HCA International Limited

The Harley Street Clinic

Inspection report

35 Weymouth Street
London
W1G 8BJ
Tel: 02079357700
www.theharleystreetclinic.com

Date of inspection visit: 24 & 25 January 2023
Date of publication: 20/04/2023

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

Ratings

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

Summary of findings

Overall summary

Our rating of this location stayed the same. We rated it as outstanding because:

- Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People thought that staff went the extra mile and care and support exceeded their expectations. Staff empowered people who used the service to realise their potential. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Consideration of people's needs was consistently embedded in everything staff did. Patients told us they valued their relationships with staff.
- There was an embedded system of leadership development and succession planning. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had supporting plans and objectives which were innovative and achievable. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in its daily work, and opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. Leaders and staff actively and openly engaged with patients, staff, equality groups and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Staff were actively participating in research and improvement projects.
- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided a high level of care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. There was a strong, visible, patient centred culture. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to support timely patient care.
- The service planned care to meet the needs of local people, and took account of patients' individual needs, and made it easy for people to give feedback. Patient individual needs and preferences were central to the delivery of tailored services. People accessed the service when they needed it and did not have to wait long for treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Medical care (Including older people's care)	Outstanding ☆	Our rating for medical care stayed the same. We rated it as outstanding because: • The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. • Staff provided a high level of care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. There was a strong, visible, patient centred culture. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available to support timely patient care. • Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People thought that staff went the extra mile and care and support exceeded their expectations. Staff empowered people who used the service to realise their potential. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Consideration of people's needs was consistently embedded in everything staff did. Patients told us they valued their relationships with staff. • The service planned care to meet the needs of local people, and took account of patients' individual needs, and made it easy for people to give

Summary of findings

feedback. Patient individual needs and preferences were central to the delivery of tailored services. People accessed the service when they needed it and did not have to wait long for treatment.

- There was an embedded system of leadership development and succession planning. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had supporting plans and objectives which were innovative and achievable. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. Leaders and staff actively and openly engaged with patients, staff, equality groups and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Staff were actively participating in research and improvement projects.

Services for children & young people

Good

Our rating for this service stayed the same. We rated this service as good because:

- The service had enough staff to care for children and young people and keep them safe. Staff had training in key skills, understood how to protect children and young people from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to children

Summary of findings

and young people, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

- Staff provided good care and treatment, gave children and young people enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available five days a week.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to children and young people, families and carers.
- The service planned care to meet the needs of local people, took account of children and young people's individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of children and young people receiving care. Staff were clear about their roles and accountabilities. The service engaged well with children, young people and the community to plan and manage services and all staff were committed to improving services continually.

Critical care

Not inspected

Outpatients

Good

This is the first time we rated this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills,

Summary of findings

understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of the communities it served, took account of patients' individual needs, and made it easy for people to give feedback. People accessed the service when they needed it and did not have to wait too long for an appointment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However,

- Patient records were not always stored securely.
- Not all single use consumables were in date.
- Not all call bells in the toilets were accessible in the event of a patient needing to call for assistance.

Summary of findings

Diagnostic imaging

Good

This is the first time we rated this service. We rated it as good because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of the communities it served, took account of patients' individual needs, and made it easy for people to give feedback. People accessed the service when they needed it and did not have to wait too long for a diagnostic procedure.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Surgery

Outstanding

Our rating of this service improved. We rated it as outstanding because:

Summary of findings

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service managed infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. They gave patients enough to eat and drink and gave them pain relief when needed. Managers monitored the effectiveness of the service and made sure staff were skilled and experienced. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. Patients had access to good information and key services were available seven days a week.
- Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People thought that staff went the extra mile and care and support exceeded their expectations. Staff empowered people who used the service to realise their potential. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered. Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Consideration of people's needs was consistently embedded in everything staff did. Patients told us they valued their relationships with staff
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- There was an embedded system of leadership development and succession planning. The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy had

Summary of findings

supporting plans and objectives which were innovative and achievable. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear. Leaders operated effective governance processes, throughout the service and with partner organisations. Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. Leaders and staff actively and openly engaged with patients, staff, equality groups and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research. Staff were actively participating in research and improvement projects.

