants reviewed their patients' condition on a daily basis and ensured pre and post-operative treatment plans were up to date.
- Staff told us that if they had concerns relating to a patient's condition the on-site surgical resident medical officer (RMO), would be called to assess the patient as well as the patient's consultant.
- The hospital wards used the national early warning score (NEWS) to identify deteriorating patients. Observations were recorded on an electronic system, which automatically calculated the level of risk which when a certain level was reached the on-call RMO was automatically informed and would review the patient.
- There were processes in place to reduce the risks to patients undergoing surgery. These included the use of the World Health Organisation (WHO) surgical safety checklist which was embedded in practice.

Assessing and Responding to patient risk

- The hospital had a pre-operative assessment team which provided advice and information to patients prior to their surgery, this included tests, screening such as MRSA, and offered the patient an opportunity to clarify any detail of their surgical journey.
- Patients were provided with a barcoded wrist band. This enabled staff to use a tablet computer at the patient's bedside to access the patient's observations and record any further observations. Staff told us the tablet computers enabled them in identifying when a patient was deteriorating quickly.
- Patients were assessed for the risk of hospital acquired venous thromboembolism (VTE) at preadmission and on admission prior to surgery. The electronic patient record (EPR) included mandatory risk assessments such as VTE, falls and skin integrity to be completed.
- There had been no reported cases of hospital acquired VTE or pulmonary embolism (PE) following surgery between April 2015 and March 2016.

Surgery

- Work was in progress for the hospital in rolling out a 'sepsis 6' implementation plan. This was a bundle of six tasks covering the management of oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring, to be instituted within one hour by non-specialist practitioners where a patient had suspected sepsis. The plan had a completion date of December 2016.
- There was a policy in place for the transfer of critically ill patients from theatres to ITU. We viewed the policy dated July 2014. The policy detailed actions staff should take from the anaesthetist being present when the patient was transferred to a trolley to post-operative handover to intensive care unit (ITU) staff.
- We were told and duty rotas confirmed that the staffing levels in theatre during surgical procedure was compliant with recommendations from the Association for Perioperative Practice (AFPP) during all surgical procedures.
- Staff we spoke with said staff vacant shifts in theatres were covered by staff working additional hours, bank or agency staff.
- The interim theatre manager told us that the majority of staff had been employed in the organisation for many years and staff we spoke with confirmed this.
- Nursing handovers within surgery were carried out at the beginning of each shift. We observed a surgery handover where a briefing was given of all the patients on the wards.

Nurse staffing

- We were provided with information about whole time equivalent (WTE) planned nurse staffing for surgery between April 2015 and March 2016. This equated to: 19 WTE cardiac nurses, the actual figure was 12.4 with another three nurses having been employed and waiting for completion of their pre-employment checks; 17.04 WTE adult surgical nurses, the actual figure was 13.01 with another five nurses having been offered employment and awaiting their pre-employment checks; 31 WTE theatre nurses, the actual figure was 25, with a further seven nurses having been offered employment and awaiting their pre-employment checks. Staff told us recruitment was on-going and they were trying to recruit some of the hospital's longer serving agency staff.
- The matron and ward managers told us that staffing levels were reviewed if following an acuity assessment there were patients with identified risks. The theatre departments used approximately 20% bank and agency staff to ensure staffing to patient ratios were maintained. This was similar to other independent acute hospitals CQC hold this data for.
- On the surgical wards including the day surgery area, there was a ratio of one nurse to two patients; ward managers were supernumerary and able to provide additional support to staff as required. Additional support was provided by a phlebotomist who took bloods and swabs for MRSA as required.
- Theatre staff were allocated to an out of hour's emergency rota to ensure there was cover if a patient had to return to theatre in an emergency. They were expected to be available within an hour.
- The vacancy rates for theatre nurses was 13%, there were no reported unfilled shifts between the period January 2016 to March 2016.
- The sickness rates for health care assistants working in theatre departments was lower than other independent acute hospitals CQC hold data for in the period April 2015 to March 2016, with the exception of October 2015.
- The turnover rate was 34.7% for theatre nurses from April 2015 to April 2016. The rate of staff turnover was higher than expected when compared to the average of other independent hospitals CQC hold this data for.

Medical Staffing

- The service was consultant led. Records we viewed confirmed that consultants reviewed patients on a daily basis in the majority of cases
- We were told that patients' individual consultants would attend the hospital if a patient review was requested by the RMO or senior nurses. If the patient's consultant was unavailable as they were working at another hospital or were on leave another consultant working in the clinical area would review the patient.

Surgery

- There was 24 hour, seven-day resident medical officer (RMO) cover for the wards. The duty rotas provided confirmed that staff worked 12 hour shifts, from 8.00am to 8.00pm. There were sufficient RMO's on the rotas to provide cover 24 hours a day, seven days a week.
- There were 13.2 WTE resident medical officers (RMO), against an establishment of 20.2 WTE. There was also a compliment of three doctors who were fellows in speciality from Imperial College, London, who were studying for Phd's. These doctors were on the cardiac and surgical rota and each worked 24 hours per week.
- The RMO cover on a daily basis was: Paediatric ITU cardiac had one RMO working from 8am to 8pm, and one RMO working from 8pm to 8am, Monday to Sunday.
- Paediatric ITU general had one RMO working from 8am to 8pm, and one RMO working from 8pm to 8am, Monday to Sunday: The paediatric ward had one RMO 8am to 5pm, Monday to Friday. One RMO working from 8am to 8pm, and one RMO working from 8pm to 8am, Monday to Sunday:
- Cardiac outpatients had one RMO 8am to 5pm, Monday to Friday:
- Adult intensive care unit (ITU) had one RMO working from 8 to 8pm, and one RMO working from 8pm to 8am, Monday to Sunday;
- Adult Oncology had two RMO's working from 8am to 8pm, and one RMO working from 8pm to 8am from Monday to Sunday;
- Adult cardiac and surgical services had one RMO working from 8am to 8pm, one RMO working from 8pm to 8am, Monday to Sunday.
- The hospital told us there was a vacancy rate of 7 WTE, but this was intentional in order to flex with service demands. There was a core group of bank doctors doing regular shifts to maintain the consistency of care, the bank doctors were supported to deliver services by having the same access to hospitals mandatory training as the hospitals core staff.
- The RMO attended ward handovers and daily bed meetings and were aware of all of the patients in the hospital, including surgical patients being cared for on

non-surgical wards. Patients who required additional medical support were supported initially by the RMO who liaised with the consultant responsible for the patients care.

- Staff told us that the anaesthetist did not leave the hospital until the patient had returned to the ward and recovered from the anaesthetic. The surgical consultant also saw the patient prior to leaving the hospital to ensure they were stable.

Major incident awareness

- The hospital had major incident and business continuity plans in place. Staff we spoke with were familiar with how to access the guidance and instruction cards for their respective areas.
- Staff had been involved in a fire drill and evacuation exercise in 2016. Staff told us the exercise had enabled the hospital to identify learning and work was in progress on an action plan following the exercise.

Are surgery services effective?

Good 

We rated the service good for effective because:

- The provider had processes in place for reviewing clinical and non-clinical policies.
- Care was evidence based and based on national guidance from the National Institute of Clinical Excellence (NICE) and the Royal Colleges.
- Staff were supported, could access training and all staff had received an annual appraisal.
- There was evidence of multidisciplinary team working across all staff groups.
- The hospital were working towards accreditation for theatres in the Anaesthesia Clinical Services Accreditation scheme (ACSA)
- Records showed that patients consent was obtained prior to treatment being undertaken.

Evidence based care and treatment

Surgery

- The selection of surgical and theatre clinical policies and procedures we looked at all referenced the relevant NICE and Royal College guidelines. For example, the 'sepsis 6' pathway was displayed on the ward.
- Adherence to best practice, NICE, and Royal College guidelines was monitored by the hospital's standards committee.
- We were told there were arrangements for staff to receive automatic notifications for the review and updating of clinical and non-clinical policies from the clinical governance team. Staff told us there would be a three month notification to the policy author when a policy was due to be updated.
- Staff received e-mail reminders via the hospital's electronic document management system when there were policy updates.
- Care was delivered in line with the relevant NICE and Royal College guidelines as well as taking account of individual consultants' preferences. There were patient pathways and protocols based on national guidance that were used to deliver care to surgical patients. These included patient pathways for a variety of complex procedures such as neurological, cardiac, breast, lung and gastro-intestinal conditions.
- There was an implementation plan in place for the National Safety Standards for Invasive Procedures (NatSSIP), The NatSSIP brings together national and local learning from the analysis of 'never events', SI's and near misses through a set of recommendations that enable staff in providing safer care for patients undergoing invasive procedures. The implementation plan was scheduled to be rolled out in August 2016.

Nutrition and hydration

- Dieticians were located on each floor to ensure that patient's nutrition and hydration needs were met.
- The wards used a malnutrition universal screening tool, (MUST) to assess patients for the risks of dehydration or malnutrition on admission.
- Records showed food and fluid intake on the wards was recorded used to monitor patients post-operatively.
- Regular 'comfort' rounds were undertaken which included patients being offered fluids. All fluids given

intravenously, through a vein, were recorded. Patients urine output was recorded and calculated over a 24 hour period and reviewed by staff to ensure patients remained hydrated.

- Dietary planning was recorded in the patient's notes as were additional food supplements when prescribed.
- Patients commented on the excellent quality and wide choice of food, which met the needs of groups of patients from a variety of religious and cultural backgrounds. The chef was available and ensured individual needs/requests were met wherever possible. A typical comment was, "The food here is gourmet."

Pain Relief

- Patients' records showed the level of pain was assessed regularly as part of their observation records. Patients' rooms had a copy of the pain tool present for staff and patients to refer to.
- Patients' notes showed that pain relief was prescribed prior to their surgery by the anaesthetist and reviewed by the consultant. The RMOs and nursing staff ensured patients prescribed pain relief was effective when they reviewed patients on a daily basis.
- Pharmacists were available to provide advice to ward staff and medical staff. Patient records we reviewed confirmed that patients were referred and seen promptly by the pain team.
- The six sets of medical notes we reviewed showed that patients had been given regular pain relief post-operatively. Patients confirmed that they were asked by staff what their pain level was and were not kept waiting for analgesia.
- Theatre staff told us that all patients were reviewed by the anaesthetist prior to leaving the recovery area to ensure they were comfortable and their pain was managed.

Patient outcomes

- Data provided showed there had been 7044 inpatient and day cases attendances between April 2015 and March 2016, in the same period there had been 41 unplanned readmissions within 28 days. However, this number was not high when compared to a group of acute independent hospitals which submitted data to the CQC.

Surgery

- In the period April 2015 to March 2016 there were five unplanned transfers of patients to other hospitals. The number of unplanned transfers was not high when compared to the performance data submitted by other acute independent hospitals.
- The hospital surgery participated in a range of national audits and benchmarking, including: the Public Health England (PHE) surgical site surveillance for benchmarking for coronary artery bypass grafting (CABG) and total abdominal hysterectomy (TAH). We found the hospital had performed better than the national average for CABG. For example, the PHE SSI audit from April 2015 to March 2016 indicated that there had been 0% infections compared to the five year average for all hospitals of 4.3%.
- The governance risk lead told us the hospital was benchmarked by the provider with other hospitals in the HCA group.
- There had been 13 cases of unplanned return to the operating theatre between April 2015 and March 2016.
- The hospital were working towards accreditation for theatres in the Anaesthesia Clinical Services Accreditation scheme (ACSA), and were in the process of completing an accreditation gap analysis.
- The name of the nurses in charge for each shift was displayed in theatres reception. Their role was to supervise and support nursing staff and treating a limited number of patients.
- The wards looked after a number of different specialties such as neuro surgery, cardiac, and colorectal surgery. A training and competency package was in place to ensure staff developed the appropriate skills to care for patients. Staff told us theatre's had two qualified 'first assist' nurses. These were practitioners who had completed specialist training in surgical first assistance. First assistants were supernumerary.
- Staff told us most surgeons brought their own surgery assistants. Staff had access to an electronic index of surgeon preferences. For example, staff told us a surgeon was allergic to a surgical skin preparation and staff knew not to use this during procedures.
- We reviewed three completed staff competency assessments which included the use of patient controlled analgesia, cardiac monitoring and the management of chest drains. Staff told us they had their competencies assessed by a senior member of staff.
- Agency nurses completed an orientation booklet on their first shift and worked under the supervision of unit staff. An agency staff nurse told us they received an orientation on their first shift and felt supported by staff.
- Some staff had trained as registered mentors with the University of London.
- Some staff in theatre told us they had access to career and professional development opportunities such as attending courses to complete additional qualifications such as degrees or anaesthetic training. For example, a manager told us they had initially started working for the hospital in a non-clinical role and had been sponsored to complete their nursing degree by the hospital. Four nurses were being supported by the provider to complete Masters degrees in clinical leadership.
- We were told that consultants brought their own surgical assistants and that their qualifications, insurance indemnity and criminal record checks were carried out prior to them assisting in surgical procedure. A log of this information was kept in theatre to confirm the checks had been carried out.

Competent Staff

- There were processes in place to ensure staff employed by the hospital had access to regular appraisals and opportunities for professional development. Managers were prompted by email when appraisals of clinical and non-clinical staff were due. Information provided by the hospital showed that across the hospital there were high levels of staff appraisal. For example, 100% of staff working in theatres had received their annual appraisal. Staff told us annual pay increments were linked to training and appraisal and this motivated staff to keep these up to date.
- There was 81% revalidation of professional registration for theatre nurses. However, this figure did not include the validation figures for staff that had been in post for less than six months.
- All new staff were provided with a mentor and preceptorship; they were also expected to complete local training during their probationary period to ensure they had the necessary skills for their role.

Surgery

- RMOs received revalidation at the Harley Street Clinic if required. The RMOs felt supported in their education and were provided with funding to attend conferences, for example. The RMOs we spoke to had a high level of training (mostly just below consultant level), and worked whilst also undertaking research. However, not all RMOs had a designated mentor.
- Consultant credentials were reviewed via a report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. There was an annual review of practising privileges, including scope of practice and activity.
- Professional registration and validation of qualification were undertaken for all staff employed at the hospital. Medical staff holding practicing privileges were required to demonstrate their revalidation had been undertaken by their employing NHS trust.
- Clinical practice facilitators told us staff training was a priority at the hospital. The practice facilitators supported the quality matron in providing staff with one to one supervision. They also monitored staff mandatory training to ensure staff updated training when it was due.

Multidisciplinary working

- Staff told us all patients received multidisciplinary team (MDT) care. There was close liaison between medical, nursing, therapy and pharmacy staff, such cardiac nurse specialist and the multi-disciplinary breast team, which included a clinical nurse specialist and reconstruction specialist consultant.
- Multidisciplinary team (MDT) meetings were held three times a week to discuss complex care and management plans for patients requiring surgery and a range of other treatments. There was also a daily handover meeting.
- The interim theatre manager told us they had introduced monthly breakfast meetings which all staff attended. During the meeting staff were updated on complaints and staffing. We did not request minutes for these meetings.
- Nursing and physiotherapy staff we spoke with said they were able to telephone the consultant surgeon for advice if required.

- We observed a theatre team brief. This was attended by the theatre MDT team. Patients' medical histories were discussed, as well as patient's anaesthetic plans. The lead nurse asked questions in regards to the WHO surgical checklist.
- Theatre recovery staff told us the anaesthetist did not leave the recovery area until the patient was transferred to the ward.
- A discharge letter was generated and sent to the patient's General Practitioner (GP) or given to the patient to take with them if they preferred to ensure the GP aware of the procedure and post-operative treatment recommended. The discharge letters also included contact details for the hospital should another health professional require further advice about patients care or treatment post discharge.

Seven day Services

- There was a 24 hour, seven days a week rota of on-call RMO to cover surgical inpatient care.
- Consultant surgeons were expected to be available 24 hours a day, seven days a week if their patients required urgent review, or if they were not available they were expected to have arranged cover by another surgeon.
- The hospital operated seven days a week. For example, neuro surgery was available at weekends.
- Patients had access to specialist nurses, including breast and stoma nurses, 24 hours a day, seven days a week.
- There was 24 hour seven days a week on-call rota for a radiologist and an intervention radiologist. Intensivists provided 24 hour on-call cover seven days a week.
- There was an on-call pharmacist service out of hours when the hospital pharmacy service was not available.

Access to information

- Staff they were able to access patient information promptly from the electronic patient record (EPR). Staff said there were sufficient supplies of computers available. Portable computers on wheels enable staff to directly enter patient information at the bedside and other areas of the hospital.

Surgery

- All medication was entered onto the EPR and all prescription charts were checked daily by the ward pharmacist to ensure patients medication was recorded on drug charts appropriately. The drug charts we viewed were recorded correctly.

Consent, Mental Capacity Act and DoLS

- Staff told us they rarely had patients who lacked capacity. Staff told us they had received e-learning on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff we spoke with were unable to demonstrate that they fully understood their responsibilities in relation to the MCA and DoLS. However, the lead oncology and discharge liaison sister understood their responsibilities and said staff would liaise with senior staff if they felt a patient lacked capacity.
- Consent was generally obtained on the day of surgery by the patient's consultant surgeon.
- There were checks that consent had been obtained on the ward, on arrival in theatre, and before the administration of anaesthesia in accordance with the world health organization (WHO) surgical safety check list and best practice guidance.
- The eight sets of notes we reviewed confirmed that all consent to surgical procedure forms were signed, dated and legible.
- Where physiotherapists had provided care each entry confirmed that they had sought verbal consent prior to treating patients and all entries were legible, dated, timed and signed.
- Patients we spoke with were very positive about their care and treatment. They told us their doctors explained their care and treatment to them and visited them usually on a daily basis. Nursing staff were reported to be kind, polite, professional and caring. Patients told us that they felt supported by competent staff whilst in hospital and by the nurse specialist following discharge from hospital.
- Information from the hospital recorded that 98.1% of patients had a scanned consent form in their EPR.

Are surgery services caring?

Good 

We rated the service good for caring because:

- Patients provided positive feedback about their care and treatment.
- Patients and families we spoke with said staff explained their care and treatment to them and visited them regularly.
- Staff were reported to be polite, professional and caring.
- Patients had access to chaplaincy services to meet their spiritual needs. There were support groups available for cancer patients and counselling services available to provide psychological and emotional support.

Compassionate Care

- The seven patients we spoke with provided positive feedback about the treatment and care they had received from the staff.
- A patient told us, "They've been very professional and very compassionate." Another patient said the call bell was responded to very quickly and they had been delighted with the care and treatment they had received.
- We observed staff being kind, respectful and polite when speaking to patients and delivering care. We saw staff knocking on patients room doors prior to entering. The interim theatre manager told us, "The human touch is important here. I am passionate about caring in healthcare."
- Patients were encouraged to complete a patient experience questionnaire on the day of their discharge; however, staff told us that many chose to take it home with them and did not return the completed form.
- The results from the patient experience questionnaire were collated by an external company on a monthly basis and fed back to the hospital. The results from January 2016 to April 2016 showed that patients (97%) were extremely with happy their care, with a 27% response rate.
- We observed that patients' privacy and dignity were respected in theatres as well as on the wards.

Surgery

Understanding and involvement of patients and those who care for them

- We saw staff explaining to patients and their relatives the care and treatment that was being provided. Patients told us they were given sufficient information before their procedure to prepare them for their surgery.
- Patients told us they had met with the pre-assessment nurse and been shown around the ward areas, as well as given the opportunity to ask questions. Patients said they could ask staff about their care and treatment at any time and someone would speak to them. A patient told us, "They've been very helpful. They have discussed convalescent centres with me." Another patient told us, "I've been fully informed. They've discussed everything with me. They discussed my discharge, medication, and told me about bandaging wounds. They've involved my wife. She has someone here she can ring for support."

Emotional support

- All the patients and relatives we spoke with told us they felt supported throughout their journey. Patients said the support provided by staff from consultation, pre-assessment and surgical intervention was very good. Patients told us that this included both the clinical and non-clinical staff.
- Patients had access to psychological support and counselling services as well as complimentary therapies such as reflexology. There were also a variety of support groups for cancer patients after their surgery such as the Macmillan team.
- Patients had access to multi-faith spiritual support. Chaplains attended the hospital daily and visited patients and their families on request.

Are surgery services responsive?

Good 

We rated the service good for responsive because:

- The service was responsive when planning the service to meet the needs of patients.
- Patients were able to access surgical services in a timely manner and their needs were met.

- Patients had access to services that met their individual needs including interpreting services for patients that didn't speak English.
- Staff worked to address any issues or complaints raised by patients at first point of contact.

Service planning and delivery to meet the needs of local people

- As the hospital provided mainly private care the majority of patients chose to use elective surgery. This meant admissions to the surgical inpatient wards were generally planned in advance. Emergency admissions were also accepted and surgeons were notified of emergency admissions by the hospital's admissions office.
- The range of surgical services had been developed in response to demand and the specialties of the consultant surgeons using the hospital with practicing privileges.
- There was a service level agreement with a local NHS trust to carry out some NHS neurosurgery at the hospital to increase the trust's capacity. There were clear guidelines on which patients would be transferred from the NHS and for which procedures.
- There was service level agreement in place for a multi-faith chaplaincy service provided by a neighbouring NHS trust. Staff said they could contact chaplains at any time and they would send a chaplain to the hospital.
- We saw plans the hospital had drawn up to redevelop the theatres area and create increased storage and better facilities for staff. Staff told us the redevelopment was still in the planning stage.
- We viewed the SLP mid-year review dated July 2016. The plan set out the objectives of the service for the next 12 months. The plan also reviewed the previous year's plan; this included the employment of an intensivist. The plan identified staff that were responsible for achieving the plan's objectives. However, the review recorded that a proposed new contract for theatre staff was on hold until a new theatre manager was recruited.
- The hospital had a kitchen available for families and visitors to use. However, the décor of the room was

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bland and dated. Staff told us visiting families used the room infrequently, as families tended to stay with patients and could order coffee or meals from the hospital's catering team.