However:

- There was no signage to the multi-faith room and the room itself was small and not accessible to wheelchair users.
- We found some consumable items which were out of date and one with packaging that was not intact.

Summary of findings

Contents

Summary of this inspection

Background to The Harley Street Clinic

The Harley Street Clinic is an independent hospital owned and provided by HCA International Ltd. The location is based in London in the Harley Street area. It consists of a main hospital building located at 35 Weymouth Street and uses areas at six other addresses in the immediate vicinity all controlled by HCA International Ltd. All these areas are covered under a single CQC registered location.

The Harley Street Clinic provides services for adults and children in the following specific service user bands;

- Caring for adults over 65 years
- Caring for adults under 65 years
- Caring for Children 0-18 years (outpatients and diagnostics only)
-

The Harley Street Clinic provides services with the following facilities;

- 85 registered beds which includes the day case oncology unit
- 12 level three adult Intensive Care Beds
- Four operating theatres
- Three cardiac catheter laboratories
- Consulting rooms
- Physiotherapy services
- Pharmaceutical services
- Radiology services
- Cardiac physiology services

The Harley Street Clinic is registered for the following regulated activities;

- Treatment disease disorder & injury
- Surgical procedures
- Diagnostic & screening procedures
- Family Planning services

1.

We previously inspected this location in August 2016 where we issued one requirement notice. The provider has since taken corrective action to rectify the issue. The location has also been inspected in May 2015, November 2013, November 2012 and July 2011.

We inspected this hospital as part of our risk-based inspection methodology. This service had not been inspected since 2016 and had undergone some changes in its service provision. We inspected surgery as this was the main service the hospital provided and this service had undergone changes in its structure and provision. We inspected medical care as this was a significant service the hospital provided and this service had undergone changes in its structure and provision. We inspected outpatients as a requirement of our inspection methodology as the way we assessed this service had changes since the previous inspection. We inspected diagnostic imaging as a requirement of our inspection methodology as the way we assessed this service had changes since the previous inspection. We inspected services for children and young people because there was a requirement notice issued in the previous inspection. We did not inspect the critical care service as there were no risks associated with the service.

Summary of this inspection

The main service provided by this hospital was surgery. Where our findings on surgery – for example, management arrangements – also apply to other services, we do not repeat the information but cross-refer to the surgery service.

How we carried out this inspection

We carried out an unannounced inspection on the 24 and 25 January 2023 using our comprehensive inspection methodology. We inspected five core services which included; surgery, medicine, outpatients, diagnostic imaging and children and young person services. The inspection team consisted of an inspection manager, lead inspector, core service inspectors, assistant inspector and specialist advisors. The inspection was overseen by Nicola Wise, Head of Hospital Inspection for London. We inspected all areas relevant to the respective core services which included; surgical theatres, inpatient wards, outpatient areas, diagnostic imaging machines etc. We talked to a total of 55 members of staff, which included managerial staff, medical staff, nursing staff, allied health professional staff, administrative staff and facilities support staff. We talked to 21 patients. We reviewed 25 patient records.

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

Outstanding practice

We found the following outstanding practice in surgery:

- There was a strong, visible, patient centred culture within the service. Staff were passionate about their work and were focused on delivering patient centred care. Surgical ward staff described how they supported a surgical patient who had been an inpatient at the hospital several times for cancer surgery. The patient had requested to receive end of life care in the hospital on the surgical ward rather than at home or on another ward and to be cared for by the staff they had become familiar with. Staff described how they had enabled this to happen with the assistance of the hospital's palliative care team.
- Patient feedback from the last 12 months was consistently positive and showed 97% of patients felt they were treated with respect and dignity and 97% of patients felt they were given enough privacy. Patients we spoke with told us care was 'exceptional' and they felt 'amazingly well looked after'.
- Theatre staff described how they supported an anxious patient with autism by showing them the theatres before their surgery and allowing their parents to accompany them to the anaesthetic room and then to be there in the recovery room when the patient woke up from their procedure. The theatre team also staggered the start times of the surgical list to ensure the theatre common area's atmosphere was calm and quiet to further ease the patient's anxiety.
- In the last 12 months, 97% of patients felt that consultants showed them understanding and 96% of patients felt the consultant explained everything to them in way which was easy to understand.
- Staff on the surgical ward had been upskilled by consultants to manage pituitary surgery patients. Consultants commented that they had empowered staff on the surgical ward to take care of their patients and this had a positive impact on the patients' recovery journey and without the need to go to the intensive care unit. Ward managers supported staff to develop by encouraging them to join courses and showing them how to conduct appraisals by letting them sit in on their appraisals.
- The service was actively involved in research. Surgical resident doctors were academically attached to a local university and regularly contributed to research papers and publications. Current fellows were carrying out research in novel technologies such as breath testing to detect gastrointestinal cancers. Other areas of research by resident doctors included kidney transplantation in older people.

Summary of this inspection

- Surgeons had introduced several innovative technologies. For example, most recently, the service was able to provide minimally invasive cardiac surgery using a three-dimensional camera system.

We found the following outstanding practice in medical care:

- Staff took time to develop exceptionally positive, professional relationships with patients which led directly to an improved patient experience. Patients and their carers were offered practical and emotional support before, during and after treatment. The service made good use of alternative therapies and innovative approaches to support patients and reduce their reliance on medicines.
- Treatment and care were adapted to meet the needs of individual patients and their families. Treatment plans and approaches were flexible to reflect the patient's physical and mental health. Staff regularly did more than would reasonably be expected to ensure patients received the best treatment and support.
- The service offered a medications direct number to pharmacy services to support patients that could be accessed 24-hours a day.
- There was a positive, progressive culture within the service with a clear focus on improving patient experience and outcomes. The culture was evident in the way staff conducted themselves and in the way the service was managed.
- Senior managers were visible and approachable in the service for patients and staff. Organisational strategy was developed with input from front-line staff and reflected the needs of patients and the local healthcare economy.
- Governance systems were highly developed and effective in promoting best-practice while sensitively highlighting areas for improvement.
- The service and the wider organisation were actively involved in research and shared information on innovative practice for the benefit of patients.

We found the following outstanding practice in children and young person services:

- The service was operating a 'Talent Beyond Boundaries' Programme where pre-registered nurses from Lebanon came over in June 2022, an initiative to give nurses in under-privileged areas a better quality of working and personal life. The matron informed us that two nurses had come over, with one having already completed their nursing and midwifery council (NMC) registration and received their PIN.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service SHOULD take to improve:

Surgery

- The service should consider improving signage, access and the environment of the multi-faith room.
- The service should ensure the multi-faith or quiet room is accessible to all patients, visitors and staff including those using wheelchairs.
- The service should ensure all single use consumables are in date and intact.

Medical care

Summary of this inspection

- The service should consider adopting a single electronic patient record system to standardise all medical care wards patient records.
- The service should implement a single standardised pain measurement tool.

Outpatients

- The service should ensure all patient records are stored securely.
- The service should ensure all call bells in the toilets are accessible.
- The service should ensure all single use consumables are in date.
- The service should ensure consent and medication forms are uploaded to the electronic patient record in a timely manner.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (Including older people's care)	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Services for children & young people	Good	Good	Good	Good	Good	Good
Critical care	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected	Not inspected
Outpatients	Good	Inspected but not rated	Good	Good	Good	Good
Diagnostic imaging	Good	Inspected but not rated	Good	Good	Good	Good
Surgery	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding

Outstanding ☆

Medical care (Including older people's care)

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

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Staff received and kept up-to-date with their mandatory training; we saw that there was 95% compliance with mandatory training for all staff in the medical care department with none of the modules below the provider completion target rate of 85%.

The mandatory training was comprehensive and met the needs of patients and staff. A wide range of topics included equality and diversity, moving and handling and basic life support. Most training modules were available online, with practical sessions also available for training such as basic life support, mental capacity act, and moving and handling.

Clinical staff completed training on recognising and responding to patients with mental health needs and dementia and on the management of sepsis. Sepsis is a life-threatening condition when the immune system overreacts to an infection and starts to damage your body's own tissues and organs.

The service ensured mandatory training compliance was monitored and leaders alerted staff when they needed to update their training. Mandatory training was also discussed with staff during one-to-one performance meetings with their manager.

Staff told us they received emails telling them when training was due to be updated.

Safeguarding

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

Clinical and administrative staff knew how to recognise and report abuse. They received training specific to their role. Safeguarding training was part of mandatory training with most clinical staff trained to level 3 for adults and level 2 for children. The service also had a designated safeguarding lead who was trained to level 4.

Staff could give examples of how to protect patients from harm, harassment and discrimination, including those with protected characteristics under the Equality Act 2010, and worked with other agencies to protect them.

The service had an up-to-date safeguarding policy and staff showed us how they accessed it easily. The policy detailed types of abuse and the role of staff when raising a safeguarding concern.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. We spoke with staff who told us who they would contact if they had concerns and how they informed their designated line manager, to make them aware of any referrals.

Cleanliness, infection control and hygiene

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

The service had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this as part of their rolling training programme. There were also named infection control lead nurses 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.

Waiting areas were clean with suitable furnishings. Environmental cleaning was performed by housekeeping staff at regular intervals. Staff used a communications log to communicate any concerns with cleaning standards. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The service performed well for cleanliness and carried out audits to assess their performance against their infection prevention and control policies. These included audits of hand hygiene, sharps handling and disposal and waste disposal and IPC principles and practices. We saw audits records that monitored sharps and waste management had recorded 100% compliance for the 3 months prior to inspection.

The service also monitored infection control risks and staff compliance with safe practice for continuing care of central venous access devices, peripheral vascular devices and urinary catheters among others. The service almost always achieved 100% compliance with standards of safe care in these audits in the 3 months prior to our inspection.

All the patient bays were single occupancy. We saw there was access in all areas to hand washing facilities, hand sanitiser and supplies of personal protective equipment (PPE), which included sterile gloves, gowns and aprons. All staff adhered to the bare below the elbows policy.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore PPE in line with provider policy. We saw that staff wore gloves and gowns for all patient contact, these were changed between patient contact. The results of the monthly hand hygiene audit for the 3 months prior to our inspection were 96 to 98% compliance for medical care staff in the hospital.

The enhanced 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 and the sliders being used with precautionary measures highlighted.

In the 6 months prior to our inspection there were zero incidences of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (c.diff) or E-Coli in both wards, with the cardiology ward not reporting any of the above for over a year.

The sluice areas for the service were clean and contained separate disposal pathways for clinical waste and chemotherapy waste.

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. As an example, we saw that all sharps bins had been signed and dated in line with the relevant Health Technical Memorandum (HTM 07-01).

Environment and equipment

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

The design of the environment followed national guidance. Treatment areas were accessed through a secure door. Entrances to the wards were controlled by keypad access, and visitors were required to identify themselves by using the intercom to staff before being granted entry.

Patients had individual rooms on the cardiac and oncology wards. The rooms were equipped with all necessary medical and physical equipment to provide safe and effective care.

The cardiac catheter laboratories area was only accessible via a secure entrance and admission by staff. For the radiotherapy unit there were radiation-controlled area lights and interlocked gates in place to restrict access when the machine was being used.