Meeting people's individual needs

- Patients' individual needs were identified prior to surgery by the consultant responsible for the patients care and during the pre-assessment process. Information about the patient was sent by the secretaries to the pre-assessment nurse. Consultants identified when patients' would benefit from a telephone assessment.
- Staff told us there were three methods of contact these included telephone, attending the clinic and on-line completion of a questionnaire. This included gaining information about each patient, such as medication taken, medical history and factors that might affect the safety of general anaesthesia.
- Where possible patients were invited to attend the pre-assessment clinic. However, international patients were not always able to attend a clinic. These patients would be sent information via email detailing the process and procedures of their treatment.
- There were systems to identify high risk surgical patients pre-operatively these included the surgical pre-assessment processes. The pre-assessment identified diagnostic tests and imaging needs for specific conditions.
- The pre-operative assessment form noted if an individual patient required an interpreter. Interpreters were available face to face and via a telephone interpreting service. There was In-house translation for Arabic, Greek and Russian patients. Printed information was available on-site in Arabic, Greek and Russian. Patient information leaflets were available for those surgical procedures commonly undertaken at the hospital in a variety of languages. Surgeons informed staff when interpreters would be required in surgery.
- Dementia training was mandatory; most staff in theatres had completed dementia awareness training to enable them to care for people living with dementia. However, staff told us patients at the hospital with a diagnosis of dementia were rare and they had not provided care or treatment for any patients with dementia.
- Staff told us that they could obtain information in the majority of languages and the majority of patients were currently Arabic, Greek or Russian. We noted that signage within the ward areas was in both English and Arabic.
- Translation and interpreting services were available in the hospital for Arabic, Greek and Russian speakers, and by telephone for other languages to ensure those patients and their relatives whose first language was not English understood their care and treatment.
- We were told by the team a variety of reading material to support all cultures and beliefs could be provided for patients during their hospital admission.
- Patients had call bells in their rooms. We saw call bells being answered promptly by staff. A patient told us, "They respond in less than a minute. They come very quickly when you use the call bell."
- The hospital was accessible for wheelchair users via lifts and mobile ramp. that could be used from the pavement outside the hospital to enable wheelchair users accessing the premises.
- Porters carried bleeps. Porter staff told us that portering services could be prioritised using the hospital's teletracking system. Porter staff said patient transfers were a priority. Porters also provided an internal and external post service to ensure patient or hospital mail was delivered in a timely way. Porters also collected samples and delivered them to the on-site pathology team.
- Patients' rooms had pull-down beds to facilitate families that wished to stay with a patient.

Access and flow

- There had been 3146 visits to theatre in the period April 2015 to March 2016.
- Bed meetings were held daily to ensure there were sufficient beds for the expected admissions and any issues from the previous day were discussed. This approach facilitated the identification of any issues such as shortage of staff or beds which could delay admissions.
- The hospital had an admissions policy in place dated 24 June 2016. The policy clearly detailed the admissions procedure to the hospital. For example, "a patient must

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be admitted under a consultant who holds practicing privileges with the hospital,” and, “In the case of potentially life-threatening emergencies, General Practitioners with privileges should refer a patient, by ambulance, to the nearest Accident and Emergency Department.” Staff we spoke with were able to explain the admissions procedure and this was in line with the published policy.

- We found patients were admitted by consultants with practising privileges following either direct referral from a GP or from an outpatient’s consultation.
- The majority of admissions for surgical procedures were elective and planned in advance. Admission was facilitated in a timely manner and could be arranged at short notice to meet patient’s individual needs and ensure they received treatment as soon as possible. We spoke with two patients who stated their admission had been arranged very quickly to meet their needs. Patients also said they had been pre-assessed prior to admission.
- The hospital reported they had cancelled 103 procedures for a non-clinical reason in the last 12 months; of these 103 patients were offered another appointment within 28 days of the cancelled appointment.
- There were minimal reported discharge delays due to waiting for medication and pharmacy monitored the time of medication requests and the time dispensed.
- The hospital told us patients did not have to wait to be treated and discharge was planned at admission to avoid delays. Follow up appointments were scheduled and staff ensured adequate arrangements for patients leaving the hospital were in place.
- International patients had transfers and transport arranged by the hospital. However, if social work or therapeutic support was required following discharge, international patients were responsible for arranging this in their own country. Staff told us they could liaise with foreign embassies and provide link nurses and escort international patients if requested.
- The hospital informed us they did not routinely audit waiting times or referral to treatment times (RTT), but

that these were monitored via the patient feedback form. Managers we spoke with told us waiting times were not an issue as most patients could be seen within days.

Learning from complaints

- Patients were aware of how to raise concerns and information on how to make a complaint was provided as part of patients information pack on admission.
- VDU screens on the wards displayed information on patient feedback and how patients could raise concerns or make complaints.
- The chief executive office (CEO) was responsible for complaints management with the chief nursing officer (CNO) taking responsibility for the day to day administration of patient complaints. Complaints were investigated in collaboration with the governance team. The surgery service manager was responsible for disseminating learning from complaints to staff in surgery and theatres.
- Staff told us that where possible they would resolve any issues with patients informally, and prior to a formal complaint being made. There was an expectation at the hospital that any concerns raised by patients on the wards would be addressed immediately by the manager and if possible resolved immediately to the patients’ satisfaction.
- The hospital received 77 complaints in the period April 2015 to March 2016. One of which was referred to the health ombudsman or Independent Healthcare Sector Adjudication Service (ISCAS). However, there had been a reduction in the number of complaints from the previous year April 2014 to March 2015. The assessed rate of complaints was as expected when compared to other independent acute hospitals.
- Patients we spoke with told us they had not had any reasons to complain. A typical comment was, “I haven’t had anything to complain about. It’s all been excellent.”
- We viewed the hospital’s complaints log for the period November 2015 to May 2016. 43 complaints were recorded. Complaints on the log were not broken down by speciality. However, there were two complaints

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relating to cancelled procedures in cardiology. The complaints had been investigated and actions the hospital had taken in response to the complaints were recorded on the log.

Are surgery services well-led?

Outstanding



We rated the service outstanding for well led because:

- There was a service wide vision and strategy that was embedded by staff in both inpatient wards and in the theatre setting. Staff were very proud of their service and felt as though their managers and members of the executive team were very approachable and caring.
- There were robust governance structures and reporting mechanism in place where performance and the quality of the service was reviewed. The surgical services risk register documented risks and assigned a manager responsible.
- Consultants felt that senior management were approachable and reported good working relationships. There was a consensus that senior management were very responsive to the needs of both staff and patients.
- The consultant body had a number of academic surgeons who had introduced innovative technologies from the NHS to the hospital, for example, laser therapy and brachytherapy.
- Surgeons collaborated with another HCA hospital to be the first hospital in the UK to trial a robotic radiosurgery system on cardiac patients.

Vision and strategy for this service

- The hospital had a mission statement, “above all else we are committed to the care and improvement of human life. In recognition of this commitment, we’ll strive to deliver high quality, cost effective care in the communities we serve.” The mission statement was promoted in the hospital’s publications. Most staff we spoke with were aware of the hospitals, “putting patients first” ethos.
- The hospital’s values were publicised across the hospital. For example, they were displayed on the wards and on the staff notice board in the theatre’s staff room.

The values included recognising patient’s individuality and uniqueness; treating patients with kindness and compassion; acting with honesty and integrity; treating staff and patients with respect and dignity. Staff we spoke with understood the hospital’s remit to improve “customer” experience and the importance of maintaining high standards of care.

- The surgery service line plan (SLP) set out the strategic direction for surgery on a 12 monthly basis. The hospital also had an infection prevention and control strategy 2016. This set out what the hospital were doing to maintain the effective prevention and control of healthcare associated infections (HCAI) and its relationship to the “overall performance of the organisation in delivering world-class medical care.”

Governance risk management and quality measurement

- There was a defined governance and risk management structure from corporate provider level to hospital and department level. There was also a designated reporting structure for quality and risk management. For example, a flowchart on the staff noticeboard in theatres clearly defined the structure for quality and risk governance. There were a number of localised committees, including: patient blood management, infection control, medicines management, resuscitation, and the theatre users group; that reported to the hospital clinical governance committee (CGC). The CGC, mortality and morbidity committee, radiation protection committee, standards committee, safeguarding committee and risk management, reported to the hospital’s quality and risk board; medical advisory committee (MAC); and ethics and compliance committee. In turn these committees reported to the hospital’s executive committee.
- The surgical services structure was structured as: anaesthetic lead; cardiac cath-lab lead; chief perfusionist; lead theatre practitioner/scrub lead team one; lead theatre practitioner/scrub lead team two; and theatre purchasing materials lead; all of these surgical services leads reported to the interim theatre manager. The interim theatre manager had been in post for a month. The interim theatre manager was the manager of the outpatients department and was covering the role until the hospital recruited a new theatre manager. The position was being advertised and work was in progress to schedule interviews for candidates.

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- The medicine management committee met quarterly and reports and data, such as medication errors and timely discharges for each area were reviewed. The CGC also reviewed unplanned readmissions, unplanned returns to theatre and incident reports.
- The theatre user group, which included the theatre clinical services manager, consultant anaesthetist and theatre staff, met each quarter to review incidents and any staffing or equipment issues, as well as discussing methods to improve processes.
- There was a surgical services risk register in place. The risk register documented nine risks, such as environment, equipment, health and safety, infection control and staffing. For example, the register recorded that theatres had one air handling unit (AHU) that served all theatres and in the event of the unit breaking down all theatres and anaesthetic rooms would be out of action. The register recorded that daily checks were performed on the AHU and a plan to upgrade the AHU had been approved. There was a designated named person responsible for each risk, and entries were updated and closed when the level of risk was reduced. The register also recorded the level of risk and the target level of risk. Managers we spoke with were aware of the risks relevant to their specific areas.
- Ward and department performance indicators and quality indicators were reported monthly to the recently introduced quality improvement and patient safety (QIPS) group and the bi-monthly MAC meeting.
- The MAC was responsible for reviewing consultants practicing privileges renewals and acceptance of applications for new clinicians. Minutes of the MAC reviewed for 23 February 2016 and 26 April 2016 confirmed this was a standard agenda item at the MAC meetings.

Leadership of service

- There was a clear management structure within the wards and theatres. Each ward had a ward manager and sister in charge who reported to the clinical services manager covering the surgical wards. Senior clinical theatre staff managed individual theatres to support junior nursing, operating department practitioners and

the portering staff in the day to day running of the theatres. The theatre complex was managed by interim theatre manager and all staff reported directly to the interim theatre manager.

- All ward managers and matrons were supernumerary and staff told us they were visible and accessible. The senior sisters participated in the duty manager's rota to give 8.00am -8.00pm senior cover across the hospital. The night senior manager cover was provided by clinical nursing staff and duty rotas were provided which confirmed continuous senior support.
- Staff spoke very highly of the support the ward managers, matrons and unit managers provided across the surgical unit to the whole team and they told us they felt valued as team members. Staff told us they were listened to and any concerns they raised were acted on by managers.
- We saw that the interim theatre manager and matrons were visible across the surgical wards and theatre complex during our inspection.
- The hospital produced a quarterly clinical operating report (QCOR). The report reviewed and monitored key performance indicators (KPI) on quarterly basis, as well as infection control, incidents including the 'duty of candour' and 'never events', the integrity of the hospital's data, and patient experience. We viewed the report for quarter 1, January to April 2016. The report carried a commentary on actions the hospital had taken to address issues raised from the hospital's data.
- The executive team were engaged with services. Members of the executive team told us the CEO and other executive team members were supportive and would step-in to chair committees and provide support for other executive team colleagues.
- The MAC had executive powers and monitored the practice of consultants and other medical staff. The MAC was regularly attended by the medical director and CEO.
- All the staff we spoke with knew the names of the executive management team. Staff told us they were visible and regularly visited the wards and attended staff meetings. A HCA told us the company president was visible and had spoken to them about their work on numerous occasions.

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- The CEO held a monthly staff meeting which all staff were invited to attend. The meetings were used to update staff on what was happening across the hospital. A staff member told us, “The CEO is very inclusive.

Culture within the service

- Staff across the hospital reported a highly visible management team who were approachable and supportive. Staff told us felt able to contact any of the management team if they had concerns, were confident about challenging poor practice if necessary and were aware of the whistleblowing policy and procedure.
- Staff we spoke with told us across the hospital staff morale was high. A typical staff comment was, “I feel proud to be part of this team.”
- Medical staff reported good working relationships with managers in the hospital and felt they were accessible.
- Staff we spoke with told us the culture was friendly and supportive. A member of staff gave us an example of having had a new bike they had parked outside the hospital stolen and the hospital replacing the bike and improving the security outside the hospital.

Public and staff engagement

- The hospital had a programme of charitable work that enabled patients who were unable to fund their care to access specialist surgical procedures.
- There were suggestion boxes on the wards together with suggestion forms. The ward sister had been pro-active in encouraging patients to return feedback.
- We viewed the hospital’s friends and family test (FFT) information for the period 1 January 2016 to 30 June 2016. There was a 27% response rate. 97% of respondents said they would recommend the hospital to their friends and family.
- The hospital employed a company to analyse and report on patient feedback. The report was sent to the hospital’s quality and risk board, who addressed any issues raised by the report.
- Staff told us they were offered debriefing when they had nursed patients at the end of their life.

- There were competence quizzes for staff. Staff told us the quizzes had engaged staff and improved outcomes of staff competence assessments.
- HCA’s had their own portal on the hospital’s intranet. Staff told us the portal carried information that was relevant to their roles.
- Staff in theatres told us they had been consulted and asked for ideas for the proposed redevelopment of theatres.
- Staff told us the hospital were flexible with staff to facilitate staff with childcare responsibilities. Staff working after 10pm at night were provided with a taxi to ensure they got home safely.
- There was a monthly hospital magazine, ‘Specialist’, produced for medical staff. The magazine carried articles on innovations and good practice.
- There was a variety of monthly staff newsletters including, ‘In focus’, a newsletter for all staff; a newsletter for hotel services at the hospital; and a quarterly consultants newsletter. The newsletters carried updates and information for staff on the hospital’s services and operations.
- The hospital had an ‘employee of the quarter’ scheme, where other members of staff could nominate their colleagues for a prize as well as the hospital making a cash donation to a charity of the staff member’s choice.

Innovation improvement and sustainability

- The hospital were in the process of developing plans to improve the theatres environment. These plans were in planning stage.
- The consultant body had a number of academic surgeons who had introduced innovative technologies from the NHS to the hospital, for example, laser therapy and brachytherapy, (this was a cancer treatment involving the insertion of radioactive implants directly into tissue).
- Surgeons collaborated with another HCA hospital to be the first hospital in the UK to trial a robotic radiosurgery system on cardiac patients.

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

Information about the service

The Adult Intensive Care Unit (AITU) at The Harley Street Clinic is on two floors; one six bedded unit on the ground floor (ITU2) and a three bedded unit in basement (ITU3). The unit has capacity for nine patients in four open bays and five single rooms. One bay in basement unit was closed and used for storage.

The unit can be flexibly staffed and configured to provide care and treatment for both level 2 high dependency patients and level 3 intensive care patients.

The AITU cared for 948 patients between April 2015 and March 2016. There were 19 deaths in AITU during that period.

There is a resident medical officer on duty in the AITU 24 hours, seven days a week along with a consultant intensivist between the hours of 8am to 6pm and on call at all other times.

Patients are admitted to the AITU from the theatre as planned admission following neurosurgical, oncology surgery, cardiothoracic and other surgery requiring close patient monitoring.

We spoke with 15 nurses, two consultants, three doctors, six other medical professionals including physiotherapists, a dietician and a microbiologist and three support staff members. We spoke with three patients and three relatives. We looked at 10 patient records and 15 prescription charts, recent Intensive Care National Audit and Research Centre (ICNARC) data from April 2015 to March 2016 and several other items of documentary evidence to come to our rating.

Summary of findings

We rated the critical care service as good because:

- The service had a robust process for ensuring that clinical incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place.
- Staffing in the unit was compliant with Intensive Care Society (ICS) guidance, with appropriate numbers of suitably qualified and registered staff. Nurse to patient and doctor to patient ratios were consistently in line with this guidance.
- There was a comprehensive programme of training and development in place for nursing staff. Patients received care and treatment from a team that demonstrated good awareness of risk assessment practice.
- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Suitably qualified nursing staff cared for patients. Medical staff received regular training as well as support from consultants.
- There was good access to seven-day services and the unit had input from a multidisciplinary team. Staff managed pain relief effectively and monitored patients' nutrition and hydration needs closely.
- The unit had fewer readmissions within 48 hours of discharges, compared to other similar units.

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- The unit met all the standards of the Intensive Care Society, with the exception of one standard related to access to a regional home ventilation and weaning unit. However, access was obtained via the referring consultant as required for transfer.
- The unit provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff ensured the individual needs of patients were met.
- ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed that the unit performed better than similar units in all quality indicators.
- The complaints process was effective, with appropriate investigations and there was culture of learning from complaints across the board.
- The leadership team had a clear vision and strategy and staff were able to verbalise the vision.
- There was a robust governance structure, both within AITU and within the hospital.
- We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was very open and any member of staff could approach the leadership team with any issues or new ideas.
- The management team had oversight of the risks within the services and mitigating plans were in place.

However:

- The consultant intensivist and visiting consultants relied on the RMO to upload patient notes to the electronic patient record on their behalf.
- There were inconsistencies in weekly checks of chest opening trolley and not all staff were clear of who was responsible and frequency of these checks.

Are critical care services safe?

Good 

We rated safety as good because:

- The service had a robust process for ensuring that clinical incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place.
- Clinical areas throughout the hospitals were visibly clean and regular hygiene checks took place.
- Equipment was adequately maintained in line with manufacturer guidance.
- There were clear systems to manage a deteriorating patient and patient risks were appropriately identified and acted upon.
- Staffing in the unit was compliant with Intensive Care Society (ICS) guidance, with appropriate numbers of suitably qualified and registered staff. Nurse to patient and doctor to patient ratios were consistently in line with this guidance.
- There was a comprehensive programme of training and development in place for nursing staff. Patients received care and treatment from a team that demonstrated good awareness of risk assessment practice.

However,

- There were inconsistencies in weekly checks of chest opening trolley and not all staff were clear of who was responsible and frequency of these checks.

Incidents

- There were 53 reported incidents in the AITU during April 2015 to March 2016. 66% of these incidents resulted in no harm to the patient.
- There have been no Never Events reported within AITU department. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to

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cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.

- The AITU reported no serious incidents during April 2015 to March 2016. We looked at the investigations reports of an unexpected death incident, which included detailed chronology of events, investigation and root cause analysis. There were recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the hospital.
- Lessons learned from incidents were shared across teams via emails and during handover. Senior staff told us incidents were discussed at the Senior sisters' meeting and action plans and learning arising from incidents were disseminated to staff at each shift. The unit was using the hospital's new initiative called "Big Four", which was a list of top four learning topics to be discussed at handover, reminding staff at each shifts. We saw nursing staff discussing this at the morning handover.
- We saw evidence of incidents discussed at the monthly clinical governance meetings and senior sister's meetings. Unit manager told us that during May 2016, there were four incidents related to communication and handover because of which they changed the handover document and clear communication during handover was highlighted in the pharmacy newsletter.
- All staff were aware of the incident reporting procedures and knew how to raise concerns. Resident medical officers (RMO) and nursing staff showed us how they reported incidents on an electronic incident reporting system. Staff said they were encouraged to report incidents.
- Though there were no regular mortality and morbidity meetings within the unit, we were informed that all deaths within the unit were discussed and reviewed at the hospital mortality and morbidity meeting.
- The senior staff kept an action log of each risk on the register. We saw that the action log was updated regularly with tasks evidenced. For example, staff acted on the recent incidents of patient falls and put measures in place to reduce the risk, including reminding all staff to put up bedside rails.

Duty of Candour

- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice. The Duty of Candour (Doc) sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff told us that they received training on duty of candour at induction.
- Duty of Candour was embedded into practice in the unit. For instance, the electronic reporting system included a prompt for staff to record that they had initiated contact with the patient or relative. Some junior staff did not always understand the terminology. However, the process they described in communicating with patients and their relatives reflected openness and transparency.
- There was no incident in the reporting period that met the threshold for DoC.

Safety thermometer

- The hospital did not use the NHS Safety Thermometer, this is a tool which measures harm to patients which may be associated with their care. However, the hospital had developed their own dashboard which monitored pressure ulcers; falls; catheters and UTIs; VTE.
- All patients had their level of risk assessed for Venous Thromboembolism (VTE), falls and malnutrition, which was reviewed at regular intervals. We confirmed this in our review of 10 patient records that VTE risk were completed and in accordance with NICE Quality Statement 3.

Cleanliness, infection control and hygiene

- The unit looked clean, well maintained and hygienic. The unit main entrance and corridors were clean and uncluttered.
- The unit followed their policies and procedures for hand hygiene and infection prevention and control and audited hand hygiene on a monthly basis. In quarter one and two (January 2016 to June 2016) unit average compliance level was at 96.5%.
- There were dispensers with hand sanitising gel situated in appropriate places around the unit including the

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main reception and entrance to the units and rooms. Hand washbasins were equipped with soap, disposable towels and sanitizer. The seven-step guidance for effective hand washing was displayed at the basins.