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. Emergency equipment was clean and ready for use. Staff were trained in its use as part of their mandatory training. We also saw that trolleys in the cardiac catheter laboratory areas each contained an emergency grab bag for ease of access. All bags were checked and dated correctly.

Electrical equipment we saw was marked as having undergone safety testing. Additionally, staff carried out daily safety checks of specialist equipment at the beginning of the day before patients attended and were recorded on the treatment system. As an example, radiotherapy machines had servicing schedules and we saw these had been completed in full.

Sharps boxes were appropriately assembled, labelled and not overfilled. We witnessed a nurse correctly assembling and signing a sharps bin.

The service had enough suitable equipment to help them to safely care for patients. As an example, due to the precise targeting required for accurate radiotherapy, patients must remain as still as possible, and for this, radiographers use immobilisation equipment. Immobilisation equipment is medical equipment that keeps a body part in a fixed position for an extended period of time. There were duplicates of all immobilisation equipment to ensure that if damage occurred these could be replaced immediately.

The service had suitable facilities to meet the needs of patients' families. There were armchairs available at each patient's bedside for family members to stay, and staff stated that visitors could always use dedicated family areas. Each area had information leaflets on services offered by the hospital to support patients and family members.

Patients could reach call bells and staff responded quickly when called. The hospital had a corridor alert system that indicated which room had activated a call bell so that available staff near the rooms could attend them faster. Patients and family members, we spoke with confirmed staff answered call bells in a timely manner. Patients reported they had no concerns for staff response on the wards even during busier periods.

We were told by all staff the maintenance team was very approachable and tried to do any minor repairs on the same day.

Assessing and responding to patient risk

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

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission and updated them when necessary using recognised tools. Patients were screened on admission and as necessary for sepsis, infection control risks, falls risk, pressure ulcers, and others. We saw consistent evidence of this recorded in patient notes and risk assessment tools in use. As an example, staff had training in sepsis awareness to support patients. There was a sepsis policy and staff knew how to access this. The sepsis policy had been developed following best practice guidance from National Institute of Clinical Excellence (NICE) and the United Kingdom Oncology Nursing Society (UKONS).

Specialist care areas assured checks and risk assessments to keep patients safe were completed and acted upon. As an example, in the radiotherapy department the service used a 3-point identification check with patients before undertaking each radiotherapy session. There were 'Pause and Check' posters in radiation-controlled areas that prompted staff to verify information and dose details before exposing patients to radiation. With each patient staff went through a 'pause and check' checklist to confirm the patient's: name, date of birth, address, body part to be treated, clinical information and previous imaging checks. This is in line with legal requirements of IR(ME)R, to prevent radiation exposure to the wrong patient.

Assurances of safe processes in the management of safety and risk to patients were also followed in the cardiac catheter laboratories. We heard how the admission process ensured there was a morning brief with the relevant consultant, nurse debriefs with patients were followed and the World Health Organisation (WHO) checklist was started. Additionally, the service ensured patients were checked for the right procedures and any possible complications, such as allergies minimised.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately in the oncology and cardiac wards. Staff used the national early warning scores 2 (NEWS2) system to assess and monitor deterioration in patients. We saw the NEWS2 form used by staff to monitor any deterioration in the patient's status, and

observed staff discussing the NEWS2 score when deciding on care plans. The service also audited the quality and standards of compliance with the NEWS2 form. This was done quarterly and the result of the latest audit indicated 100% compliance on the oncology ward and 98% compliance on the cardiac ward. Where standards of compliance were not met this was highlighted to the team and an action plan implemented.

The hospital had an on-call intensivist and on call 24-hours daily cardiac catheter and cardiac resuscitation team to support any emergency calls and patient deteriorations. The team worked well with the wards, theatres and intensive care unit on site and processes assured a rapid response.

The service had an enhanced oncology area with 4 rooms and an antechamber room. Two of the rooms could be set up for negative pressure to support the management of highly infectious patients who attended the service and minimise the spread of infectious diseases.