- During our visits, we observed staff consistently complying with hand hygiene practice. There was a dedicated infection prevention and control nurse (IPCN) who liaised with a consultant microbiologist and provided infection control advice and education to staff, visitors and patients. We saw the IPCN attended the unit multidisciplinary team (MDT) daily ward round at 11 am.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons, were available and we saw staff using these appropriately. We noted that staff adhered to the “bare below the elbows” policy throughout the unit.
- All of the equipment we examined such as vital sign monitors, mobile computers and infusion pumps were visibly clean. We observed green ‘I am clean’ labels were in use to indicate when equipment was cleaned. We observed staff cleaning equipment with sterile wipes.
- We observed housekeeping staff cleaning the department throughout the day in a methodical and unobtrusive way. We spoke to a cleaning staff, who showed good understanding of separating different types of waste and the use of colour-coding to dispose of waste and colour code mops for different areas. We checked the cupboard where disposed waste was kept. This was locked in line with the policy. Waste segregation and storage was in line with Department of Health 2011 Safe Management of Waste guidelines.
- Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them. We inspected the linen storage areas and noted that there was sufficient clean linen available.
- There was a programme of infection control audits carried out which included audits of hand hygiene, central venous catheters, waste and linen management by the link infection control practitioner for the area. The results for quarter one (January 2016 – March 2016) showed 100% compliance with MRSA screening with two positive MRSA screen cases on admission. Isolation precautions were found to be 100% compliant, waste management was 100%, linen management was 91% compliant with hospital policies. The hospital target for standards in these areas was above 95%. However, unit compliance with ventilator associated pneumonia (VAP) care bundle was at 84.6%. We saw evidence where staff

had identified areas for improvement where audits indicated lower rates of compliance, such as emails sent to staff including pictures of what to complete on ICIP. Sister and IPC link nurse spoke to staff on one to one basis about the importance of completion of data and areas of non-compliance. Infection Control Nurse talked to staff about recent results and importance of raising compliance.

- The Intensive Care National Audit and Research Centre (ICNARC) data regarding infection prevention and control, for the period April 2015 – March 2016 showed no reported case of unit - acquired blood infection.
- The unit had no MRSA (Methicillin-resistance Staphylococcus Aureus) or MSSA (Methicillin Sensitive Staphylococcus Aureus) case during January 2016 to May 2016. The unit reported no case of C.difficile and two cases of E-Coli during the same reporting period. We saw that information was shared with staff and displayed on the staff notice board.

Environment and equipment

- Patients were protected from the risks associated with the unsafe use of equipment because staff maintained a reliable and documented programme of checks. Equipment was labelled and listed in the unit asset register. Maintenance and servicing was planned and carried out in accordance with manufacturer guidance. We saw the dialysis machines being serviced by the manufacturer during the inspection.
- We saw the results of the environment and equipment audit for quarter one (January 2016 – March 2016) which showed AITU compliance was 95% for environment, 100% for equipment audit. We spot checked number of equipment, such as syringe pumps, ventilators, bed mattress and cardiac monitor and all equipment were checked and had PAT (portable appliance test) within date.
- Nursing staff on the unit had maintained resuscitation and emergency intubation equipment on both units with twice daily, documented checks. The trolleys were clean, secure, fully stocked. We reviewed the logbook, which showed that both trollies had been checked and logged on a daily basis with the exception of one day in

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May 2016 when this check was missed in ITU two. We saw the unit meeting minutes, which showed 100% compliance with resuscitation trolley checks in March 2016.

- Bed spaces in the CCU complied with the Department of Health's Health Building Note 00-09, which dictates a minimum standard of space for effective infection control.
- We found both units to be clean, well-lit and bright with appropriate equipment. However, there was no natural light source in ITU3.
- Access to the AITU was restricted by the structure of the building, corridors were narrow and ITU3 had a significant slope on entering the unit. However, since last inspection in February 2015 the provider had installed a new patient lift, to improve the patient journey moving off the unit or from theatre to the unit.
- There was an emergency chest opening trolley available. Spot check of the trolley showed it was fully stocked and all items were in date. Senior staff informed that they never had to use this trolley and theatre staff did weekly checks but not all staff were clear about who was ultimately responsible to do the checks and the frequency of these checks. Theatre staff we spoke with confirmed that an operating department practitioner (ODP) from theatres would check the trolley weekly. However, the records log showed that there were inconsistencies in these checks and the trolley was checked in three out of four weeks in March and April, two out of four weeks in May, only once in June and July with the last check done on 12th July 2016.
- Staff completed competency based equipment training during the probationary period of their employment and worked under supervision until successful completion of their first line assessment. We looked at seven staff records which showed competence was reassessed bi-annually. Agency nurses were required to sign a declaration of the equipment they were competent to use and were provided with training for any equipment they were not familiar with.
- The facilities in the relatives and visitors waiting area and quiet room were well maintained with clean chairs and sofas. A coffee machine and a well-stocked fridge were available for them.

Medicines

- Medicines were stored safely and available for patients when they needed them, including controlled drugs. Staff we spoke with were aware of how to access medicines out of hours. We saw that when ITU3 was not in use the medicines were secure and still subject to the same daily checks.
- A specialist critical care pharmacist spent time on the ward and was involved in multidisciplinary meetings and decisions about patient care. Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. There was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. Nurses could describe to us how learning was disseminated to them from the pharmacist by way of bulletins, emails and attendance at meetings.
- Medicines were stored in a secure, temperature-controlled room, which staff checked and documented for safe temperature twice daily. A temperature checking system was in place for refrigerated medicines that complied with the Royal Pharmaceutical Society of Great Britain (2005) guidance.
- Controlled drugs were only stored on the main ITU and were checked twice a day. Nurses described how they would access these medicines in a safe and timely manner when working in ITU3. Controlled Drugs (CDs) were stored in a locked cupboard, which the nurse in charge held keys for. The nurse in charge, along with a qualified nurse, checked drug stock daily and a spot check of the register confirmed levels were correct. We saw the unit meeting minutes of April 2016, which showed 100% compliance with CD audit.
- Emergency medicines and equipment were available on both units and were checked daily. We saw that diazepam rectal solution was kept in the controlled drug cupboard not in the emergency trolley, which could lead to a delay in access.
- Prescriptions we saw were written clearly and administrations were signed for or coded and recorded as to why they were not given.

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- At the last inspection, we observed intravenous fluids were stored in an unlockable cupboard on ITU 3 and the drug fridge was found to be unlocked. We saw that both these issues were resolved and the fridges had keypad locks and IV fluids were stored in locked cupboards.

Records

- We found patient records were detailed, fit for purpose and included evidence of personalised care and multidisciplinary input that adhered to the guidance of the General Medical Council (GMC) and the Nursing and Midwifery Council. Patient records and clinical notes were created and stored using a paperless electronic system that was compliant with GMC Confidentiality (2009) guidance. On discharge from the unit staff printed a copy of the completed documentation which was incorporated into the in-patient medical records.
- We looked at a random sample of 10 electronic patient records and we observed how these were reviewed and updated during ward rounds. Staff noted communication with relatives and subtleties in a patient's behaviour or outlook were noted.
- Patient bedside physiological and ventilation monitoring equipment was linked to the electronic patient record and the record was continuously updated. RMOs were able to view patient telemetry at the nurse's station and staff escalated concerns as appropriate.
- Staff demonstrated a good understanding of the need for confidentiality and we observed them using appropriate electronic password protection systems effectively.
- The audit to ensure compliance with DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) policy showed there were seven DNACPR orders during July 2015 to April 2016 in AITU. The data showed 100% compliance with most of the standards, such as reason for DNACPR decision documented, form completed by relevant consultant, decision not to give CPR was documented, patient date of birth and name documented.
- All records we looked at included details of allergies, a daily treatment plan and evidence of daily consultant reviews. Specialist assessments were conducted and recorded appropriately, including feeding, neurology and respiratory needs. However, we noticed that after

the ward round, RMO inputted the information of consultant daily review. Although the information was always inputted in detail there were inconsistencies in where this information was included on the electronic patient records and not always in the "consultant review section" of the record. This was identified as an area for improvement to ensure good record keeping.

Safeguarding

- Safeguarding policies were up to date and readily available for staff on the unit, who knew where to access them.
- Staff had good knowledge of their responsibilities regarding the safeguarding of patients and were able to demonstrate this in practice. However, they informed us that they had never made any referrals.
- Staff completed annual safeguarding training as part of the mandatory training programme. We saw individual staff training records which showed staff had completed the training and were 100% compliant.
- All nurses in charge and above had level three safeguarding adult training.

Mandatory training

- The clinical practice facilitator tracked the training needs of nurses in the unit and planned reminder staff via email to reduce the risk that training would expire. All staff we spoke with on the unit had up to date mandatory training.
- Mandatory training included moving and handling, safeguarding, mental capacity and infection control. Staff spoke highly of their opportunities for training and said that they never felt under pressure to take on more than they could handle. They said that protected time for this away from clinical practice enabled them to keep up to date.
- Adult basic life support (BLS) was part of mandatory training for all staff. Hospital data showed that 78% of all staff and 100% of AITU staff had completed BLS training.
- The unit data showed that 100% of staff had completed infection control and dementia training. 60% of staff had advance life support (ALS) and 40% had intermediate life support (ILS) training.

Critical care

- All designated nurses in charge in ITU had completed advanced life support training and were available to support the resuscitation team and attend emergencies outside of the unit.
- Mandatory and statutory training was delivered in line with provider policy and monitored through the appraisal system in line with revalidation. All RMOs attended corporate and/or local induction on commencement of employment and received training specific to their role. RMO then attended annual updates either within their NHS trust or through the provider and completed the e-learning. Those without e-learning access were sent paper copies to complete and return. RMOs receiving training via their NHS trust were asked to provide evidence of completion. There were two lead RMOs for the hospital that supported this process.

Assessing and responding to patient risk

- The ITU used the national early warning system (NEWS) to monitor patients for signs of deterioration electronic system, which automatically calculated the level of risk and patients which trigger a review were seen by the RMO and where required they were escalated to the Consultant Intensivist.
- Assessment tools were used for assessing and responding to patients risks. For example, the Malnutrition Universal Screening Tool (MUST), venous thromboembolism tool (VTE) and Safer Skin Care (SSKIN) were all in use. This information was utilised to manage and promote safe patient care.
- The unit monitored incidents of falls, pressure ulcers, venous thromboembolism (VTE), central venous catheter infections and catheter associated UTIs. Nurses in charge (NIC) were tasked with checking risk assessments completed prior to end of shift, monitored by senior nursing team. Duty Managers monitored all new admissions and assessments completed. We reviewed ten set of electronic patient records, NEWS was documented in all cases and all included evidence that VTE assessments were completed daily on every patient.
- The hospital had an emergency/ resuscitation team who assessed deteriorating patients and incorporated the outreach team role. Team members were assigned specific roles daily and this was reviewed at the start of

the each shift. The ITU RMO, consultant intensivist and the nurse in charge were part of the team. All members of the emergency team were trained in advanced life support (ALS) and were contactable by emergency bleeps. During June 2015 – June 2016, the emergency team responded to 80 calls, 13 of which were escalated to AITU including in one case of cardiac arrest in AITU with 24 hours of trigger.

- The hospital informed us, that the role of the duty manager would be changed to clinical site manager. A clinical site manager with extensive critical care background (band 7), will start in September 2016 and another in October 2016. They would hire a total of four clinical site managers who would be covering critical care outreach services.
- There was a policy in place for the transfer of critically ill patients from theatres to ITU. We viewed the policy dated July 2014. The policy detailed actions staff should take from the anaesthetist being present when the patient was transferred to a trolley to post-operative handover to intensive care unit (ITU) staff.
- The Adult intensive care service was consultant led. All patients were admitted via a consultant. A consultant intensivist reviewed all patients every day.

Nursing staffing

- We saw all patients received 1:1 registered nurse support. There was a designated supernumerary nurse in charge for every shift in line with the Standards for Intensive Care Services published by the Joint Standards Committee of the Faculty of Intensive Care Medicine and the Intensive Care Society (2013).
- The unit had an establishment of 21 full time nursing posts. There were 19 staff in post and two new staff were to start in the week following our inspection visit. There were one senior sister, four sisters, four senior staff nurses and 12 staff nurses, supported by one health care assistant. Bank and agency staff were used to fill vacant post.
- 71% of the nurses held a post-registration award in critical care nursing. This was above the minimum recommended requirements of the Royal College of Nursing.
- During the handover, staffing and patient levels were discussed and it was confirmed that the staff to patient

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ratio met RCN guidelines. Availability of the resuscitation team, supernumerary staff, times of any planned procedures for patients were confirmed and contact with multidisciplinary colleagues was discussed. After the detailed handover nurses handed over to each other at the patient bedside again using the electronic record to ensure all pertinent information was communicated. We observed good leadership skills from senior staff during handovers.

- Agency and the hospital's own bank staff were used to ensure that staffing levels remained safe. Bank nurses were employed by the provider and completed all mandatory training and competencies to meet the needs of unit. We saw the "temporary nursing staff tick list guide" introduced by the senior sister, who would also interview the agency nurses to ensure they had the qualifications and skills required to work in ITU. There was a formal induction process for new staff and agency staff working in the unit for the first time. The unit used the same nurses wherever possible to ensure consistency and that the temporary staff were familiar with unit systems, equipment and protocols. The unit met the ICU core standard of not utilising more than 20% of registered nurses from bank or agency on any one shift.

Medical staffing

- There were three consultant intensivists, all of whom also held NHS contracts working a one week in three rota to provide 24 hours a day, seven days per week cover. The consultants we spoke with confirmed they had no other clinical commitments whilst on call and physically attended the unit as a minimum, once a day with frequent telephone contact with the RMO on duty dependent on patient acuity. There was accommodation available close to the unit for the on-call medical staff and they were required to be able to reach the unit within 30 minutes. The unit met the Intensive Care Society Standard.
- Consultants worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) was responsible for approving practising privileges for medical staff, Chief Executive Officer (CEO) had the oversight and this was reviewed centrally on annual

basis. Consultants with practising privileges had their appraisals and revalidation undertaken by the medical director if they did not work at an NHS trust. For RMOs who also worked in an NHS Trust, a copy of their appraisal and revalidation undertaken at the NHS trust was provided to the HR department of the hospital.

- The unit had a bank of 12 resident medical officers (RMOs) to cover four fulltime posts and provide 24 hours a day, seven days cover. Working 12 hour shifts for example 08.00am to 8.00 pm or 24 hours shift. All Bank RMOs had NHS contracts and worked in the NHS. Consultant intensivist informed us that they interviewed the RMO's prior to employment and that they had suitable previous experience in the anaesthesia and critical care setting. These arrangements met the Intensive Care Society guidelines for ensuring there was immediate access to a practitioner who had skills in advanced airway techniques.
- In addition to this, there were eleven regular agency RMOs that the unit would use during holiday times. During July 2016 – August 2016, there were 14 shifts in six weeks, filled by agency RMOs.
- There were structured handovers between the RMOs at shift changes and there was a daily multidisciplinary ward round held at 11.00am led by the RMO and involved the nursing staff, physiotherapist, pharmacist, dietician and infection prevention and control nurse.
- All staff we spoke with confirmed that there were sufficient staff in the unit to care for patients.

Major incident awareness and training

- We examined the emergency preparedness, resilience and response policy which was available on the hospital intranet. All staff we spoke with were able to describe the process to follow in case of a major incident and plans were in place for wide range of uses. For example, staff showed the fire exits and pathway to move patients out of the unit in case of an emergency.

Are critical care services effective?

Good 

We rated effective as good because:

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- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- Bank and agency staff competence was also assessed and bank and agency staff used regularly on the unit had a critical care qualification.
- There was good access to seven-day services and the unit had input from a multidisciplinary team. Staff managed pain relief effectively and monitored patients' nutrition and hydration needs closely.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- The unit had fewer readmissions within 48 hours of discharges, compared to other similar units.
- The unit met all the standards of Intensive Care Society, with the exception of one standard related to access to a regional home ventilation and weaning unit. However, access was obtained via the referring consultant as required for transfer.

Evidence-based care and treatment

- The selection of ITU clinical policies and procedures we reviewed all referenced relevant NICE and Royal College guidelines. Evidence was seen of recent activity in reviewing policy and guidance and all policies were up to date.
- Staff demonstrated how they accessed guidance, policies and procedures on the hospital intranet. Staff told us the guidelines were clear and comprehensive and updated frequently. For example, the infection prevention and control lead told us that the hospital will review the recently issued NICE tuberculosis guideline to ensure current best practice care was provided.
- Appropriate care pathways and protocols were available for the management of complex surgical admissions and for the management of postoperative cardiac patients and neuro-surgical patients.
- There was an on-going programme of local clinical audits based on the needs of the unit and individual

professional interests. However, there was no audit led by the medical team or consultant and all audits were either nurse led or by the relevant allied health professional team.

- There were systems to identify high-risk surgical patients pre-operatively. Surgical pre-assessment processes were in place and patients were able to visit the unit prior to admission.
- Patients were assessed for their level of delirium by staff who used the Confusion Assessment Method (CAM), Glasgow Coma Scale (GCS) and would occasionally use the Richmond Agitation Sedation Scale (RASS) if required.
- All patients received daily physiotherapy as required by the NICE guidance and Intensive Care Society Standards.
- The unit met all standards of the Intensive Care Society, with the exception of one standard related to access to a regional home ventilation and weaning unit. However, access was obtained via the referring consultant as required for transfer.

Pain relief

- There was a policy in place to provide guidance on pain management, agitation and delirium.
- We reviewed 10 patient records, which showed that staff used a standardised scoring tool to assess patients' pain and recorded pain assessments in patients' notes. We saw that pain scores were documented hourly in electronic patient records by staff who demonstrated good understanding of how pain could be assessed.
- The discharge protocol included consideration of pain management during the transfer of patients to the ward. There was no dedicated pain management team and advice was sought from the pain specialist team at a local NHS trust if needed.

Nutrition and hydration

- Our review of clinical notes showed us that staff used the Malnutrition Universal Scoring Tool (MUST) to identify those at risk of malnutrition.

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- The dietician would visit the unit daily and attended the daily MDT review meeting at 11:30 am. The dietician would screen patients who required oral, enteral or parenteral nutrition on a daily basis and advise on use of nasogastric tube (NG) feeding.
- Patients were enabled to eat independently during mealtime and drinks were placed within their reach.
- Staff could order hot meals on demand from the hospital kitchen. Relatives we spoke with told us that they enjoyed the food provided. All patients told us that the food was lovely and they had a menu to choose from.

Patient outcomes

- The average length of stay on the unit for patients was 176 hours (7 days) which was lower than other similar units nationally (353 hours or 14 days).
- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The latest ICNARC data available at the time of our inspection was for the period from April 2015 to 31 March 2016.
- ICNARC data for April 2015 to 31 March 2016 showed that the majority (91.2%) of patients were planned admissions to the ITU following elective surgery, 0.6% unplanned admissions following elective surgery, 1.2% admitted following urgent surgery and 5.8% were admitted from the wards.
- In the same reporting period, there were less unplanned readmissions within 48 hours from unit discharge compared to similar units. Unplanned readmissions were 0.7% of 667 eligible admissions compared to 1% in similar units.
- There were no occurrences of non-clinical transfers out of the unit in the same period. This was also better than similar units, which had 0.1% non-clinical transfers.
- ICNARC data for the period, April 2015 to March 2016 showed no cases of unit-acquired infections in the blood. This was better than similar units (2.8).
- Risk adjusted acute hospital mortality ratio was 0.64. This was lower than compare to similar units.

- Risk adjusted acute hospital mortality ratio with a predicted risk of less than 20% was 0.28. This was lower than compare to similar units.
- The cardiac arrest outcome audit in AITU showed there had been five cardiac arrest events between July 2015 and July 2016. The audit showed that overall survival to discharge was 25% which was above national average of 18.5%. We saw detailed action plans including regular resuscitation and simulation training to assist in maintaining staff skills and knowledge.

Competent staff

- There were systems to ensure staff (RMOs and nurses) were competent to carry out their role. This included an induction programme that ensured new staff were familiar with local policies and procedures, particularly in relation to standards of patient assessment and record keeping.
- Clinical practice facilitators monitored nurse competencies on a rolling basis to ensure that nurses maintained competencies based on national benchmark standards. The unit had implemented the National Competency Framework for Registered Nurses in Adult Critical Care. 71% of the core nursing staff on the unit held a post registration critical care course. This was compliant with the national standards for nurse staffing in critical care which stipulates a minimum of 50%.
- We reviewed seven competency documents that included the use of patient controlled analgesia, cardiac monitoring, insertion of catheters and removal of chest drains. The documents showed evidence of the completed assessments and competency checks. Staff told us they had their competencies assessed by a senior member of staff and they could approach senior staff for help and support. Nurses we spoke with told us that they were very happy with the standard, frequency and quality of training and that it helped them to develop their clinical skills.
- All staff nurses had undergone an appraisal in the last year.
- Agency nurses completed an orientation booklet on their first shift and worked under the supervision of unit staff. An agency staff nurse told us they received an

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orientation on their first shift and felt supported by staff. The unit also introduced a safety checklist for regular agency staff to be completed at the end of the shift to share key policies and procedures in the unit.

- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover.
- Senior members of staff attended management and leadership courses, where available.
- Medical staff used regular meetings, such as unit meetings and governance meetings to review practice guidelines and identify areas of good practice and areas of improvement.

Multidisciplinary working

- We observed exceptional working relationships between all grades of staff and all professional disciplines.
- A daily multidisciplinary (MDT) ward round took place at 11:00 am. We observed two MDT ward rounds, which were well attended by a multidisciplinary team of specialists, including a pharmacist, a dietician, and a physiotherapist. The team discussed all patients and the dialogue between the whole team was both professional and caring with all risks and strategies discussed. We saw exemplary discussions about a long-term patient with good emphasis on the personal caring needs and detailed MDT discussion regarding the medication.
- The lead RMO openly encouraged feedback and input from every specialist for each patient and treatment plans were updated accordingly to reflect the MDT input. However, consultant intensivists were not part of these MDT rounds.
- Nursing staff conducted twice daily handovers with the whole team, at 8am and 8pm. We observed two handovers and found them to be structured, detailed and with a focus on personalised care. For instance, it was discussed if a patient had experienced a restless night or if they were anxious and what staff had done to assist them. Staff had a high degree of understanding of individual needs and it was clear to us that compassion was very much a part of the handover process. For example, staff were well aware of the cultural

differences and needs of one patient and family from overseas and they felt that the family was more settled following discussion regarding bringing their own food on the unit.

- Staff had a thorough understanding of external MDT relationships for patients who would be transferred to the ward, such as the need for active liaison with the ward staff and patients requiring input from specialist teams in other hospitals.
- We looked at 10 sets of patient records and all of them showed evidence of MDT input.
- The AITU was part of the corporate provider's critical care delivery group and we saw the monthly quality newsletter used to share practice and learning.

Seven-day services

- Medical and nursing staff provided cover for 24 hours a day, seven days a week.
- A consultant intensivist was available 24 hours a day, seven days a week and was available to attend the unit within 30 minutes.
- A dietitian was available for five days per week, with on-call cover out of hours
- Physiotherapy service was available seven days a week.
- Pharmacy services were available Monday to Friday between 9:00 am and 6:00pm, 9:00am – 1:00pm on Saturdays and 9:30am – 12:30 pm. There was an on-call pharmacist for out of hours support.
- Imaging service was available 9:00 am to 8:00 pm Monday to Friday and 9:00 am to 1:00 pm on weekends. Out of hours cover was via on-call system.

Access to information

- Guidelines and protocols were accessible to clinical staff on the hospital intranet. Staff told us they could access information in a timely way.
- The unit used the electronic patient record system. Nurses provided a printed copy of the patient record and discharge letter for inclusion in the patient medical record on discharge from the unit as part of the handover procedure as the wards used a hybrid system of paper and electronic documentation.

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- Staff had access to patients' care plans, risk assessments and case notes on the ITU electronic system. Staff also had access to patients' paper file containing assessments, test results and other patient records taken prior to their admission to the ITU.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff adhered to the systems in place to protect people from the risks associated with providing care and treatment without appropriate consent. Our review of patient notes found that in all cases consent to treatment had been obtained and documented wherever possible prior to treatment and whenever a patient's condition changed.
- We reviewed four consent forms in patient notes and all were completed correctly.
- Staff were able to tell us how they would obtain consent. Where consent could not be obtained, staff told us care was provided in the patient's best interest.
- Staff told us they had received e-learning on the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff also routinely re-assessed capacity whenever a person's condition improved, in line with the guidance of the Mental Capacity Act (2005).
- Staff had access to best practice guidance and local mental capacity policies on the unit.
- Most of the staff we spoke with were able to explain about the Deprivation of Liberty Safeguards (DoLS) and how this could impact a patient in the unit. One staff nurse said that although they rarely saw such an authorisation in place, they showed us where the unit's DoLS protocol was stored for quick access.

Are critical care services caring?

Good 

We rated caring as good because:

- The AITU provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.

- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff provided emotional support to patients and there were psychological supportive services including counselling and alternative therapies for patients available.

Compassionate care

- Nurses and doctors introduced themselves to patients. Interactions between staff and patients were positive across the unit.
- Staff had a caring, compassionate and sensitive manner. We observed staff speaking to patients and their relatives in a caring manner and reassured patients and answered questions about their care. They made sure that patients and their relatives were informed about the daily care plan.
- Staff demonstrated a tireless and on-going dedication to treating patients and their relatives with dignity and respect, above and beyond the basic requirement for privacy.
- We observed staff ensured patients' privacy and dignity was maintained at all time by closing doors and blinds. Curtains were drawn around bed bays when providing personal care. We observed the consultant morning ward round. The doctors were very courteous towards the patient, always knocked on the door of each cubicle before entering and the privacy and dignity of each patient was preserved. Each patient was asked for consent before the handover process was commenced.
- Staff in the unit encouraged patients and their relatives to complete the AITU questionnaire. The Senior Nurse and Nurse in Charge reviewed the feedback and actions were taken to improve the service. Patient feedback was discussed at the Heads of Department meetings and Senior Nurses meetings throughout the year, and compliments were shared at Patient Experience and Satisfaction meetings. We saw the results of April 2016-June 2016, which showed that 87% of patient rated the overall experience in the ITU as 'excellent'.
- Staff showed great commitment to encourage patients to gain independence in their care and tried innovative

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ways to motivate patients to recover. For example, they organised a shopping trip for a long term patient in the unit, who was not initially willing to go outside the room.

- We saw thank you cards from patients stating “thank you for taking so good care of me” and another said “you guys are so amazing”.

Understanding and involvement of patients and those close to them

- We spent time speaking with the relative of a patient who had been in the AITU for an extended period of time. They told us how happy they were with the care and treatment their family member had received. They felt treated with kindness and compassion and said “care from nursing and medical staff is very good and knows all the nurses by names and faces”. One patient said, “Staff are marvellous and feels involved in care”.
- Discussions with patients and families were evident in all of the notes that we examined, including discharge planning, decisions to transfer to the ward and obtaining consent. Family involvement was also discussed in the handovers that we attended.

Emotional support

- The nurse in charge visited all patients and relatives on the unit daily to assess if they had any concerns with their stay in the ITU.
- We saw that staff put up family pictures by the bed side on a board of a long term patient staying in the unit.
- Relatives we spoke with said that they were aware of the quiet room and the refreshment room for their use and that staff were very good at offering them refreshments.
- Staff provided emotional support to patients and told us that there were psychological supportive services including counselling and alternative therapies for patients. These were readily available and tailored to patient’s needs.
- Staff were aware of the procedures to follow in the event of a bereavement of a patient. Support was offered from the bereavement team who would come to the unit at any time if needed. Staff showed us the information booklet for relatives and friends relating to the death of a patient at the HCA hospital.

- However, the unit did not provided any follow up clinics. Staff told us that patient’s main consultant provide the follow up and patients discharged from the unit were followed up on the ward by the ITU RMO. Majority of the patients would have had the opportunity to visit the unit during their in-patient stay on the ward after being discharged from the unit and ITU staff would normally follow up patients on the wards and would go and visit them.

Are critical care services responsive?

Good 

We rated ‘responsive’ as ‘good’ because:

- Staff ensured the individual needs of patients were met. There were well maintained facilities available for relatives and visitors, including dedicated waiting area, quite room and multi faith room.
- Access and flow was a particular focus for staff. There was only one out of hours discharge and no non-clinical transfers compared to similar units nationally.
- ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed that the unit performed better than similar units in all quality indicators.
- The complaints process was effective, with appropriate investigations and there was culture of learning from complaints across the board. Formal complaints in the unit were rare and issues arising from formal and informal complaints led to changes to systems and practice.

Service planning and delivery to meet the needs of local people

- The unit provided care and treatment primarily to patients after complex elective surgery and some medical patients. The unit was able to accommodate patients escalated from wards in the hospital if their condition deteriorated or unexpected complications occurred following planned surgery. However, the unit did not take emergency admissions from other hospitals or critical care units.

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- There was a service level agreement for a multi-faith chaplaincy service provided by a neighbouring NHS trust. Senior nurses told us that they could contact chaplains at any time and they would send a chaplain to the hospital. There were also links with local mosque and staff were able to access the Imam when required.
- The service provided by the unit was planned in advance with the surgeons and the admissions office. New admissions were reviewed daily on the unit and at the hospital bed meeting to ensure there was sufficient capacity to meet patient needs. In the event of an unplanned admission, staff told us they would have some advance notice from theatre and were usually able to make suitable arrangements such as additional RMO and nursing staff.
- Staff were equipped to provide a service that met people's needs outside of the clinical treatment plan. Religious and cultural needs were met and staff had access to a comprehensive portfolio of advice from religious organisations to help them to provide care that met the needs of individuals.
- The corporate provider's overseas offices managed all aspects of care of patients from abroad. They oversaw the full referral process from pre-admission to follow-up care.

Meeting people's individual needs

- Patients told us that they felt safe on the units and they had adequate pain relief in a timely manner. Patients told us that their relatives could visit and they could receive phone calls from relatives and had Wi-Fi access.
- The facilities in the relatives and visitors waiting area were well maintained, clean and had sufficient comfortable seating available with access to toilet and free refreshments. There was a coffee machine with a selection of hot beverages, well stocked fridge, water dispenser and selection of current newspapers and magazines. One relative told us that the waiting area was well stocked and nice.
- There was a separate quiet room for relatives, which could be used to discuss any care issues with staff and doctors.
- A prayer room and a multi faith room were available on the second floor and relatives were allowed to pray by the bedside if they wished to do so.

- Majority of the patients admitted to the unit were Arabic speaking, we saw many signs and instructions in Arabic and staff were able to access interpreting services at any time. There was a full time Arabic liaison co-ordinator to liaise with families and foreign embassy.
- The unit had a range of information leaflets available for patients and relatives. We saw a detailed ITU information leaflet for patients and relatives explaining what to expect during their stay and patients told us that they were well informed and prepared for their stay in AITU.
- All staff we spoke with had good understanding of meeting the needs of patients living with dementia and patients with learning disability.

Access and flow

- There were 1,830 level two critical care bed days available in the hospital during April 2015 to March 2016. 1,040 Level 2 critical care bed days were used, giving an occupancy rate of 56% for the same reporting period. There were 7,686 level three critical care bed days available in the hospital and 2,127 level three bed days were used, giving an occupancy rate of 28% for the same reporting period.
- ICNARC (Intensive Care National Audit and Research Centre) data for April 2015 to March 2016 showed that out of 4392 available bed days in the unit, 7.8 bed days of care provided post eight hour after the reported time of fully ready to discharge. This was higher than similar units (0.1%) but lower than all units.
- There were no occurrences of non-clinical transfers out of the unit in the same period. This was better than similar units nationally (0.1%).
- There was one out of hour discharge or 0.1% of 667 patients discharged to a ward. These are discharges occurring during the hours of 10pm and 6:59am and not delayed. ICNARC data analysis showed that this was lower than similar units, which had 0.4% out of hours discharges.
- There were five (0.7%) unplanned re-admissions to the critical care unit with 48 hours between April 2015 to March 2016.
- There were arrangements in place to admit patients to the unit from the wards in an emergency. The decision

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to transfer was made on medical grounds and involved the ward RMO, the ITU RMO/consultant intensivist and the nurse in charge of the unit in consultation with the patient's lead consultant.

- Data provided by the hospital showed that no elective surgeries were cancelled in the last year due to the lack of critical care beds.
- We saw that AITU capacity management was on the unit risk register. Contingency and escalations plans were in place to manage ITU and HDU bed capacity. This was managed via daily bed management meeting and weekly nurse in charge review of planned AITU bed usage for coming week. Unit Manager informed us that an AITU full capacity contingency plan was available to ensure acute patient admission was not compromised by long-term wait for critical care. In the case of only two beds remaining, this would be escalated and there would be identification and assessment of any patient who could be transferred to HDU environment if an AITU bed was required. These patients may be transferred prior to the AITU becoming full aiming to keep a bed free for emergencies. They were also able to utilise the HCA network as a further back-up.

Learning from complaints and concerns

- The unit manager had an enthusiastic approach to learning from complaints and this was reflected in the discussions we had with staff. Formal complaints on the unit were rare and staff were confident in speaking with relatives who had minor concerns or issues.
- There were two formal complaints in ITU during April 2015 - March 2016. We saw that where a complaint had been made, the investigation and response processes were robust. Learning from complaints were monitored via the Patient Experience and Satisfaction meeting and action plans were created and shared with relevant teams and groups.
- We saw evidence of informal complaints that resulted in change. For example, patient commented on experiencing a delay in receiving refreshments in AITU, as a result of which catering manager implemented hourly rounding to ensure all patients received their required needs. In another case, where a patient complained about lost medication, patients own

medication management was reinforced to all staff and patients and their relatives educated about medication management of patient own medication during their inpatient stay.

- We were informed that staff aim to resolve concerns immediately if possible, and inform their manager of the concerns raised. A complaints leaflet was available in all areas which described the process should a patient want to raise a concern. There was also the ability for people to provide feedback on the hospital website. Patients we spoke with were aware of the complaints process and said that staff were always there to resolve any concerns and they received the information and leaflet in the pre admission pack.

Are critical care services well-led?

Good 

We rated 'well-led' as 'good' because:

- The leadership team had a clear vision and strategy and staff were able to verbalise the vision.
- There was a robust governance structure, both within AITU and within the hospital. The management team had oversight of the risks within the services and mitigating plans were in place.
- We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was very open and any member of staff could approach the leadership team with any issues or new ideas. There was evidence of staff engagement and changes being made as a result.
- Patients' feedback was sought via patient satisfaction questionnaire and compliments were shared at Patient Experience and Satisfaction meetings.

Vision and strategy for this core service

- The HSC critical care strategy 2016 – 2018, underpins corporate provider's vision. All staff were aware of the corporate provider's vision and values that included care being delivered with compassion, dignity, respect, and equality and how AITU was part of this strategy. Staff stated quality was a key priority for the hospital.

Critical care

- All staff told us the hospital was constantly improving and spoke passionately about the service they provided and were proud of the facilities. Unit managers told us about how the AITU role was always considered in any expansion projects to ensure there were provisions for capacity.
- We saw the minutes of “patient satisfaction” meetings which were designed to discuss and improve the patient experience.
- Staff we spoke with in all roles and at all levels told us the vision for the service was to improve the safety and quality of patients experience and that they were aware they had an important part to play in that on a day to day basis.

Governance, risk management and quality measurement for this core service

- There were arrangements in place for governance, risk management and quality measurement associated with the care of patients within AITU. We found that these arrangements enabled them to measure the quality of the services they provided while noting areas needed for improvement. Staff were able to tell us about the department governance arrangements and which individuals had key lead roles and responsibilities within the department. They were clear of their own individual roles and responsibilities and where to access information from when needed.
- The unit performance indicators and quality indicators were reported monthly through a variety of meetings such as the senior sisters’ forums and clinical governance meeting. We noted from the minutes of these meetings that complaints, incidents and emerging risk were discussed, evaluated, and monitored.
- Medical advisory committee (MAC) was responsible for approving practising privileges for medical staff, Chief Executive Officer (CEO) had the oversight and this was reviewed centrally on annual basis.
- There were a number of localised committees, including: patient blood management, infection control, medicines management and resuscitation, that reported to the hospital clinical governance committee (CGC). The CGC, mortality and morbidity committee, radiation protection committee, standards committee, safeguarding committee and risk management,

reported to the hospital’s quality and risk board; medical advisory committee (MAC); and ethics and compliance committee. In turn these committees reported to the hospital’s executive committee.

- A number of audits were undertaken regularly, which provided assurance that delivery of services were in line with national guidelines. However, the audit programme was heavily nurse led and there were no specific clinical audits led by the AITU doctors. The unit undertook regular audits of its compliance with blood transfusion, medicines reconciliation and continuing care of central venous catheter (CVC) and these ward assurance results were displayed on the staff notice board. However, as there was no staff room within the unit, this notice board was located in a locked room, used for medicine storage and accessible by clinical staff only and was not displayed outside in the unit. The audit action plans were reported to the Standards Committee and to the Quality and Risk Board.
- Senior staff maintained a risk register for the unit that identified risks in all areas of the service, including in areas such as facilities, staffing and access to MDT services. Risks were assessed according to the potential impact on patients and the service and actions were allocated to a responsible individual. The senior staff kept an action log of each risk on the register. We saw that the action log was updated regularly with tasks evidenced. For example, there were business continuity plans for any disruption to adult ITU in case the IT system goes down which could lead to inaccessibility of key patient information in a timely manner and how to access the paper forms to request any urgent blood test and paper documentation.

Leadership of service

- There was clear communication with staff regarding their role and responsibilities for the shift. Staff said managers were approachable and they could discuss any issues with them. The senior management team were visible to staff and were contactable if issues arose.
- All staff we spoke with told us that the CEO and other executive members did regular walk rounds and were very approachable. Staff felt they had a rapport with the executive team and could talk to them easily.
- Lines of accountability and responsibility in the unit were coherent and staff were clear of their roles and how to escalate problems. The nurses and RMO we

Critical care

spoke with were clear about their lines of supervision.

They told us how supportive the unit manager and consultants were. Them and the leadership team were all approachable and responsive to communication.

- There was a designated lead consultant responsible for providing clinical leadership to the medical and surgical staff overseeing patient care.

Culture within the service

- Staff nurses told us that the culture in the department was one of coherence, stability and mutual support.
- There was a strong team spirit from top to bottom and each member of staff said, in their opinion, their contribution was valued, which meant morale in the department was high. We observed good team working among nurses and unit manager, nurse in charges and clinical leads were very committed to support their staff.
- We saw collaborative working between AITU, pharmacy and dietician teams. RMOs felt very well supported in their supervision. We saw that the medical team worked well together, with consultants being available for RMOs to discuss patients and to give advice.
- We noted staff were proud of the team dynamics and the willingness to go the extra mile to deliver care.
- All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and all said everyone got on well. Staff including ward hostess and cleaners, worked supportively to meet the needs of patients. They spoke highly about their work and were able to contribute as part of the team. One staff said that “it’s like a family away from home.”






Public and staff engagement

- From speaking with staff, reviewing the minutes of meetings and from our observations, we found that staff at all levels were able to provide feedback and input into the running of the service. All of the staff we spoke with told us they felt listened to and could tell us who they would approach with different ideas for the service or when they had concerns.
- Staff told us that appraisals were a useful process and development was positively encouraged. All staff told us they felt valued for the work they did and it was like a second family.
- Patients and relatives were asked to complete a feedback questionnaire about their experience in the AITU. Relatives and a patient we spoke with told us that they felt involved in care and treatment decisions and that the level of information given to them was appropriate and very clear.
- There was an on call room for the RMOs on a different floor but there was no staff room with in the unit; however, they said that space was a challenge but the canteen was nice and they would take their breaks there.

Innovation, improvement and sustainability

- The unit introduced various improvement initiatives to ensure safe delivery of patient care. For example, creation of ITU handbook for all medical and nursing staff for better orientation and "Big Four" discussion process twice daily to improve communication.
- Staff told us that they participate in Project World Class to maintain quality customer services.

Services for children and young people

Safe	Requires improvement 
Effective	Good 
Caring	Outstanding 
Responsive	Good 
Well-led	Good 

Information about the service

The children and young people's (CYP) services at The Harley Street Clinic (THSC) specialise in congenital heart conditions, neuroscience and cancer treatments, alongside general paediatric services for children and young people up to the age of 18. This service at the clinic comprises: a 15 bedded acute paediatric ward (with both an indoor and outdoor play area and sensory room), a 12 bedded intensive care unit with five isolation rooms, and a day unit for patients attending for oncology treatments and procedures such as blood transfusions. Outpatient appointments take place in a designated paediatric outpatient building open Monday to Saturday. Across the five floors of the building, there are 12 consulting rooms, an assessment area and two treatment rooms. The outpatient department provides care for patients with booked appointments and walk-ins, to both private and NHS patients.

In the 12 months prior to inspection, there were 590 admissions to the paediatric ward, with an average length of stay of five days. The largest patient group was oncology patients (196 admissions). There were 8,702 outpatient attendances within the same time period.

In 2015 the CYP services were inspected by the Care Quality Commission (CQC) and rated as 'Requires Improvement'. The main concerns related to high numbers of medication errors, the paediatric anaesthetic rota, staff training in safeguarding and the insufficient safeguarding policy.

During our inspection, we visited the CYP services on Wednesday 3, Thursday 4 and Friday 5 August 2016 and during our unannounced visit on 17 August. We visited all the areas where children and young people were cared for. In addition to this, we interviewed service leads, and ward

managers of the services. We spoke with over 20 members of staff including consultants, registered medical officers (RMO's), nurses, allied health professionals and play specialists. We observed patient care and treatment, as well as staff interactions with families and looked at 8 care records. In addition to this, we reviewed local and national data and performance information about the service.

Services for children and young people

Summary of findings

We found the children's and young people's services to be 'Good' overall because:

- Care and treatment of patients and their families was delivered in an individualised and holistic way with comprehensive multidisciplinary input. Staff demonstrated that they went the extra mile to care and support patients and their families.
- There was a strong, visible person-centred culture. Doctors, nurses and play specialists were highly motivated and inspired to offer care that was kind and promoted dignity. Relationships between those who use the service, those close to them and staff are strong, caring and supportive. These relationships were highly valued by staff and promoted by the leaders of the service.
- Staff demonstrated an understanding of each family's situation and worked with empathy. They communicated in a way that managed patients anxiety, speaking to them in a kind and empathetic manner.
- Staff were open and transparent, and fully committed to reporting incidents and 'near misses'. Learning from incidents was demonstrated to be a high priority within the service. We saw thorough analysis and investigations completed when things went wrong and saw that learning was shared appropriately amongst staff.
- Clinical areas we visited were visibly clean, well-organised and clutter-free. There were systems in place to audit infection prevention and control practices and infection rates were low.
- Staff were aware of their roles and responsibilities in relation to safeguarding and there was an updated policy that reflected best practice guidelines. Most staff were trained to have the appropriate level of safeguarding knowledge for their role.
- Appropriate assessments were completed for all patients and risks were responded to in a timely and efficient way in order to ensure patient safety.

- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality patient care. Managers supported and encouraged staff to acquire new skills and access learning opportunities.
- We saw staff responding to patients and their families compassionately. Patients' privacy and dignity was respected at all times. Feedback attained from patients and their families who had used the service was positive.
- Ward managers and senior staff had a shared purpose to deliver the highest quality of care to patients. We saw new nursing leaders in post who were driving forward change to improve quality and safety within the department.

However:

- Staffing skill mix in the paediatric intensive care unit did not meet guidelines set out by the Royal College of Nursing as there were not always two trained paediatric nurses per shift. Staff in the recovery area were not trained in paediatrics and told us there was no formal training in the care of paediatric patients.
- Medication errors on the ward remained high. We saw that reporting of medication errors had increased and learning from incidents has been reinforced across the department. Although various safety mechanisms were introduced to improve this, June 2016 saw a sharp increase in medication errors. This demonstrated that improvement was still required.
- There were some areas where children and young people were cared for (such as recovery areas and diagnostic imaging) where none of the staff had the required level of safeguarding training.
- Risk registers were updated regularly but did not always reflect current concerns. For instance, issues with the staffing skill mix of nurses in the paediatric intensive care unit (PICU) were not included. Senior members of staff were unable to recall what was on their departmental risk register.