The service assured staff were aware of key risks to patients and their safe care. We saw in multidisciplinary team meeting records of how activities such as logging and tracking syringe drivers, the implementation of a new wound care bundle and using correct specimen logs were highlighted and good practice reinforced with staff.

Staff handovers included all necessary key information to keep patients safe. There were daily morning huddles to discuss the upcoming working day, this was attended by both clinical and administrative staff. The notes from these huddles were recorded electronically and accessible by all staff in the service. We reviewed notes from previous huddles and saw that they contained areas to record risks and provide staff with an oversight of the day's tasks. There were details regarding patient advice to be communicated and also note any new rapid alerts or incident reporting.

Nurse Staffing

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

Staffing was in line with national guidance of the Royal College of Nursing for enough nursing staff on both wards. The service determined 1 registered nurse would be allocated to a maximum of 3 patients on the oncology ward and 4 patients in the cardiology ward. The enhanced oncology unit had a ratio of 1 member of staff for 2 patients. In addition to these core nursing staff, there was a ward manager, a nurse in charge and at least 1 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.

Managers recognised an increased use of bank and agency staff during the 3 months prior to the inspection, which was due to a marked increase in patient volume and the requirement to ensure adequate staffing for patient safety. Staff we spoke with stated that the wards used bank staff where possible, instead of agency staff, as they would be more familiar with the hospital processes and could deliver better continuity of care. Managers made sure all bank and agency staff had an induction and understood the needs of patients. However, we were made aware of ongoing recruitment campaigns to reduce this number with the service having successfully recruited 16 new members of staff across all the medical services in the last 3 months.

New nursing staff had recently been appointed to the service. Staff we spoke with confirmed this. Management was aware of the situation and had made staff recruitment and retention a top priority. Training, courses and education had been improved, with the aim of increasing staff retention.

Outstanding ☆

Medical care (Including older people's care)

There was always sufficient staff available. Staff on duty matched the planned number in all rotas we reviewed.

Nursing staff were supported by healthcare assistants (HCA) on both the day and the night shifts in the oncology ward. HCAs could provide support in caring for the patients, but also monitoring of patients with more complex risks such as falls and mental health issues.

In addition to the wards the service had enough staff to keep patients safe in radiotherapy and the cardiac catheter laboratories. We saw therapeutic radiographers worked on treatment machines as a pair. This was in line with IR(ME)R guidance.

Medical Staffing

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

The service directly employed 37 resident doctors including 4 consultants. However, most medical staff worked under 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 service had 187 practising privileges consultants in medical care.

The medical advisory committee (MAC) reviewed each application for practising privileges. The advisory function covered granting, renewal, restriction, suspension and withdrawal of practising privileges. Consultant credentials were reviewed regularly. If there were delays in receiving evidence of up-to-date documentation, the provider suspended the privileges accordingly until credentials were provided. There was an annual review of practising privileges, including scope of practice and activity.

All patients were admitted under the care of a named consultant. Lead consultants were available on admission and were available to be reached on-call at all other times. We heard from staff and patients that they reviewed their patients regularly and communicated any changes or concerns with the Resident Doctor (RD).

During normal working hours, there were 2 RDs present on the oncology ward and 1 RD 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 1 RD per ward at night.

Permanent core and bank staff mostly covered the RD rota with a few consultants on this list as well. Nursing staff told us they felt well supported by RDs and consultants, and that cover was enough to ensure patient safety.

A physician and an interventional radiologist provided further on-call cover for the medical department throughout the week, including weekends.

Records

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

Outstanding ☆

Medical care (Including older people's care)

Patient notes were comprehensive, and all staff accessed them easily. The service stored notes electronically and on paper forms. Only authorised staff were able to access these records, using a password protected system. When records were created in paper, for example referral forms, these were signed and scanned into the electronic system to maintain a single complete record.