Services for children and young people

Are services for children and young people safe?

Requires improvement 

We rated the children's and young people's services as 'Requires Improvement' for safe because:

- There were times when the department operated with a team of staff with an inappropriate skill mix. This was recognised but had not been addressed by the senior management teams. Staffing in the paediatric intensive care unit (PICU) did not meet Royal College of Nursing (RCN) guidance, as the majority of nurses were not trained specifically in paediatrics.
- Mandatory training in some areas was not up-to-date. Staff caring for children and young people (CYP) in the recovery area did not have the appropriate level of safeguarding training.
- Staff in the recovery area were not trained to care for paediatric patients and did not have level three safeguarding training.
- Although there were systems in place to improve medicines management, performance in this area had not improved since the previous inspection. The paediatric ward still had the highest number of medicines incidents across the hospital.

However:

- Staff were open and transparent in their approach to their work, and fully committed to reporting incidents and 'near misses'. Learning from incidents was shared appropriately amongst all staff.

Incidents

- There were 151 incidents reported within the children's and young people's (CYP) services between June 2015 and May 2016. The largest number of incidents occurred within the children's inpatient services and related to medication errors which resulted in no harm to patients.
- We saw clear reporting logs of all incidents which included details of the incident, actions taken, any lessons learned and how learning was shared.

- Staff across CYP services were able report incidents through the electronic system. They could identify situations requiring completion of an incident form. Staff told us there was a good reporting culture and that they were encouraged to report 'near miss' situations in addition to incidents that had occurred. Staff had adequate time to complete incident forms when required. They were well-supported by senior members of the team when incidents occurred and needed to be reported.
- Feedback from incidents was shared with staff through a variety of means, such as email, communication diaries, safety huddles and display boards. Both senior and junior nursing staff were able to provide examples of learning from previous incidents and how their practice had changed as a result. Senior staff were familiar with monthly reports produced and shared via email to ensure monitoring and awareness of any incident trends.
- We saw detailed examples of root cause analysis (RCA) which had been completed for all serious incidents (SIs). Each RCA included consideration of care delivery issues, service delivery issues, contributing factors and lessons learned.
- The most common type of incident reported within the CYP services related to medication errors. These included incorrect and inappropriate prescribing, drug errors and missed doses. Senior and junior nursing staff and doctors were able to clearly describe mechanisms in place to reduce these errors. These included double signing of medications by two nurses, senior nursing support and presence in the drug preparation room, prescribing tests and reflection and self-directed learning when errors occurred. However, there remained an increase in the number of prescribing errors noted in June 2016.
- Mortality meetings took place after every patient death within CYP services. This allowed for reflection and learning to be shared between clinicians. However, these meetings did not include discussions around patient morbidity, so complications and errors were not considered. We saw meeting minutes of 10 mortality meetings. These included time lines of events, summaries of discussions and areas were noted for improvement and learning.

Services for children and young people

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- All staff we spoke with had good awareness of duty of candour requirements. Staff explained that patients should be informed an incident had occurred, given an apology and told that an investigation would take place. We saw examples of incidents where the duty of candour requirements had been applied.

Cleanliness, infection control and hygiene

- Clinical areas we visited were visibly clean, well-organised and clutter-free. We observed staff washing their hands and using hand gel between seeing patients. There was easy access to personal protective equipment (PPE), such as gloves and aprons. Staff demonstrated good hand hygiene practices and appropriate use of PPE.
- 'I am clean' stickers were used in all CYP departments to indicate when equipment had been cleaned. All stickers we looked at indicated cleaning had taken place within the previous 12 hours.
- The hospital had a dedicated lead nurse for Infection Prevention and Control (IPC), who reported to both the IPC committee and the director of nursing. Clinical staff knew the name of the IPC nurse and how to contact her. They told us she was available for advice and support when needed. Link IPC nurses on each ward audited IPC practices monthly and this was shared through email.
- Monthly hand hygiene audits based on the World Health Organisation (WHO) 'five moments for hand hygiene' were completed. Results from April to May 2016 demonstrated 100% compliance. This slipped to 90% in June 2016 but returned to 99% in July 2016 (against the hospital target of 95%). These audits were completed by the ward area IPC link nurse and included action plans if improvement was required. Results were displayed on the IPC hospital dashboard.
- All children and young people staying overnight on the first floor ward were cared for in individual rooms with en-suite bathrooms, which reduced the risk of infection.

- There had been no cases of meticillin resistant staphylococcus aureus (MRSA) within the last 12 months.
- There had been one case of clostridium difficile within the previous 12 months. This patient had been transferred into the hospital from another service. There was no onward spread of this infection to other patients, demonstrating good IPC practices.
- Waste segregation and storage was in line with Department of Health (DoH) 2011 safe management of waste guidelines. We saw posters advising staff of these guidelines.
- On the paediatric intensive care unit (PICU) side rooms were in use for patients at risk from infections. There were five isolation rooms within the unit. Three of these could provide both positive and negative pressure environments.

Environment and equipment

- We saw paediatric resuscitation equipment available in all clinical areas where CYP were cared for, with security tabs present and intact. Resuscitation equipment was checked daily. We saw that checklists had been completed for the previous three months, with no omissions.
- A range of equipment sampled throughout the wards and the theatre department had been recently safety tested and a date for the next service was identified on each item. Equipment sampled included: monitors, syringe drivers, portable suction devices, fluid warmers and infusion pumps.
- Environmental and equipment audits were completed monthly. These audits assessed general appearance of items, labelling of sharps bins, storage of equipment, linen management and availability of equipment. Results for July 2016 demonstrated 100% compliance with specified standards within the CYP services.
- We saw daily equipment checklists available in each clinical room which ensured equipment was clean and ready to use. Checklists were fully complete in the four patient rooms we visited.

Services for children and young people

- We visited all areas of the hospital where CYP were cared for. On the first floor ward and the in children's outpatient department we found child friendly environments with age appropriate toys and suitable decoration.
- We saw the environment of the ward was specifically designed to meet the needs of children and was safe, warm and welcoming. Patients and families had access to dedicated indoor and outdoor play areas. We noted there was adequate space on the ward for families to spend time together.
- In theatres, there was a small area designated to caring for paediatric patients. This area was not separate from the adult area and therefore did not meet the recommended Royal College guidelines as we saw adults and children cared for in the same area.

Medicines

- Medicines, including controlled drugs (CDs), were stored and managed appropriately. Medicines were stored safely and available for patients when they needed them. Chemotherapy preparations were stored separately. Intra-theal chemotherapy was collected individually by the practitioner administering it and was not kept on the ward. This reduced the risk of error in this high risk category of medicines. Staff we spoke with were aware of how to access medicines out-of-hours.
- Both a specialist paediatric pharmacist and pharmacy technicians spent time on the wards and were involved in decisions about patient care. The time they spent on each ward depended on patient need and was not dictated in their job plans. There were two designated paediatric pharmacists, one specifically for oncology and one for general conditions. There was on-call pharmacy support provided out-of-hours.
- Fridge and pharmacy room temperatures were monitored on a daily basis. We saw records across the CYP department with no omissions for the months of July and August 2016.
- Prescriptions were written clearly and administered correctly, with two nurses checking and signing for each medication that was given. Any missed doses were

audited regularly and those that could not be accounted for by a valid reason (for example where the patient's parent had given the medicine) were investigated. All allergies were clearly recorded.

- Nurses told us how they were involved in learning from incidents. We saw one example of a bulletin from the pharmacy team about paracetamol doses.
- The paediatric outpatient department held a small stock of pre-packed medicines to enable patients to take medicines home with them when needed. They followed a procedure to make sure this was done safely.
- Patient Group Directions (PGD) were not currently used in the outpatient department but we were told about the development of one for anaesthetic cream which would support patient care. PGDs are written instructions which enable nurses or other health care professionals to supply or administer medicines to patients under planned circumstances without a doctor being present.
- Emergency medicines and equipment were available and checked daily. A risk assessment had been carried out to ensure that specific medicines for seizures were available quickly but safely.

Records

- Patient information and records were stored securely on all the wards and in all departments we visited.
- We looked at six sets of patient notes on the paediatric ward, and a further two sets of notes in PICU. We found the standard of record keeping to be good. Appropriate risk assessment tools were completed, patient information was present, legible and comprehensive and pre-operative checklists that included consent forms were present. The notes showed that there had been multidisciplinary input into each child's care where necessary.
- Records were audited on a monthly basis and feedback was provided to staff by email.
- There were a number of electronic systems in use throughout the CYP services. Staff showed us how these systems were used to record patient information and how they interacted with one another to ensure continuity of care. There were also paper notes in use.

Services for children and young people

Staff informed us that if a consultant preferred they could write in the paper notes and this would be transcribed onto the electronic systems by the RMO to provide assurance that information was not missed.

Safeguarding

- The hospital had a named nurse and named doctor in post, responsible for children's safeguarding as dictated by statutory guidance. There also were safeguarding children leads on individual units, trained up to child safeguarding level 4. Processes were in place to provide appropriate safeguarding supervision and support for all staff. This included out of hours cover.
- National guidance specifies that all clinical staff working closely with children and young people should receive training in level 3 safeguarding. Data provided demonstrated 62% of staff in relevant posts were up-to-date with this training. Senior nurses told us training was booked for those who were not compliant. Both the ward manager and the service lead were trained in safeguarding level 4. Staff told us they would contact the hospital duty manager if they had any concerns out-of-hours.
- In the theatre recovery area, where staff cared for children and young people post-surgery, staff did not have level 3 safeguarding training. Staff told us they were not booked onto this training.
- We noted that the hospital safeguarding policy had recently been updated and was currently still under review. We saw adequate references to the 2015 national guidance on working together to safeguard children. We saw detailed safeguarding flow charts for staff to follow if they had concerns across all departments.
- Staff were aware of their roles and responsibilities to safeguard children and young people. Staff were able to identify potential signs of abuse and the correct process for raising concerns and making a referral.
- There have been no safeguarding concerns reported to CQC in the reporting period April 2015 to March 2016.

Mandatory training

- Senior members of staff monitored completion rates of mandatory training using an electronic tracking system. They told us this was quick and easy to access. Clinical practice facilitators in each paediatric area ensured line managers updated staff training as part of their role.
- An induction programme for all new staff included all mandatory training for their individual roles. All new staff we spoke with said they had completed the induction training and had found it detailed and comprehensive.
- Mandatory training topics included: health and safety, manual handling, infection control, safeguarding, fire safety, code of conduct, information governance, equality and diversity and basic life support. Completion rates varied across the service. On the paediatric ward completion rates, dependent on topic, ranged between 71% and 96%. In the PICU, completion rates varied from 75% to 100%. Completion rates were lowest in the outpatient department, where they fell between 67% and 89%.

Assessing and responding to patient risk

- Nurses we spoke with said they were well supported by doctors and senior nurses when dealing with deteriorating patients. The service used a paediatric early warning score (PEWS) system on the wards for monitoring the condition of children and young people. This measure involved observation of the patient such as regularly recording their pulse, respiratory rate, temperature and pain score. If a child's condition deteriorated, the PEWS increased accordingly and gave an indication that intervention may be required. An electronic system for recording patient observations was used on the paediatric ward. This system would automatically alert the resident medical officer if the PEWS indicated any risk (a score above four). An audit conducted in July 2016 demonstrated that 100% of patients with a PEWS of above four were seen by a doctor within 15 minutes. We saw staff using the PEWS during handovers and safety huddles to plan patient care and treatment based on anticipated need. During handover, staff were encouraged to use the situation, background, assessment and recommendation (SBAR) structured method for communication to ensure critical information was handed over effectively.

Services for children and young people

- The hospital had an emergency/ resuscitation team who assessed deteriorating patients. The ITU RMO, consultant intensivist and the nurse in charge were all part of the team. All members of the emergency team were trained in paediatric advanced life support (ALS) and were contactable by emergency bleeps. During June 2015 – June 2016, the emergency team responded to 80 calls.
- PEWS, PEWS escalation and SBAR communication ward based competency learning was a mandatory training requirement and had been completed by all new staff.
- Staff used various tools to assess and respond to patient risks. For example, Safer Skin Care (SSKIN), falls assessments and nutritional screening were all in use and we saw completed examples within patient records.
- In the paediatric outpatient department, patients were first assessed on the ground floor before being taken upstairs to the consultation rooms. Staff were able to recognise any signs and symptoms which would require the child to be admitted directly to the ward.
- The most common emergency admission to the ward was febrile neutropenic sepsis (the development of fever and infection in patients with a low white blood cell count). Accordingly, a clear protocol governed the admission, treatment and further management of these patients. Staff were able to describe the signs and symptoms of sepsis which would prompt the use of the pathway. There were laminated copies of the 'sepsis 6' pathway in each bedside folder.
- There was a consultant intensivist available 24 hours a day, should a patient deteriorate on the ward and need enhanced (level 2 or level 3) care.
- Large numbers of bank and agency staff were used. In June 2016, 17% of all nursing shifts on the paediatric ward were covered by bank and agency staff. In the same month, 5% of shifts on PICU were covered by agency staff.
- The Royal College of Nursing (RCN) provides national guidance on defining staffing levels for children and young people. This states there should be a minimum of two registered children's nurses at all times in all inpatient and day care areas. Guidelines recommend that one nurse can care for up to three children under the age of two, and four children if they are over this age.
- An audit in February 2016 demonstrated the paediatric ward was meeting these RCN requirements. The audit demonstrated compliance against 16 core staffing standards set by the provider, which included the standards from the RCN. Other requirements ensured the shift supervisor and clinical nurse specialists were supernumerary, that at least one nurse each shift was APLS trained and that there was a ratio of 70:30, registered to un-registered staff.
- However, other areas providing services to CYP did not follow the same RCN standards. In the PICU, only four nurses (out of the 24 nurses employed) were registered children's nurses. Therefore, each shift did not meet the minimum staffing standard of two registered children's nurses. Not all PICU nurses had a post-registration paediatric intensive care course. Although 57% of staff held this qualification this did not meet the 70% national standard requirement. In the recovery area of theatres, there were no children's nurses at all.
- Agency nurses had an induction, and we saw completed induction checklists that evidenced this. Agency nurses were all trained paediatric nurses.
- We saw that all children and young people requiring enhanced level 3 care in PICU received 1:1 registered nurse support. Those requiring level 2 care were allocated one nurse per two patients. These staffing ratios were better than most comparable units according to the Paediatric Intensive Care Audit Network (PICANet).
- The CYP services had a low sickness absence rate (0.8% in June 2016), compared to the England average (4%).

Nursing staffing

- Nursing staffing levels were planned and assessed using the corporate HCA workforce planning tool. On the paediatric ward, nursing levels had recently been adjusted to provide more senior nursing support.
- The vacancy rate within the CYP services was currently 9%.

Services for children and young people

This had significantly reduced since January 2016, when the rate was 12%. On the paediatric ward, there had been no staff sickness hours between May and July 2016.

Medical staffing

- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. There were 67 paediatric consultants currently holding practising privileges, who covered a wide range of specialities.
- Consultants provided cover for their inpatients 24 hours a day, seven days a week. They arranged alternative cover by a named consultant if they were not available.
- There were three permanent trained paediatric associate specialists for general/oncology patients, critical care and cardiac surgery. They all worked during the week managing the day-to-day resident medical officer (RMO) staffing rotas and training.
- Daily ward rounds were led by the senior paediatric RMO. Each patient was assessed and reviewed. Any planned changes to care and treatment were discussed with the admitting consultant and clearly documented in the patient's notes.
- There were two separate paediatric consultant anaesthetic rotas, one for cardiac surgery and one for all other surgeries. These provided effective out-of-hours emergency cover.
- There were currently 13.2 whole time equivalent (WTE) RMOs against an establishment of 20.2 WTE. Due to this shortfall in permanent RMOs, the service used bank staff. We were told that most of the bank staff had worked within the service for between three to five years. Bank RMOs were unable to work out-of-hours until the senior resident RMO were satisfied with their knowledge and skills.

Major incident awareness and training

- The hospital had a clear and concise major incident plan which was available in each clinical area and on the intranet.
- Each ward had a plan for evacuating patients safely in the event of an incident.

- We saw major incident packs in prominent places in all departments we visited.

Are services for children and young people effective?

Good 

We rated the children's and young people's services as 'good' for effective because:

- There was a holistic approach to assessing, planning and delivering care and treatment. This was facilitated through coordinated multidisciplinary working that was individualised for each patient and their family, depending on their needs.
- Children's and young people's care and treatment was planned and delivered in line with current evidence-based guidance, standards and best practice. This was monitored through audits to ensure high standards and consistency of care.
- Children and young people received comprehensive assessments of their needs, including consideration of clinical issues, their mental health and general wellbeing..
- The continuing development of staff skill, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were supported and encouraged to acquire new skills and access appropriate learning.
- Data was submitted where appropriate to national audits and result were positive, consistent and exceeded expectations.

However

- Audits were completed for adults inpatient areas only and we did not see pain audited in the children's services.

Evidence-based care and treatment

- We saw care pathways which reflected national evidence based guidance. These were audited regularly to monitor compliance.

Services for children and young people

- We saw data submitted to national audits including the paediatric intensive care audit network (PICANet) and the national institute for cardiovascular outcomes and research (NICOR).
- There was a clear corporate audit program which all departments adhered to. This included monthly and bi-monthly audits on pain management, record keeping, risk assessment completion and oxygen prescribing.
- The majority of local audits were corporately determined. The ward manager and senior nurses were currently working to expand the audits completed to ensure all relevant paediatric care was audited to monitor compliance and encourage improvement.
- We saw nutritional care audited and managed in line with the National Institute of Clinical Excellence (NICE) guidelines.
- Care was provided in line with NICE CG50 and a 'paediatric early warning score' was used to detect deteriorating patients and escalate deteriorating patients through the escalation framework.
- A screening tool for the assessment of malnutrition in paediatrics (STAMP) was used to monitor and record the nutritional status of patients. We saw these fully completed in all patient notes. These were monitored by a dietician to ensure nutritional needs were fully met.
- An audit in July 2016 demonstrated that 100% of patients found to be at high risk of malnutrition were referred to the dietician.
- The same audit demonstrated that only 71% of all children and young people had STAMP assessments completed in their records. The service planned increased education in this area, to increase staff awareness and told us they planned to re-audit this in six months to monitor improvements.
- A band 7 dietitian was available Monday to Friday for the PICU. Out of hours there was an on-call dietician who staff told us was contactable via switchboard for advice. All patients admitted to PICU were screened by the dietician daily as part of the ward round. There was a mixture of band 7 and 8 dieticians to cover the general paediatric ward Monday to Friday.

Pain relief

- Staff told us pain relief was managed by the multidisciplinary team as there was no specific pain team working in the hospital.
- Pharmacists were available to provide advice to nursing staff on the administration of pain relief medication.
- We saw nurses assessing pain scores using appropriate pain scoring systems for the age of the child and recording these on the electronic system.
- Play specialists were used to assist in preparing children for certain procedures. We observed them using distraction techniques and relaxation methods to help children manage their own pain.

Nutrition and hydration

- Children and young people's weight and height were recorded on admission. Nurses told us they would be weighed weekly thereafter. However, during inspection there were no records of children who had stayed longer than a week available to view.

Patient outcomes

- The hospital did not participate in the majority of children's national audits because the number of patients having specific procedures was too small. However, the hospital did submit data when the volume of patients was higher.
- The National Congenital Heart Disease Audit Report 2012 -15 demonstrated the hospital had a 98.8% survival rate for patients admitted with this condition. This was better than the expected predicted survival rate of 97.3%. The data looked at 695 patient cases in total, of which 104 were paediatric.
- The paediatric intensive care unit submitted data to the Paediatric Intensive Care Audit (PICANet), a national audit on all children admitted to intensive care units across the UK. Data demonstrated the unit's performance was in line with other similar units.
- The service complied with national key performance indicator (KPI) monitoring, which included recording numbers of unplanned readmissions, unplanned returns to theatre and unplanned transfers.

Services for children and young people

- There had been three unplanned readmissions from April 2016 to June 2016 due to post-operative complications. There had been no emergency returns to theatre and two unplanned non-emergency returns to theatres within the same reporting period.
- Regular internal audits were carried out to assess adherence to local policies and procedures such as hand hygiene, consent and record keeping. Results of these audits were available electronically and could be compared to different wards and other HCA facilities to drive improvement.

Competent staff

- To assess whether staff had the necessary skills, all nursing staff were initially employed with three month probationary period. New staff nurses on the ward told us they had completed all mandatory training within this period and that patient allocation was gradually increased with support from the shift leader.
- To assess whether medical staff had the necessary skills, all medical staff competencies were reviewed by the lead RMO. On discussion with the lead paediatric RMO we were told that staff would work Monday to Friday until competencies had been assessed.
- A learning and development pathway that spanned 36 months was available for all nurses working within the CYP services. The pathway first focused on basic nursing skills and then progressed to more specialised advanced skills, such as pain management and oncology nursing. The paediatric ward manager told us the aim of the pathway was to ensure all nurses could perform the functional, extended and advanced nursing duties required in domains such as assessment, reflection and clinical supervision.
- Nurses we spoke with on the ward told us there were good opportunities to develop within their roles. Some described competencies they had developed in areas such as chemotherapy administration or cardiac nursing. We were told that the work books used to assess oncology competency were utilised across London to ensure consistency in nurse training.
- In the theatre recovery department, there were no nurses trained specifically to care for children. Staff were unsure if there was any formal competency-based

learning available for adult nurses caring for children in this area. There was currently no formal assessment that took place to ensure they possessed the appropriate knowledge and skills.

- Nurses told us the hospital was pro-active in helping them prepare for their revalidation.
- Placements were provided within the CYP services for student nurses. We spoke with one student nurse who had returned to the paediatric ward for their final placement. They found the learning and development opportunities on the ward varied and valued the supportive environment.

Multidisciplinary working

- The Senior RMO conducted daily ward rounds, accompanied by the nurse in charge. These were followed by a multidisciplinary team (MDT) safety huddle at midday. This ensured consistency of information and avoided potential gaps in shared staff knowledge.
- The CYP services had dedicated physiotherapists, psychologists, dieticians, occupational therapists, play therapists and pharmacists. Throughout our inspection, we saw evidence of good MDT working in both the wards and all other clinical areas.
- We observed the clinical practice of a number of play therapists that followed good practice guidance. Clinical staff told us that the play therapists were effective and available when needed. For example, play therapists were used when a child needed distraction from a difficult procedure, such as taking a blood sample.
- There were two specialist paediatric physiotherapists that worked within the CYP services on the ward and the PICU.
- Staff told us that they rarely transferred children out of the hospital as they were able to manage most clinical cases. There were rare occasions when the service may transfer children to another hospital using the Children's Acute Transport Service CATS. There were clear policies in place which outlined the procedure if this was required.
- Psychological support was provided to children and their families. Ward rounds were conducted every two weeks by the psychology team to ensure patients were reviewed regularly.

Services for children and young people

- Weekly ward MDT meetings discussed on-going patient care and treatment. On the PICU, there was also a daily mid-morning MDT ward round. This was well attended and included the RMO, consultant intensivist, surgical fellow, unit manager, dietician and physiotherapist.
- There was palliative care provision available through links with two NHS hospital trusts. Nurses were aware of how to access these services. The consultant in charge of the patient's care would decide which palliative provision to use.
- A high percentage of inpatients were from overseas (over 60%). In this case, a medical report from the child's home country was required prior to admission. Discharge summaries and reports were also provided to ensure continuity of care.
- Department specific guidance and leaflets had been developed for agency staff to ensure they could access all relevant information about the service. This included various policies, procedures and knowledge of how to escalate concerns.

Seven-day services

- A rota of RMOs provided inpatient care over 24 hours a day, seven days a week.
- Consultants visited the children they were responsible for caring for on a daily basis. Consultants made their own arrangements to ensure adequate cover during periods of absence. RMOs and nurses told us there were no concerns in contacting consultants whenever needed.
- Seven day services for pharmacy, radiology, dietetics and physiotherapy were provided out-of-hours through the use of on-call rotas. Play specialists told us they would come in over the weekend if required.
- Outpatient appointments were available six days per week, from 8am to 8pm Monday to Saturday.

Access to information

- Policies, guidelines and procedures were available on the hospitals intranet. In PICU, there was one computer provided per patient bed space. There were adequate computer stations available for nurses to access this information on the ward too. Staff we spoke with were able to describe where to find any information they may need.
- Information was mostly shared with staff through emails. Staff told us they received information regarding incident reporting and learning, pharmacy updates and learning and development opportunities via email in the first instance. This information was also shared through team meetings, handovers and on noticeboards.

Consent

- The corporate policy relating to consent and capacity was updated in July 2016. Staff were aware that this policy included information regarding obtaining consent for children and young people.
- We found that consent to treatment was obtained following correct procedures. All staff we spoke with were aware of the hospitals consent processes and all staff understood their role and responsibilities when obtaining consent.
- Families and carers were involved in discussions about consent. Staff had an awareness that issues of consent changed as children became older and were able to make more of their own choices. We were told that parents provided informed, written consent for the treatment of their child and that older children were encouraged to participate in decision-making when appropriate. Staff were aware and could describe the principles of gillick competence to ensure a child was able to consent.
- We saw signed surgical consent forms in children's records which clearly outlined the proposed procedure, risks and benefits.
- Paediatric consent forms were paper-based, and therefore not captured by the monthly consent audit program that was in place for the rest of the hospital. When we asked staff about this they informed us that work was in progress to develop an audit methodology for a review of the paper consent forms currently in use across paediatric services.
- We observed that decisions not to resuscitate children and young people were made jointly by both the consultant and the family. We saw do not attempt cardiopulmonary resuscitation (DNACPR) forms in

Services for children and young people

patients' notes which reflected this. Nationally devised DNACPR forms were used to document these decisions. However, we were told that the wording on the forms had been revised to aid staff in holding these discussions with families.

Are services for children and young people caring?

Outstanding



We rated the children's and young people's services as 'outstanding' for caring because:

- There was a strong, visible person-centred culture. Doctors, nurses and play specialists were highly motivated and inspired to offer care that was kind and promoted dignity. Relationships between those who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by the leaders of the service.
- Staff demonstrated an understanding of each family's situation and worked with empathy. They communicated in a way that managed patients anxiety, speaking to them in a kind and empathetic manner.
- Patient and relative feedback was collected on patient discharge and demonstrated high levels of patient satisfaction which went above and beyond what was expected.
- Families from overseas were supported to build and develop relationships and social networks with other families who also had children being cared for in the hospital.
- Children and their siblings were rewarded for their strength and courage when undergoing treatments at the hospital. For example, the 'rainbow beads' initiative.
- There were various therapies for assisting a patient with the emotional side of treatment e.g. scrapbooks, psychology and even bringing in beloved pets.

Compassionate care

- Throughout our inspection, on the wards, in outpatients and in the PICU, we observed patients and families being treated with patience, kindness and understanding. We saw staff ensuring they were

available to spend time with families when they raised questions or concerns even when this was not part of their schedule or during busy times. We saw that staff would re arrange their days and shifts to ensure the best care was available when children needed this.

- Concierge staff were ready to greet patients at the entrance to the hospital and escort them to the ward or clinical area they required. We saw that concierge staff were polite and friendly towards patients and their relatives.
- We saw a range of interactions tailored to children's age and individual culture in all areas we visited.
- Staff responded compassionately to patients, treating them as individuals and in a holistic way. For example, we saw one patient who had suffered a loss of confidence and self-esteem after hair loss due to treatment being offered a choice of wigs, free of charge.
- During the inspection there were low numbers of patients and families due to summer holidays. Patients who were being treated were from other countries and therefore we were unable to speak with them directly about their experiences. However, we saw numerous thank you cards where patients and their relatives had detailed that staff went above and beyond their expectations.
- We saw patient feedback information where patients and families had praised the care of staff both for the patients and for families. We saw feedback where parents had commented how fantastic and understanding the play specialists were and how they had made a real contribution to their child's recovery.
- Events and parties were organised by the play specialists to celebrate patients birthdays and different religious festivals.
- We observed staff agreeing to change their working hours and provide an on-call service to ensure they were available to support the family of a sick child.
- We saw nursing staff in PICU doing everything possible to ensure a child could be moved out of a side room back onto the main unit as they were happier around the staff. They showed determination and creativity to overcome the obstacles to ensure this could be achieved.

Services for children and young people

Understanding and involvement of patients and those close to them

- We saw nurses, doctors and therapists introducing themselves to patients and their families, and explaining what they were going to do. During ward rounds, we observed doctors and nurses talking directly to children, as well as making time to speak to their parents and carers.
- Patients were involved in art therapy to help them understand the hospital environment.
- Mothers groups were facilitated monthly by a consultant psychologist, in order to provide support for mothers from different countries.
- We observed staff encouraging parents to be involved in their child's care. This included tasks such as washing, dressing and learning how to administer their medication.
- Patients were encouraged to communicate their feelings through artwork. We saw artwork that patients had produced that detailed what helped them cope when they were in hospital.

Emotional support

- Staff demonstrated an understanding of the parents' and children's situation and worked well to lower people's anxiety, speaking to them in a kind and empathetic manner. For example, play therapists were available to calm and reassure children who were upset or anxious and to distract them during treatment and procedures.
- The 'rainbow beads' initiative had been implemented for children receiving a course of treatment. Each child was presented with a bead after each procedure. The beads were designed to represent strength and courage and children were presented with these beads on specific days of the week. Patients siblings were also offered beads when they accompanied their brother or sister to the hospital.
- Staff told us how they were arranging dog therapy for a patient who loved animals and was in hospital for an extended period.

- We looked at examples of patients scrap books which documented their treatment and feelings throughout their hospital stay through drawings, paintings and different collages.
- A multi-faith chaplaincy team was on-call. Ward staff were aware of how to contact members of this team.
- We saw the psychology team available on the ward. Nurses told us they completed twice weekly ward rounds to provide support for the child and their families.

Are services for children and young people responsive?

Good 

We rated the children's and young people's services as 'good' for responsive because:

- Services were tailored to the needs of each individual patient and were delivered in a way that ensured flexibility and choice.
- Patients and their families were able to access services without waiting times, delays or cancellations. Patients were able to access care without an appointment in the outpatient department and be admitted for care and treatment if needed without delay.
- There was a proactive approach to understanding the varying needs of the different groups of patients and families that accessed care. This was facilitated by a variety of means, including support groups, education and immediate availability of translators.

However:

- Accommodation was not provided for the parents or carers of children or young people (CYP) in the paediatric intensive care unit (PICU).
- There was no formal training or lead nurse for patients with learning difficulties.

Service planning and delivery to meet the needs of local people

Services for children and young people

- Support groups had been set up for families who had come from abroad for their children's treatment. These groups, facilitated by clinical psychologists, were set up to provide a support network for families while they were away from family and friends.
- Support groups had also been set up by the ward manager to provide support, education and information as it was recognised that many of the service users families were unfamiliar with the process of palliative care.
- Interpreters were directly employed by the hospital and they were accessible at any time. Staff told us there were rare occasions when an interpreter could not be booked and staff would therefore access telephone translation services.
- The main languages currently spoken by patients accessing the clinic were Greek and Arabic. We saw translators for these languages readily available around the hospital. Information leaflets were also available in different languages. Leaflets provided by external companies had been translated by the hospital with permission.
- The corporate provider's overseas offices managed all aspects of care of patients from abroad. They oversaw the full referral process from pre-admission, obtained visas and organised follow-up care, amongst other duties.
- There was provision on the ward for parents and carers to stay with children overnight at the bedside, with camp beds provided in the rooms. On the PICU, accommodation could be arranged for parents.
- Children and young people were also seen in the diagnostic and imaging department. This area had not been made child-friendly. However, we were told that children and young people did not spend long in the department. A relative we spoke to told us their child had never spent longer than a few minutes waiting for diagnostic imaging services. Toys were also available for children if needed for distraction.
- We saw samples of menus available on the ward. Each child or young person was able to choose from a wide variety of foods. We were told the catering department could provide a variety of food and drink outside of these set mealtimes, in order to meet individual needs.

- On PICU, we saw that parents, families and carers were also offered a wide selection of food and drinks.

Access and flow

- During the course of our inspection, there were four patients on the paediatric ward and two patients in the PICU. Patients were also scheduled for treatments in the day case area of the ward, which appeared busy. Staff told us that this was normal for the summer months, when ward admissions were usually less frequent.
- Assessment, diagnosis and treatment were prompt. Patients were able to choose when to attend for a procedure at a time that was convenient to them. Due to the low low bed occupancy rates, beds were available on both the ward and the PICU as and when required. There were no delays in providing treatment and immediate access was available if required.
- Consultants individually scheduled their patients for treatment and therefore waiting times were not monitored by the hospital. Both doctors, nurses and senior members of the leadership team told us waiting times were not a concern and children accessed care at times that were suitable to them and their families.
- Patients could access medical care without an appointment in the outpatient clinic. Nurses there would assess the patient and could take these patients straight to the ward if urgent or emergency treatment was required.
- There was a clear access policy available for patients presenting with symptoms of febrile neutropenic sepsis. These patients would be accepted directly to the first floor ward for treatment.
- Daily bed meetings were held with staff from both the ward and the PICU in attendance to facilitate coordinated care and share information regarding expected admissions and discharges.

Meeting people's individual needs

- In all waiting and clinical areas, information about services and treatments was readily available. Relevant organisations and charities had also provided additional information. These leaflets had been translated into Greek, Arabic and Russian by the clinical nurse specialist.

Services for children and young people

- Service line agreements (SLAs) with the Portland children's hospital provided both stoma and tissue viability care to patients when required and we were told that speech and language therapy (SALT) was provided through the corporate organisation and could be booked if required.
- There was no link nurse for patients with learning disabilities (LD) but we were informed that the ward manager could provide advice, in their capacity as complex care provider. The ward manager told us that nursing staff received training on how to care for LD patients. This formed part of their training regarding how to care for patients with complex needs. There was also a health care assistant with specialist knowledge, training and experience in this area.
- On the paediatric ward, there was both an indoor and outdoor play area, as well as a sensory room. The indoor play area had a range of age appropriate toys, books and activities.
- Facilities for parents were provided throughout the department. On the ward, there was a sitting room overlooking the outdoor play room. Parents were able to stay with their children overnight on camp beds provided in the rooms. The PICU did not provide overnight accommodation, but there was a lounge for relatives that was stocked with hot drinks and snacks.
- Translators were available for patients who spoke Greek or Arabic, as these were the most commonly spoken languages amongst the patient population. A telephone translation service was available if required for other languages. The on-site translators were available Monday through to Friday and we saw examples of them being accessed quickly for patients.
- Clinical nurse specialists (CNS) worked throughout the service to provide specialist care to specific groups of patients. For example, a CNS for oncology patients provided continuous holistic care to patients and their families throughout their cancer pathways. They were available via mobile and made themselves available at weekends, for emergencies.
- Transition of patients into adults services was managed by the MDT. There were clear up-to-date patient transition policies and guidelines available for children

over 14 years old. Staff told us that although these guidelines were followed they were adapted for individual patients and families, due to the differing cultures and backgrounds of their patient group.

- The hospital provides the service of administration of medication using Convection Enhanced Delivery (CED) for patients with Diffuse Intrinsic Pontine Gliomas (DIPG) through MHRA approved name patient use only.

Learning complaints and concerns

- Complaints were dealt with in line with the code of practice set out by the Independent Sector Complaints Adjudication Service (ISCAS). Information about how to make a formal complaint was displayed on walls throughout each department and in relative's rooms. Complaints leaflets outlined the entire process and outlined what the patient should expect from the hospital throughout.
- Staff told us they initially tried to resolve complaints and concerns at a local level, to ensure they were dealt with and resolved as soon as possible.
- There were agreed timelines for responses to formal complaints agreed by the hospital. An acknowledgement should be sent within two working days and a full response should follow within 20 working days. The CYP service had responded to 100% of complaints within the previous six months.
- Managers told us it was their responsibility to investigate complaints and provide the CEO and CNO with a detailed investigation response.
- Weekly patient experience and satisfaction meetings, chaired by the CNO, were attended by all paediatric department managers. These meetings supported the managers throughout the investigation process, as well as providing opportunities for interdepartmental learning from complaints that had occurred elsewhere in the hospital.
- There had been 12 formal complaints within the last year. These were all related to the paediatric wards and various aspects of care, treatment and communication. There were complaints logs that detailed the complaint and outcome, as well as any actions taken to improve. Learning and training opportunities were provided when required.

Services for children and young people

Are services for children and young people well-led?

Good 

We rated the children's and young people's services as 'good' for well-led because:

- Ward managers and senior staff had a shared purpose and strived to deliver the highest quality of care. They motivated junior staff to succeed and encouraged them to attend training to develop their careers.
- There were high levels of staff satisfaction. Staff were proud of the organisation and spoke highly of their colleagues and the open culture and atmosphere.
- The nursing leadership aimed to ensure continuous improvement in their clinical areas. They were knowledgeable about various aspects of quality assurance, risk management and patient safety. There had been many positive improvements noted since new managers and leaders had started within the services.
- There was a clear statement of organisational visions and values, underpinned by consideration of quality and safety. Staff were able to demonstrate how they contributed to achieving these goals.
- Strategies were being developed to overcome perceived risks to the service. This included ensuring continuous staff development and skill retention during quieter times of the year, when patient numbers were low.

However:

- Risk registers did not reflect the main concerns identified during the inspection. Senior management staff were not able to recall what was currently on their departmental risk register.

Vision and strategy for this this core service

- Staff were aware of the corporate provider's values of integrity, respect, equality, appreciation, compassion and honesty. Staff reflected these values in the way staff treated patients and their families.

- The main vision of the hospital was: 'together, we consistently deliver exceptional care'. Staff had been consulted on the development of the vision through workshops before it was considered by the executive team.
- The CYP services had their own vision, which directly aligned to the corporate vision. The vision stated that each child and family should be treated with compassion and should receive the highest standard of evidence based clinical care. This care should also be holistic and individualised, delivered collaboratively by the MDT in order to ensure the best possible outcomes for the child and family.
- There were low numbers of patients within CYP services and we were told this was normal for the summer months. Plans were in place to rotate staff to other hospital CYP services to ensure skill retention and continuous progression. Senior member of the leadership team were hopeful that this would also contribute to staff retention.

Governance, risk management and quality measurement for this core service

- There were two paediatric consultant doctors who were part of the medical advisory committee (MAC). This included a paediatric critical care doctor and a paediatric surgeon. Staff were aware that the MAC were there to oversee and promote best medical practice at the hospital.
- There were clear governance arrangements in place to ensure high standards of care were maintained through regular audits, review of incident and complaint data and consideration of risk.. Information from the MAC committee was shared with wider groups of clinical staff, who could also contribute information to future meetings. Staff of all levels described how they would escalate concerns or ideas appropriately.
- Due to recent staff changes, the paediatric ward were still in the process of forming their local governance, risk management and improvement structures. However, it was clear from talking to nurses, doctors and the wider MDT that improvements in patient safety management and quality measurement had already been made. Senior staff meetings and wards meetings were taking place on a regular basis, even though the formal structure of these was not yet cemented.

Services for children and young people

- On the PICU, there were clearer governance structures. Nurses were organised into teams and met regularly to discuss governance, risk and improvements. There were regular monthly team meetings with minutes produced.
- Departmental risk registers were available for the different areas of the CYP services. However, not all senior members of staff were able to recall what was on their departmental risk register. High level risks from the paediatric services fed into the main hospital risk register. We were told that these would feed into the corporate risk register if they were unable to be resolved. registers did not fully reflect the concerns identified during our inspection. For example, concerns regarding staffing skill mix and retention of skilled staff were not mentioned on the PICU risk register but staffing retention was a risk on the hospital wide risk register.
- Quality measurement was ensured by a clear corporate audit programme. Senior staff on the paediatric ward told us they were developing audits specific to paediatric practice to ensure the audit programme addressed areas specific to children.
- Staff performance was monitored through the appraisal process and the development of personalised performance plans. Staff in all areas of the CYP services told us their appraisal was completed yearly. They told us they met individually with their line managers once every eight weeks to discuss their ongoing performance and development.
- We saw mortality reviews for four paediatric patients who had died within the previous 12 months. Each review included a detailed documented timeline of events. However, we noticed only two of these deaths had been discussed during an MDT case review and had learning/areas for improvement noted.

Leadership and culture

- There had been many changes within nursing teams on both the ward and in the PICU. On the paediatric ward, the ward manager had been in post for 10 months and the clinical service lead had been in post for just six months. There were also four new senior sisters, who had all started within the last six months.
- Staff were passionate about providing empathetic and holistic, family centred care. They were evidently proud

to work for the hospital. During the course of our inspection, various team members told us about how they ensured an inclusive family-orientated working environment.

- Consultants had direct access to the chief executive officer (CEO) and told us they had regular 1:1 meetings every month to discuss any concerns around the wider organisation or aspects of patient care. Consultants told us the senior executive team operated an open door policy and were available when as and when required to deal with concerns.
- Senior nursing staff (band 7 and above) were positive about the hospital's leadership team. They told us the CEO and chief nursing officer (CNO) were always accessible and visible within their departments. Staff were able to give examples of when they had contacted them directly and told us they were highly responsive.
- The ward manager of the paediatric first floor ward had been in post for 10 months. Staff at all levels were overwhelmingly positive about the changes he had already made to the department. They felt the quality and safety of patient care had improved dramatically. This was largely due to improved communication, support and team working amongst staff.
- Managers and service leads were aware of the challenges the department faced. For example, they told us there were challenges recruiting and retaining the trained paediatric staff needed to meet RCN standards in the PICU.

Public and staff engagement

- Children had been involved in designing posters for the ward. We saw examples of children's artwork on posters used to guide patients and relatives in infection prevention and control measures.
- Patient feedback was collected via either paper or electronic questionnaires upon discharge. Questionnaires included questions on pain relief, nutrition, staff competency, dignity and effective communication. Responses were reviewed in the weekly patient experience meeting.





Services for children and young people

- In the PICU a new feedback questionnaire had been produced with the aim of increasing the response rate of families in this area. Questions included topics about nursing care, availability of staff, ability to be involved in the child's care and privacy and dignity.
- Staff were awarded with employee of the quarter awards for exceptional performance, which reflected the vision of the organisation.
- There were weekly activity calendars available in each patient's room. These calendars outlined the activities available to children on the ward. We saw varied activity lists appropriate for a wide range of age groups, including art, music and sports days.
- In 2016, the psychosocial team had made improvements to their activity programme. These included: increased music therapy provision, attendance at two royal academy of music concerts, relaxation sessions for parents and increased parties and events to celebrate special occasions or milestones.

Innovation, improvement and sustainability

- Staff told us the department participated in 'project world class', which aimed to maintain the quality of both patient and family care. 'Project world class' was the result of poor patient feedback and was based on the 'mystery shopper' model. People would attend services as if they were actual patients and feedback any ideas for improvement to staff.
- The ward manager had developed a 36 month training program for new staff, to improve staff development and retention within the service.

Outpatients and diagnostic imaging

Safe	Good 
Effective	
Caring	Good 
Responsive	Good 
Well-led	Outstanding 

Information about the service

The outpatient and diagnostic imaging department at The Harley Street Clinic (THSC) provide services to private patients from overseas and from the UK. Outpatients and diagnostic imaging services includes all areas where patients under go diagnostic testing, receive diagnostic test results, are given advice or provided care and treatment without being admitted as an inpatient.