We reviewed 10 patient records as part of our inspection. The records included appropriate care plans for patients, with risk assessments completed throughout and clear clinical notes kept regarding the input from each clinician involved in the patients care. Care plans also reflected the individual needs of patients, such as care for dementia, end of life care, and patients with common clinical risks such as falls.

Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. We reviewed 3 DNACPR forms during our inspection and all had discussion records with patients and their relatives. All forms had been signed by a consultant, as per local policy.

Records were stored securely. We saw that staff locked computers when leaving them to keep information secure. Paper based notes were stored appropriately in locked trolleys and filling cabinets in the nursing stations and on the wards that we visited.

There was an information governance module as part of all staff mandatory training. As part of the audit programme, designated staff completed an information governance audit to check staff were following policies and keeping patient records secure. We were informed that the 2 most recent audits had recorded compliance of 98% compliance for medical care.

When a patient completed their treatment, staff prepared a discharge summary for the patient and a copy for their GP or referring clinician. We reviewed 2 discharge summaries and saw that they contained appropriate information and highlighted ways to contact the service should specialist follow up information be required to support ongoing care.

Medicines

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

Medicines were stored safely and available for patients when they needed them, including controlled drugs. Staff followed systems and processes when safely prescribing medicines.

All medicine stock items were monitored effectively, and all items checked were in date. The service used an electronic automated medication dispensing system which helped analyse prescription trends and assure that the right medicines were always in stock. This system also ensured that controlled drugs were well managed and delivered to the right people.

Controlled drugs were also managed with this system and counter checked using a controlled drugs book. We saw processes, checks and drug checks were within practice guidelines.

The service had access to pharmacy services at all time. A pharmacist was available 7 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 service manager and RDs had access to the pharmacy at all times to obtain medications for inpatient use only. In addition to this, pharmacists spent time on the wards and were involved in decisions about patient care. This supported patients by reducing the amount of time spent in the service and time waiting for medicines.

A specialist oncology pharmacist was involved in the screening, prescribing and preparation of chemotherapy medication. 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 or not to proceed. We observed the correct administration of chemotherapy intravenously by nursing staff.

“To take out” medications were processed in advance of discharge. Doctors reviewed the medication on time and managed medicines reconciliation well. Additionally, the service offered a medications direct contact number to pharmacy services to support patients. The number could be accessed 24 hours a day.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Incident reporting formed a part of mandatory training and all staff completed this.

Staff raised concerns and reported incidents and near misses in line with provider policy. Managers investigated incidents thoroughly. Patients and their families were involved in investigations. When things went wrong, staff apologised and gave patients honest information. We reviewed the 2 most recent closed incidents and saw they had been reported correctly. The records we reviewed showed staff providing information to assist with effective incident investigation and all steps in the management and sign off of the incident report clearly followed.

We saw there was a designated lead who was responsible for investigating incidents and completing root-cause-analysis for incidents. Policies ensured major incidents were escalated to the health and safety and risk committee at provider level. This ensured learning was shared more widely between other services the provider offered.

The service reported 569 incidents between January 2022 and December 2022. 344 were no harm incidents, 165 were rated low harm and 6 as moderate harm. The service also reported 54 expected deaths.

The service had reported no serious incidents or major incidents in the 12 months prior to inspection.

The service had no ‘never events’. Managers shared learning with their staff about never events that happened elsewhere. Staff told us there were ‘flash updates” which informed them on and serious incidents or never events within the provider group.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Duty of Candour formed a part of staff mandatory training and we saw that all staff had completed this.

Outstanding ☆

Medical care (Including older people's care)

Staff we spoke with received feedback from investigation of incidents, both internal and external to the service. In addition to “flash updates”, staff told us that learning from incident investigation was shared at the morning huddle. This gave staff a chance to reflect and receive feedback from incidents.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Capacity Act 2005.