The Outpatients & Diagnostic Imaging departments at the THSC provided a service to a total of 55,936 patients in the reporting period of April 2015 to March 2016.

THSC outpatient department holds clinics for a range of different specialities including orthopaedics, plastic surgery, cosmetic surgery, gastroenterology, ENT, gynaecology, general surgery, cardiac surgery, vascular surgery, dermatology, rheumatology and oral surgery. The diagnostic and imaging services offer Computerised Tomography(CT), Magnetic Resonance Imaging (MRI), X-Ray, Positron emission tomography, Digital Mammography and Ultrasound. A pharmacy service was also available Monday to Friday.

The oncology service is THSC largest revenue stream. The most common outpatients procedure carried out in the reporting period of April 2015 to March 2016 was radiotherapy with a total of 1044 cases, followed by chemotherapy with a total of 587 cases. The radiotherapy and medical physics department has two Varian linear accelerators and a pre-treatment CT scanner. The Cyberknife clinic is registered separately and thus will not be a part of this inspection.

The outpatient services are provided from various locations within the Harley Street vicinity. There are 97 consulting rooms. As part of this inspection we visited all outpatient

locations and diagnostic areas. We spoke with 20 patients and their relatives, 30 staff and departmental managers. We observed care and treatment and looked at care records. Information provided by the hospital before the inspection was also reviewed.

We did not look at outpatient services for children; this service is reported under the children's services section of this report.

Outpatients and diagnostic imaging

Summary of findings

We rated the service as good because:

- The radiotherapy department in collaboration with a London NHS trust lead a unique scalp sparing technique study aiming to improve the quality of life of palliative brain patients; the study won the LangBuisson 2015 award for Innovation in Care.
- The radiotherapy department used a paperless system and has guided other independent and NHS departments in implementing the same system.
- Staff felt encouraged to move up the career ladder taking inspiration from the CEO and other colleagues who all progressed from junior roles within the hospital.
- The outpatient department “Nurse in charge” initiative encouraged junior staff nurses to develop leadership skills.
- Outpatient, radiotherapy and diagnostic services were delivered by caring, committed and compassionate staff and care was planned that took account of patients’ needs and wishes.
- An electronic patient record (EPR) was used to ensure constant availability of medical records.
- All radiological reporting was conducted within 24 hours and all diagnostic results were available with minimal delay.
- The hospital consistently met the target for category 1 and 2 cancer patients to receive first definitive radiotherapy treatment within 31 days of diagnosis.
- Concierge staff was available to assist patients and their families during their hospital journey.
- We observed that staff were very accommodating to patients individual needs.
- We observed minimal waiting times for appointments.
- Managers and clinical leads were visible and approachable and had a good knowledge of performance in their areas of responsibility. There

was an open and honest culture within the service, morale was excellent and there was evidence of continuous improvement and development of staff and services.

However,

- Hand hygiene audit data showed inconsistencies in compliance rates for the outpatients, radiotherapy and radiology department.
- Resuscitation equipment was not located on all floors of the outpatient department instead the department relied on a dedicated porter to transport the equipment when needed. The hospital did provide risk assessments and were aware of the situation.

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services safe?

Good 

We rated the service good because:

- Incidents were discussed at monthly departmental governance meetings and information and lessons learnt were shared with staff. Staff knew how to report incidents.
- Policies and procedures were in place for the prevention and control of infection and maintenance contracts were in place to make sure specialist equipment was serviced regularly.
- No controlled drugs were stored in the outpatients or imaging departments. All prescription pads were stored securely and usage tracked.
- An electronic patient record (EPR) was used which ensured availability of medical records for outpatients clinic.
- Emergency resuscitation equipment was in place, however resuscitation equipment was not located on all floors of the outpatient department, however there was a policy and the situation was risk assessed and mitigated by the use of a dedicated porter to transport the equipment when needed.

However;

Hand hygiene audit data showed inconsistencies in compliance rates for the outpatients, radiotherapy and radiology department.

Incidents

- There was one serious injury incident during the reporting period of April 2015 to March 2016.
- There were 143 clinical incidents reported in the period of April 2015 to March 2016. The department had a rate of 0.2-0.3 incidents per 100 outpatient attendances; this rate was lower than the average rate of other independent acute hospitals during the reporting period of April 2015 to March 2016.
- There were 47 non-clinical incidents reported in the period of April 2015 to March 2016. The department had

a rate of 0.1 incidents per 100 outpatient attendances; this rate was higher than the average rate of other independent acute hospitals during the reporting period of April 2015 to March 2016.

- Incidents were reported using an electronic reporting system. Staff could describe how to report incidents and told us the reporter always received feedback.
- Incidents were discussed at monthly governance meetings and information and lessons learnt were disseminated to staff via staff meetings. Staff could describe examples of previous incidents that had occurred across the hospital.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- All staff we spoke to were aware of duty of candour and could describe circumstances when it would be exercised. We were shown example incident records of when the duty of candour was applied.

Cleanliness, infection control and hygiene

- All of the clinical and waiting areas we visited were visibly clean and tidy.
- Completed cleaning checklists for the period of January 2016 to June 2016 were observed in outpatient, radiology and radiotherapy.
- Policies and protocols for the prevention and control of infection were in place and all staff attending clinical areas adhered to “bare below the elbow” guidelines. All staff we spoke with were aware of using the specified cleaning wipes and spill kits to decontaminate clinic areas after infectious patients.
- There were sufficient hand washing facilities including basin, hand wash, hand gels and moisturiser and we observed staff being compliant with the recommended hand hygiene practices.
- Stickers were placed on equipment to inform staff when equipment had been cleaned and we saw evidence of this being used across the departments we visited.

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- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled and were disposed of immediately when full.
- Hand hygiene audit data showed that the outpatient department did not achieve the 95% compliance target for quarter 1 of 2016, but achieved 88% compliance. The radiology department had a compliance rate of 95% and 86% split over their two areas respectively.
- There were disposable curtains in all the treatment and consulting rooms with a date on when they were put up and when they were due to be changed.

Environment and equipment

- The outpatients, radiotherapy and diagnostic imaging department were well designed and maintained. Patient waiting areas were clean with sufficient seating for patients and relatives. All clinical areas seen in the outpatients, radiotherapy and diagnostic departments were visibly clean and tidy.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic and radiotherapy equipment.
- Safety testing for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the radiotherapy and radiology departments to warn people about potential radiation exposure.
- Daily quality assurance logs for the radiotherapy linear accelerators were observed for the period of January 2016 to July 2016. Medical physics provided monthly quality assurance logs detailing more specialised safety testing for the period of January 2016 to July 2016.
- Monthly quality assurance logs were provided for the CT scanners for the period of January 2016 to June 2016. We were assured that procedures were in place for the safety testing of all diagnostic imaging machines on a daily, monthly and annual basis.
- All clinical staff we observed in both the radiology and radiotherapy departments had valid in-date radiation monitoring badges.

- Personal protective equipment was available in all clinical areas we observed in the outpatients, radiotherapy and imaging departments.
- Emergency resuscitation equipment was in place in all areas of the outpatients, radiotherapy and imaging departments and followed national resuscitation council guidelines. Trolleys we reviewed were checked on a daily and weekly schedule and had their seals intact; trolleys that were asked to be opened had all the required equipment and medication valid in-date.
- Due to the limited space available in outpatient's upper floors, the use of resuscitation bags was in place. The bags were stored on the basement and ground floors of the outpatients building, however we were assured as there was a policy and the situation was risk assessed and mitigated by using a dedicated porter to transport the bags when needed.
- There were working emergency call bells in every clinic room and toilet. We observed the weekly checking process and reviewed the testing logs for one month for call bells in the outpatients department.

Medicines

- Staff we spoke with were aware of medicine management policies and the systems in place to monitor stock control and report medication errors. Medication audits were undertaken by the pharmacist, these showed minimal drug errors and staffs were trained in medicines administration.
- All medicines in outpatients were found to be in date and stored securely in locked cupboards as appropriate, and in line with legislation. The keys were kept in a secure area with a keypad lock.
- Drugs were marked if they needed temperature controlled storage and there was a new electronic system in place to monitor drug fridges across the hospital and to alert the relevant staff if a fridge needed attention.
- No controlled drugs (CD) were stored in the outpatients department. When a CD was prescribed a member of staff would go and collect the drug from pharmacy, the CD register confirmed that CDs were always checked and signed for by two nurses before administration this was in line with the hospitals policy.

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- A record was maintained regarding administered drugs recording the relevant patient details.
- Prescription pads were stored securely and usage tracked.

Records

- The hospital used an electronic patient record (EPR) which ensured availability of medical records for outpatient's clinic. New patients arrived with all relevant records from their referring clinicians and if on occasion this is not available administrative staff will contact the clinicians to source the required details. We were assured patients were not seen without relevant records.
- Service managers told us that there were not any plans to mitigate the risk in case of disruption of the EPR. We were also told that there has never been a time where the EPR was unavailable for clinics; there were paper forms to request diagnostics as a back-up.
- We reviewed 10 sets of patient records in the outpatients department. All contained details of past medical history, allergies, infection control, medicines and discharge planning. Evidence of consent was also observed as appropriate.
- Records could be viewed off site in any HCA hospital due to the EPR. In such cases where physical records need to be moved off site for continuity of patient care then copies are made and the notes are tracked. Medical record bags are available for transport and staff were not permitted to remove original records off site.

Safeguarding

- Safeguarding policies and procedures were in place. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Staff described how they had dealt with safeguarding incidents and how a recent referral in radiotherapy had been initiated to social care.
- The hospital target for completion of safeguarding training was 95%. Hospital data showed that outpatients, radiology and radiotherapy safeguarding adults training rates to be 100%, 93% and 89% respectively. Data showed that outpatients and radiotherapy safeguarding children level 3 training rates

were 94.5% and 80% respectively. Hospital data showed that for outpatients, radiology and radiotherapy staff safeguarding children level 1 & 2 training rates were 55%, 55% and 69% respectively.

- Radiology staff were not required to do safeguarding children training as the department did not do any paediatric imaging. Radiology staff told us that children were not allowed in clinical areas within the department, if safeguarding concerns regarding visiting children in the waiting areas would be referred to the safeguarding lead and recorded on the incident reporting system. The outpatients and radiotherapy managers explained lower safeguarding training rates were caused by new members of staff that were on probation and were waiting to attend the training sessions.
- Safeguarding flow charts to help staff escalate concerns correctly were on display in the radiology and radiotherapy departments.
- There was a chaperone policy and we saw posters throughout the outpatient clinic and diagnostic imaging department advising patient how to access a chaperone should they wish to do so.
- All staff spoken with were aware of the hospital's whistleblowing policy, known as the ethics policy. They told us that they would feel happy using this policy to raise concerns if necessary.

Mandatory training

- There was a mandatory training policy that detailed which training staff were required to attend. The training included resuscitation, safeguarding, information governance, basic life support, ethics and code of conduct training. The training records showed attendance was monitored and non-attendance was flagged and managers were required to take action to ensure that the staff members attended all mandatory training.
- Mandatory training completion was linked to staff annual appraisal system; failure to complete mandatory training would not allow staff to receive their pay award.
- Mandatory training rates in outpatients were 100% for all courses except 'ethics and code of conduct' and 'information governance' which were 90% and 80% respectively.

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- Basic life support completion rates for outpatients, radiology and radiotherapy were 85%, 76% and 72% respectively. We were assured by reviewing a training programme that this was due to some staff completing immediate life support training and also due to new members of staff still on probation.
- Senior managers told us consultants with practising privileges at the hospital completed mandatory training at their employing NHS hospital. The practising privileges were reviewed annually through a HCA centralised process with the hospital CEO providing oversight, consultants had to update their validation, mandatory training and competency records, otherwise privileges would be suspended.
- The rate of use of bank staff for nurses working in the outpatients department was low when compared to the average of other independent acute hospitals during the reporting period of April 2015 to March 2016; however the data showed that the rate was steadily rising from 3% to 15% during the reporting period.
- The rate of use of bank staff for health care assistants working in the outpatient department were variable when compared to the average of other independent acute hospitals during the reporting period of April 2015 to March 2016; During September 2015 to November 2015 the rates were higher than the average at 62%, 73% and 46% respectively, also February 2016 had a rate of 24%.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- The three point identification check was used in both radiology and radiotherapy as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000). In addition we saw staff in radiotherapy check patients against their digital photograph attached to their radiotherapy specific electronic notes.
- We observed staff checking female patient's pregnancy status in the radiology department before initialising an imaging procedure.
- Radiation Protection Supervisors were appointed in each clinical area within the radiology, radiotherapy and nuclear medicine departments and details of Medical Physics support were available to staff in their local rules.
- Staff were able to describe the procedure if a patient was suspected of suffering from a cardiac arrest. All staff knew the hospital internal cardiac arrest help number.

Nursing & Health Care Assistant staffing

- The outpatient department had a ratio of 9 qualified nurses to 1 health care assistant.
- The outpatients managers told us that the outpatients department does not use agency nursing staff and instead relies on permanent, bank or bureau staff (bureau staff are employed to work where they are needed across the London HCA hospitals).

- The outpatient's sister told us there were adequate staffing levels to enable the clinics to run effectively. Staff told us any staff shortage due to sickness and annual leave were either covered by bank staff or bureau staff.

Medical staffing

- There were approximately 868 consultants with practising privileges attending the hospital, however not all of them regularly saw patients in outpatient clinics. We were not given information regarding the number of consultants who worked in the outpatients' clinic and diagnostic imaging department.
- Practising privileges were processed centrally by HCA with the CEO and medical advisory committee (MAC) providing oversight, with privileges being reviewed annually.
- The hospital employed 16 Resident medical officers (RMO's). RMO's are doctors of varying experience that are full time hospital employees. The RMO's provided medical cover in case of patients requiring to be seen urgently or in need of prescriptions if their consultant was unavailable.
- Staff told us that clinics were rarely cancelled, but if consultants were on annual leave they would ask a colleague to see their patients. This was confirmed by long term patients we spoke with.

Allied health professionals

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- The radiotherapy department reported that they had 15 permanent, five part-time and two bank radiotherapists, one admin support staff and one radiotherapy sister. There were two vacancies for radiotherapy service manager and radiotherapy staff nurse respectively.
- The radiology department reported that they had 22 permanent radiographers of varying seniority and one agency radiographer. Staff told us that the staffing level was adequate but that more senior members of staff at superintendent level were needed.

Major incident awareness and training

- The hospital had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as loss of electricity, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, and loss of water supply.
- We could not find any evidence that there was a number for staff to call or a call-out system for the appropriate coordination of staff at home.
- Staff in the outpatients and imaging departments told us they could identify the designated fire marshals in their own departments and that most concierge staff were also fire marshals.
- All staff we spoke with confirmed that they had or were booked on to major incident training and all staff we spoke with could identify the major incident folder containing action plans specific to their department.

Are outpatients and diagnostic imaging services effective?

At present we do not have the legal duty to rate effective in outpatients and diagnostic core service. We inspected the service but did not rate it, the following are areas of good practice we have found:

- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance.

- Staff worked together in a multi-disciplinary environment to meet patients' needs.
- Staff were competent to perform their roles and took part in shared learning schemes.
- All diagnostic images were reported on within 24 hours.
- There were procedures in place to deal with patients requiring urgent pain relief.

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Radiotherapy pathways and prescription doses all followed professional body guidelines and NICE guidelines.
- Radiology dose reference level audit results were available for staff to read, the department's 2015 results complied with the national dose level. The CT radiographers told us in past instances where the department did not comply, the imaging machine manufacturer was called to resolve the issue immediately.
- The nuclear medicine department has participated in the DaTSCAN Audit 2015 conducted by the British Nuclear Medicine Society. We were shown a valid certificate of participation.
- Audits of compliance with IR(ME)R 2000 were completed and Radiation Safety Committee meetings were held quarterly to monitor radiation safety throughout the hospital.
- Staff told us they participated in local audits. We saw evidence that when audits identified areas for improvement action was taken; an example was given whereby an instruction pack was sent out to external referrers to improve the completion of diagnostic request forms.
- The outpatients department conducted monthly environmental inspection audits.
- Staff meetings were held in outpatients, radiotherapy and radiology to share information and promote shared learning.
- A regular journal club is held in the radiotherapy and medical physics department to promote shared learning and continual professional development (CPD).

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- Safety alerts were received by the outpatient and diagnostic imaging managers and all relevant alerts were cascaded to staff via email, displayed in the staff office and discussed at team meetings.

Pain relief

- RMO's could be used to assess the patient and prescribe relevant medication in cases requiring urgent attention. If the patient's consultant is available then they would assess the patient.

Patient outcomes

- The hospital in collaboration with other HCA hospitals has published the Breast Quality Framework Report; this report contains outcome data collected as a retrospective audit of breast cancer patients treated in the period of 2010 to 2014. The hospital is working collaboratively with Public Health England to collate and publish patient survival rates.
- The radiotherapy department is accredited by Caspe Healthcare Knowledge Systems (CHKS) for ISO 9001:2015 quality management system.
- The radiology deputy manager told us that the hospital is looking at participation in the Imaging Services Accreditation Scheme (ISAS), however this is being considered at a corporate level to be rolled out across other sister hospitals.
- All diagnostic images were reported within 24 hours unless the referrer requested earlier this is compliance with the national guidelines for radiological reporting. This included all images being quality checked by radiographers before the patient left the department.

Competent staff

- Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals and we saw evidence that the appraisal completion rate for outpatients and diagnostic imaging staff was 100%.
- Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities to develop their skills

- and knowledge through training relevant to their role. This included completing competency frameworks for areas of development and they were also supported to undertake specialist courses.
- Evidence was provided to show all staff in the outpatients, radiotherapy, medical physics and radiology departments had CPD and competency records for their specific role.
- Medical consultants with practising privileges had their appraisals and revalidation undertaken by the medical director if they did not work at an NHS trust. For those working in a NHS Trust a copy of their appraisal and revalidation undertaken at the trust was provided to the hospital.
- Managers told us they had procedures in place for the induction of new staff and all staff, including bank staff completed local induction and 2 weeks supernumerary time in the department before commencing their role. We saw evidence that attendance at these induction sessions.

Multidisciplinary working

- Multidisciplinary working was evident throughout the outpatients, radiotherapy and imaging departments.
- Regular consultant led multidisciplinary team meetings were held to discuss patients based on their treatment area. All service managers we spoke with said that nursing staff, allied health professionals and managers were encouraged to attend.

Seven-day services

- Seven day a week outpatient services were not provided. The outpatient service, including radiology was provided Monday to Saturday 8.00am to 8.00pm. There was an ad-hoc Sunday clinic as and when required.
- The radiology department also did not provide a seven day service. The service was available Monday to Friday 8.00am to 8.00pm except 2 days a week when it ran later till 9.00pm. A Saturday service was also available from 10.00am to 6.00pm
- The radiology department provided 24 hours on-call services.

Access to information

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- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet.
- The radiology department used a nationally recognised system to report and store patient images. The system was used across the hospital and allowed local and regional access to images.
- The outpatients and radiotherapy service managers told us that patients were provided with discharge letters directly from their consultants. Consultant secretaries would forward a copy of treatment details or discharge letter to the patient's GP. The radiology department gave the patient their diagnostic images after the procedure and the radiologist report was forwarded to the patients referring consultant and GP.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2005 and its implications for their practice. All staff we spoke with told us that level one adult safeguarding training included elements of the Mental Capacity Act 2005.
- Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any procedure.
- 10 sets of patient records in the outpatients department were checked, all contained evidence of appropriate consent process.
- Consent forms for patients lacking capacity were available in outpatients, radiotherapy and diagnostic imaging departments.
- Radiotherapy consent process included seeking permission to use immobilisation devices.
- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the EPR.

Are outpatients and diagnostic imaging services caring?

We rated the service good because:

- Outpatient, radiotherapy and diagnostic services were delivered by caring, committed and compassionate staff. We observed staff interaction with patients and found them to be polite, friendly and helpful.
- Concierge staff was available to assist patients and their families during their time in the hospital.
- The patients we spoke with were positive about the way staff looked after them. Care was planned that took account of patients' needs and wishes.
- Complimentary therapies including massage, reiki, aromatherapy and so on were available for oncology patients.
- Psychological and emotional support was available for patients.

Compassionate care

- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, asking them if they needed help and pointing people in the right direction.
- Concierge staff were ready to greet patients and escort them to their desired location.
- Patients' privacy was respected and they were addressed and treated respectfully by all staff. Staff were observed to knock on consulting room doors before entering. Curtains were drawn and doors closed when patients were having their consultation or treatment.
- The environment and the consulting rooms in the outpatients department allowed for confidential conversations.
- Patients consistently gave very positive accounts of their experiences with staff and the processes followed.
- Complimentary therapies including massage, reiki and aromatherapy were available to cancer patients free of charge.
- The 20 patients we spoke with were satisfied with the overall experience of visiting the outpatients and

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diagnostic department. Patient had positive feedback to share with us regarding the doctors and other staff who they saw while in the imaging department and at the clinics.

Understanding and involvement of patients and those close to them

- We saw staff spent time with patients, explaining care pathways and treatment plans. All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- Patients told us they were given time to make decisions and staff made sure they understood the treatment options available to them.
- The hospital collected patient views using a patient satisfaction questionnaire and there was an action plan in place to address issues raised by patients in a timely manner. The outpatients manager acknowledged that there was a lower return rate for outpatient questionnaires than they would like so the department was developing ways to improve the return rate by using new methods of patient engagement such as the use of tablet computers.

Emotional support

- Nursing staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.
- Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.
- Physiological and counselling services were available for patients and their relatives.

Are outpatients and diagnostic imaging services responsive?

Good 

- The hospital had a dedicated international patient centre (IPC) to arrange the entire process from pre-visit to aftercare for the large demographic of international patients attending the hospital, additionally the IPC facilitated patient needs by organising accommodation, travel arrangements and tourist day trips.
- All waiting areas were furnished to a high standard provided free refreshments and were well stocked in the latest newspapers and magazines.
- We observed that there were minimal waiting times for outpatient clinics and diagnostic imaging. Patients we spoke with confirmed this.
- The radiotherapy department benchmarked themselves against national cancer targets, although they were not required to do so they did this to understand their performance against national standards. Data showed they consistently met the target for category 1 and 2 cancer patients to receive first definitive radiotherapy treatment within 31 days of diagnosis.
- In house interpreters were available for Arabic, Russian and Greek. A telephone hotline was also in place for over the phone translation in any language.
- Diagnostic appointment slots were available to accommodate patients needing tests or images conducted on the same day.

However

- The radiotherapy department benchmarked themselves against national cancer targets, although they were not required to do so they did this to understand their performance against national standards. Data showed category 3 patient wait times were variable with data showing that some tumour group treatments breached the national guideline of 12 days.

Service planning and delivery to meet the needs of local people

- The hospital had a dedicated IPC staffed by liaison officers. This service was designed to meet the needs of the large demographic of international patients the hospital received. The centre arranged visa's and handled all payments, liaising with insurance companies if required, additionally the centre arranged the entire process from pre-visit to after care including services such as; translation, escorting patients to appointments, accommodation booking, travel booking and arranging tourist activities.

We rated the service good because:

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- The outpatients service manager told us that the hospital executive team were aware of the need for larger lifts which are more suited to bariatric patients or patients travelling on wheelchairs and have since installed one new lift in the outpatients department with planning approval in process to install additional lifts.
 - The cardiac physiology department is open 8am to 6pm Monday to Friday, however due to increased use of the service by patients the department has increased their operating hours one day week from 8am to 8pm. This change was viewed positively by patients and consultants further increasing demand, to which the department will be permanently increasing operating times on all days following a one month trial period.
 - All nursing staff were given the option to work flexible annualised hours to meet the needs of the service, this allowed staff to reduce their working on a quieter day.
 - Patients told us they received instructions over the telephone when booking the appointments for outpatient or diagnostic appointments.
 - The waiting room amenities were designed around the needs and expectations of all patients. All waiting areas seen within the hospital were clean and contained ample comfortable seating with access to toilets, selection of free hot beverages and refreshments, water dispenser and selection of current newspapers and magazines.
- Access and flow**
- Patients we spoke with said they were informed of how to book an appointment at the clinic and they knew how to access to other services such as blood test and diagnostic imaging.
 - Outpatients managers and reception staff told us waiting times, delays and cancellations were rare, and if there were any delays, these were minimal and managed appropriately. This was confirmed by all the patients we spoke with.
 - An audit of radiology wait times showed that in 2015 the average wait time from arrival in the department for a MRI scan was 7 minutes. This remained the same throughout 2016; however the maximum wait time was reduced to only 10 minutes. The data showed wait times for a CT scan in 2015 was 8 minutes this increased in 2016 to 12 minutes, however the maximum wait time was reduced to 20 minutes. The data showed wait times for X-ray in 2015 to be 8 minutes this reduced in 2016 to 4 minutes, also the maximum wait time was reduced to 10 minutes. The radiology department found these results to be acceptable and meeting minutes provide evidence that there will be continual data collection and learning.
 - Data showed that radiotherapy patients would arrive on average 23 minutes before their scheduled treatment time and the start of their treatment would begin on average 2 minutes around their scheduled time.
 - The radiotherapy department as part of independent health was not required to use national cancer waiting time targets, however the department chose to benchmark themselves against the national targets to measure their performance. Cancer patients are prioritised into three categories with category 1 patients have the fastest growing tumours, category 2 patients having slower growing tumours and category 3 patients are those requiring palliative treatment.
 - The hospital consistently met the target for cancer patients to receive first definitive radiotherapy treatment within 31 days of diagnosis between July 2015 and June 2016. Category 1 patient wait times were consistently lower than the national guideline with the data showing a maximum average wait of 20 days and minimum average of 14 days.
 - The hospital consistently met the target for cancer patients to receive first definitive radiotherapy treatment within 31 days of diagnosis between July 2015 and June 2016. Category 2 patient wait times were consistently lower than the national guidelines with the data showing a maximum average wait of 20 days and a minimum average of 5 days.
 - The target for category 3 cancer patients is to receive first definitive palliative treatment within 12 days of diagnosis. Data showed that during the period of July 2015 to June 2016 some tumour group wait times were consistently lower with an average wait time of 5 days, whilst other tumour groups breached the national guideline of 12 days with an average wait time of 20 days.
 - Consultants provided direct referral patients and post-operative follow up appointments within hours or

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days for most outpatient appointments and radiological diagnostics. All patients we spoke to confirmed this and also told us they had timely access to diagnostic investigations and minor treatment within a few days of their appointment at the hospital.

Meeting people's individual needs

- Staff told us the provisions they would make for patients suffering with learning difficulties or dementia such as a special needs assessment and fast track service, however staff said that these types of patients are rare. We noted that all reception desks and clinical areas had dementia patient flowcharts to help staff deal with these situations containing recommended actions and specialist numbers.
- The sign posting we observed in the outpatients, radiotherapy and diagnostic imaging departments did not stand out and was difficult to read in some locations. However the hospital did employ concierge staff to escort patients to their desired locations, so we did not observe any patients that were lost.
- In house interpreters were available for Arabic, Greek and Russian. We did not observe any posters or signs advertising this service to patients. A language line telephone number was available for all other languages.
- There was no specific provision made for bariatric patients as they were a very rare type of patient for the department. Staff told us that arrangements could be made for patients with individual requirements, such as the consultant seeing the patients on the ground floor, being seen in a large consulting room and specialist equipment could be ordered.
- Within the outpatient, radiotherapy and diagnostic imaging areas there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. The information we observed was only given in English, reception staff told us that all information is able to be received in any print size, language, braille and audio loops.
- The hospital had a Macmillan accredited information centre which provides specialised information in the forms of booklets, CD's, DVD's and so on for cancer patients.

- The Macmillan centre has a designated quiet room for the use by patients and relatives.
- The diagnostic imaging department has slots available to fit in patients that require imaging the same day in order to meet their individual needs.

Learning from complaints and concerns

- In the period of November 2015 to April 2016 there were four formal complaints regarding the radiology department, three regarding the nuclear medicine department, one regarding the medical physics department, and one regarding the outpatients department. We saw evidence that all formal complaints were logged and action was taken appropriately in a timely manner.
- Initial complaints were dealt with by staff in the outpatients and diagnostics departments in an attempt to resolve issues locally; however if this was unsuccessful staff escalate it to the department manager who then starts the complaints process.
- Patients told us they knew how to make a complaint if needed.
- Details of complaints were discussed with staff in monthly team meetings. We saw minutes of meetings to demonstrate that learning from complaints had taken place; there was evidence to show that action had taken place to address the issues in a timely manner.

Are outpatients and diagnostic imaging services well-led?

Outstanding



We rated the service outstanding because:

- Innovation was strongly encouraged within the service and staff felt empowered to introduce new ideas such as; the radiotherapy department in collaboration with a London NHS trust lead a unique scalp sparing technique study aiming to improve the quality of life of palliative brain patients preventing hair loss during such an emotional time. The study won the LangBuisson 2015 award for Innovation in Care.
- All areas we visited had a clear strategy for expansion or service improvement, all staff we spoke with were aware

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of their local and hospital wide vision. The vision and strategies for each department were created in part by the staff who worked there and were clearly embedded in to the culture.

- All staff we spoke with were overwhelmingly positive regarding their local managers and the CEO. The local and hospital wide leadership clearly had a genuine rapport with staff members. Staff felt encouraged to move up the career ladder by their managers.
- We found there to be a clearly defined governance and reporting structure within the hospital with various monthly committee meetings feeding back from a departmental to board level. Staff were encouraged to observe these meetings and we found the learning from these meetings were disseminated quickly to all departments.
- The views of patients were actively sought and patient experience was seen as an important driving factor in service improvement, data from a cancer patient feedback audit showed 91% of patients recommend the hospital to friends and family based on the care and support they received.

Vision and strategy for this service

- All staff we spoke with could recall the hospitals vision and values that included care being delivered with compassion, dignity, respect, and equality. Staff stated quality was a key priority for the hospital.
- All staff told us the hospital was constantly improving and spoke passionately about the service they provided and were proud of the facilities. Managers told us about the various service expansion projects being considered for the outpatients, radiotherapy and diagnostic imaging departments.
- The deputy radiology manager explained the department was preparing for ISAS accreditation as a joint venture with all other HCA radiology departments, this was scheduled to be initiated in quarter 1 of 2017. The MRI staff were passionate about the completion of the MRI scanner upgrade which would allow the scanner to accurately measure liver iron concentration, the department was currently trialling the new system with completion in the medium term. Longer term plans for

the department involved recruiting more staff in accordance with increasing referral activity, it was noted that some new senior staff were recruited to join in the upcoming months.

- The interim radiotherapy managers told us the short term goal for the department was to recruit a new radiotherapy manager due to the predecessor retiring. Medium term goals included further developing current staff competencies and integrating new members of staff within the team, rotating staff to all areas within the department creating a multi-skilled workforce allowing cross-area cover. Longer term plans included replacing the current linear accelerator machines with higher-spec models allowing the department to offer advanced stereotactic body radiotherapy techniques as standard procedures. The department was also planning the rotation of radiographer staff to medical physics in order to develop their treatment planning competencies allowing cross department cover in times of increased activity.
- Senior Managers explained that there were plans underway to further integrate the HCA sister hospital oncology pathways with the longer term goal to create a cross HCA cancer network allowing the current separate services to work more closely together, this was especially prominent for the THSC as all HCA cancer patients would be referred to the THSC radiotherapy department for treatment. The reasoning behind this strategic development is to provide a seamless consistent level of care for patients using the service.
- The outpatients service managers were very passionate about the recently constructed bespoke department so there was not currently any goal of physical expansion. One of the outpatients department goals was to increase patient feedback, the managers explained they were working with the publication team to redesign and implement a new more refined outpatients feedback questionnaire which was scheduled to be completed in the upcoming months. The medium term goals were being worked towards which included the new establishment of a senior sister workforce created by the promotion and development of existing staff, this goal was currently underway with two vacancies already filled. Longer term plans included establishing a cross

Outpatients and diagnostic imaging

HCA workforce rota allowing the sharing of highly skilled staff members especially from professions difficult to recruit including; clinical nurse specialists, paediatric nurses and senior physiotherapists.

- We saw minutes of “patient satisfaction and improvement” meetings which were designed to discuss and improve the patient experience. Areas of improvement which were identified in these meetings directly influenced strategic goals for the related departments.

Governance, risk management and quality measurement

- There were quarterly clinical governance meetings attended by senior staff members, service leads and service managers. Minutes of the clinical governance meeting confirmed audit results and quality improvement programs were discussed at clinical governance and quality meetings. Additionally the meetings looked at comments, compliments and complaints by patients and staff.
- There were regular team meetings to discuss issues, concerns and complaints. Staff were given feedback at these meetings about incidents and lessons learnt by their line managers.
- Radiation Safety Committee meetings were held quarterly to ensure that clinical radiation procedures and supporting activities in the outpatients, radiotherapy and radiology departments were undertaken in compliance with ionising and non-ionising radiation legislation.
- The radiotherapy department held monthly quality assurance meetings where members of the quality assurance team would meet to discuss internal department governance, quality management and research and development.
- We saw evidence of monthly outpatients and diagnostic services meetings where attendees included head of outpatients, sisters, service managers, senior nurses, housekeeping manager and front of house staff. The meeting minutes confirmed that these meetings were designed to facilitate open and frank discussion on how to implement best practice.
- The radiology and outpatients department recorded risks on the clinical services risk register. We were shown

the risk registers which did not contain any major risk apart from general hospital associated risks. The interim radiotherapy department managers explained the main risk was the vacancy of a permanent radiotherapy manager, however this was being addressed with the recruitment process underway, the rest of the risks were general radiotherapy related risks.

- We saw evidence to confirm that outpatients, radiotherapy and radiology departments had active quality control measures and audit programmes that were regularly discussed and reviewed in meetings designed to incorporate all staff at differing seniority levels.

Leadership of service

- We found evidence of strong leadership in the service at a local and executive level. Although the radiotherapy department was lacking a permanent manager, all staff we spoke with praised the interim managers highly and confirmed all their managerial needs were being met.
- Managers had a sound knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- It was evident from talking to managers and staff and from our observations that managers in all departments we visited had genuine good rapport with staff.
- It was clear from our conversations and the information we reviewed that staff felt supported and valued in their role. They told us they felt supported and valued by colleagues, line managers and the executive team.
- Staff told us that they were happy to escalate matters to the executive team and felt that they were confident that they would be listened to.
- All staff we spoke with told us that the CEO and other executive members did regular walk rounds and were very approachable. Staff felt they had a rapport with the executive team and could talk to them easily.
- All staff we spoke with were full of praise for their local managers and the CEO.
- All department performance indicators and quality indicators were reported monthly to the recently introduced quality improvement and patient safety (QIPS) group and the bi-monthly MAC meeting.

Outpatients and diagnostic imaging

- The MAC was responsible for reviewing consultants practicing privileges renewals and acceptance of applications for new clinicians. Minutes of the MAC reviewed for 23 February 2016 and 26 April 2016 confirmed this was a standard agenda item at the MAC meetings.

Culture within the service

- We found the care and service delivered in the outpatients, radiotherapy and imaging departments showed a strong cohesive team approach to work. It was clear that an open, transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- We found an established multidisciplinary and inclusive culture in the outpatients, radiotherapy and imaging departments. Staff were encouraged to challenge clinical decisions and empowered to 'speak out' if they had concerns or comments to make.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- During our inspection we noted staff being positive and caring towards patients who used the service. We also observed that staff had a caring and respectful nature towards each other, their immediate teams and the organisation as a whole.
- Staff expressed pride and commitment to working for The Harley Street Clinic. Administration staff told us they felt valued in their roles and felt very much part of their teams.
- All staff we spoke with praised the approachability and availability of the CEO and other executive team members. Staff felt they could raise a concern or make comments directly with senior management which demonstrated an open culture within organisation.
- We were also told by staff that they "love to work here", "it is the best job I've ever had" and "people only leave if they move away".
- Staff told us that they felt inspired and encouraged to move up the career ladder. Managers also told us they encouraged staff to develop themselves to progress

their careers. All staff we spoke to confirmed this and said they were inspired by the CEO and other senior colleagues as they all progressed from junior roles in The Harley Street Clinic.

Public engagement

- The views of patients were actively sought within outpatient's radiotherapy and diagnostic imaging; patients were given a department specific and general outpatient's feedback questionnaire.
- Managers told us that feedback questionnaire return rates were lower than they would like, however there were plans being considered to increase the return rates including using tablet computers and redesigning the questionnaire.
- An example of feedback being listened to was that patients asked for a clock and television to be provided for the main outpatients waiting area, which have since been provided.
- Senior managers told us that patients were asked if they would like "You said, We Did" posters and the result was negative. Instead the hospital actively reviews all comments, compliments and complaints as evident from the information provided.
- We saw results from a patient feedback audit conducted by the cancer information centre in oncology outpatients. The data showed that 91% of patients would overwhelmingly recommend the hospital to friends and family based on the care and support they received.

Staff engagement

- Staff told us they could approach and talk to the CEO or other executive members any time.
- Service managers from the outpatients, radiotherapy and radiology departments told us they had monthly meetings with the CEO where issues were actively discussed and best practice was encouraged to be implemented. Managers felt they could engage with the CEO and felt they could raise issues on behalf of their staff and that there would be action.
- Engagement indicators used by the hospital showed that 97% are committed to doing their best for HCA and 75% of staff would recommend the hospital as an employer to friends or family.

Outpatients and diagnostic imaging

- Staff told us they were encouraged to make suggestions and implement best practice, we saw evidence of this in the form of “You Said, We Did” posters aimed at staff.
- The outpatients department recently implemented “The rule of 5” based on staff suggestions; this ensured all trolleys would only have a maximum of five equipment or medication on each level to prevent confusion and incidents.
- We saw evidence of a mentoring programme within the outpatients department with regular meetings between staff and mentors.
- The radiotherapy department has also implemented a fully paperless system of working. This system mitigates the risks associated with a paper based system and also is environmentally superior. The superintendent radiotherapists have trained and guided other independent and NHS departments who have then implemented the same system.
- The outpatient sister told us they had developed a “Nurse in charge” work initiative. This was specifically tailored to encourage junior staff nurses to develop leadership skills. All nursing staff are encouraged to participate and are rostered on to being a nurse in charge for specified shifts. This initiative contributed to the five new outpatient senior nurse roles and has allowed the department to promote internally.
- The outpatients department is in the process of launching a 2 hour weekly working schedule for senior nurses and sisters to work alongside more junior staff nurses. These sessions are designed to keep up the skills of senior staff and to encourage team bonding and further breakdown of barriers between differing seniority levels.

Innovation, improvement and sustainability

- The radiotherapy department in collaboration with a London NHS trust has lead a unique scalp sparing technique study. This study is aiming to investigate the possibility of sparing the hair from radiation dose when treating patients requiring whole brain irradiation. The goal of the study is to improve the quality of life of brain palliative patients without them having to lose their hair at such an emotional time. The study was the winner of the LangBuisson 2015 award for Innovation in Care.

Outstanding practice and areas for improvement

Outstanding practice

- The cancer service offered innovative patient-centred care through access to latest diagnostic and therapeutic methods and by seeking out new treatment options and taking a holistic approach to patient care. This high quality care included psychological support and complementary therapies such as relaxation or aromatherapy for example. Patients were given access to early phase clinical trials for new cancer drugs through partnership with a cancer research institute.
- We found excellent multidisciplinary team (MDT) working with close collaboration between all staff. National experts in their field with access to latest diagnostic and treatment methods attended regular MDT meetings. Outcome and learning from those meetings were shared through a standardised MDT format and documentation.
- We found approachable and motivational leadership that promoted staff development and career progression, teamwork and high-quality patient-centred care.
- The 'rainbow beads' project provided an opportunity to recognise the courage and strength of children and young people who were accessing the hospital for long term treatments. Children and young people were rewarded with a bead for each treatment or intervention.
- We saw new leaders and managers in the paediatric services who were driving forward change to improve staff development and patient care. We saw and heard about the improvements to the working culture and how staff satisfaction had improved. New ways of working had been introduced to promote safe and effective patient care.
- The radiotherapy department in collaboration with a London NHS trust has lead a unique scalp sparing technique study. The study is aimed at improving the quality of life of patients requiring whole brain radiotherapy treatment, by trying to remove the side effect of hair loss at such an emotional time in the patient's life. The study was the winner of the LangBuisson 2015 award for Innovation in Care.
- The radiotherapy department has also implemented a fully paperless system of working. This system mitigates the paper based system risks and is also better for the environment. The department has assisted other independent and NHS departments in the implementing the system.
- A "Nurse in charge" work initiative was in place in the outpatients department specifically tailored to encourage junior staff nurses to develop leadership skills. This initiative contributed to the five new outpatient senior nurse roles and has allowed the department to promote internally.
- Service managers had monthly meetings with the CEO where issues were actively discussed and best practice was encouraged to be implemented. Staff felt they could engage with the CEO and felt managers could raise issues on their behalf and they would be listened to.
- All radiological imaging results were available within 24 hours or earlier if requested.
- There were allocated appointment slots for patients that wanted same day diagnostic procedures.
- All staff were caring, compassionate and polite; focussing on accommodating every patient's individual needs.
- There was active local data collection with key point indicator (KPI) monitoring against national standards and local waiting time audits which were regularly reviewed. This demonstrated an outstanding commitment to continual improvement of the outpatient, radiotherapy and diagnostic services.
- The hospital in collaboration with other HCA hospitals published the Breast Quality Framework Report; containing outcome data collected as a

Outstanding practice and areas for improvement

retrospective audit of breast cancer patients treated in the period of 2010 to 2014. The hospital is working collaboratively with Public Health England to collate and publish patient survival rates.

- Surgical services were collaboratively using 'cyberknife' a robotic radiosurgery system. The system offered a non-invasive alternative to surgery for the treatment of both cancerous and non-cancerous tumours anywhere in the body by delivering beams of high dose radiation to tumors, providing a pain-free, non-surgical option for patients who had inoperable or surgically complex tumors.

Areas for improvement

Action the provider **MUST** take to improve

The provider must take action to ensure the skill mix in the paediatric intensive care reflects current recommendations set out by the Royal College of Nursing.

Action the provider **SHOULD** take to improve Medicine

- The hospital should ensure all written entries in medical records are clearly legible and conform to professional standards.
- The hospital should improve staff awareness of the meaning of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

Outpatient and diagnostic imaging

- The hospital should improve the hand hygiene compliance rates for the outpatients, radiotherapy and radiology departments.
- The hospital should consider placing resuscitation equipment on each patient accessible floor of the outpatient department
- The hospital should consider implementing a major incident hotline for staff at home to call and receive instruction.

Services for children and young people

- The provider should ensure all staff that have contact with patients under the age of 18 are trained to a minimum of level 3 in safeguarding training.
- The provider should ensure all staff are up-to-date with the mandatory training requirements.
- The provider should ensure all departmental risk registers reflect current risks to their services.
- The provider should consider innovative approaches to ensure staff maintain their skills and competencies during times of low bed occupancy.

Critical Care

- The provider should have systems in place for consultant intensivist and visiting consultants to be able to input directly on the electronic patient record to ensure good record keeping.
- The provider should ensure that chest opening trolley on the unit is checked consistently and unit staff are aware of line of responsibility and frequency of these checks.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Surgical procedures	Staffing skill mix in the paediatric intensive care unit did not meet guidelines set out by the Royal College of Nursing as there were not always two trained paediatric nurses per shift.
Treatment of disease, disorder or injury	Staff in the recovery area were not trained in paediatrics and told us there was no formal training in the care of paediatric patients. There were some areas where children and young people were cared for (such as recovery areas and diagnostic imaging) where none of the staff had the required level of safeguarding training.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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