The service used a range of evidence-based guidance, legislation, policies and procedures to plan, deliver care and treatment, and support patients. We saw the staff had access to all policies and all policies we saw were in date. The service stored policies electronically and these were accessible for all clinical and administrative staff. Policies were easily retrievable.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. We saw care pathways followed the National Institute for Health and Care Excellence (NICE) guidance. Staff had quick access to national policies guidelines and updates and policies being considered for implementation through the monthly Quality and Effectiveness Bulletin.

We reviewed 6 guidelines and policies on the hospital intranet. All listed the approver, date of acceptance and review date. All were within the next due date for review.

Staff told us the quality team worked at provider level to monitor policies, when a policy was approaching the review date, they contacted authors to alert them. The team also checked that sources used following a review were the most recent. Following a review, when a policy was reissued all staff were informed through email, electronic communication channels including bulletins and huddles.

Staff protected the rights of patients subject to the Mental Capacity Act 2005 and followed the service’s code of practice. They were provided with appropriate training and support to identify patients who had additional needs covered by the Act. Staff understood their responsibilities to provide support and report any concerns.

Patient outcomes

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

Outstanding ☆

Medical care (Including older people's care)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time, compliance and receive assurance and accreditation. Medical services carried out an annual programme of audits to evaluate the quality of care being received by patients and overall performance. The audit programme clearly outlined frequency and mandatory status of the proposed audits and had the flexibility to be changed if non-compliance was found.

Audit results were compared with other services across the provider to learn from them. Regular patient outcome audits included medication chart audit, pain audit, venous thromboembolism audit and sedation audit among others.

The service reported audit results at provider level. This allowed audit performance benchmarking against similar services within the provider group. Audit outcomes were discussed at various sub-committees and informed key governance structures such as the clinical governance board, information governance board and health and safety and risk board. Staff told us if the service failed an audit, an action plan would be developed to monitor the actions implemented and measure improvement was occurring.

We reviewed the service's quarterly quality report for the period between April and September 2022 and were assured the service was providing consistently good outcomes of care for their patients. The report monitored patient outcomes on quality indicators such as unplanned readmissions within 48 hours and risk-adjusted acute hospital mortality, among others. It also monitored physiology, case mix, infection, length of stay and organ support.

At the time of inspection, the service participated in national clinical trials and audits. Examples of this where the Intensive Care National Audit and Research Centre Quarterly Quality Report, the National Institute for Cardiovascular Outcomes Research. The most recent reported results suggested the service was providing excellent care.

The service also undertook a radiotherapy and dosimetry audit British Standards Institution ISO 9001 on 17 and 18 January 2023. No major non-conformances were raised at the time of the audit.

The service achieved accreditation to the Macmillan Quality Environment Mark. This accreditation looked at design and use of space, the users' journey, service experience and the users' voice. The service scored a maximum score of 5 for their assessment and accreditation

The service submitted data to Private Healthcare Information Network (PHIN). PHIN is intended to improve the availability of information to patients for private healthcare services, making the information comparable with that which is already available for the NHS.

Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the specialist palliative care team. Medical or nursing staff on the oncology unit would make a referral to the palliative care team if appropriate. The palliative care consultant and clinical nurse specialist would then review patients accordingly. We saw related documentation in medical records. There was a "Excellent care in the last days of life" booklet to support staff and good communication when managing patients at end of life.

Monthly Morbidity and Mortality meetings were held where both expected and unexpected deaths could be 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.

Nutrition and hydration

Medical care (Including older people's care)

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

All patients attending for treatment were screened using the Malnutrition Universal Screening Tool (MUST) on the service electronic system. There was a dedicated nutrition champion that linked with the dietetic team.

Patients had good access to a wide range of different food and drinks. Patients we spoke with on the day of inspection were complimentary about the food.

The dietetics service was available to all patients and produced recipe cards for patients to encourage them to cook and eat healthy meals that would be palatable during their chemotherapy treatments.

The service informed us that they supported the discharge process to assist patients with symptom management, namely, nausea and vomiting. The service made use of both the dietetic team and pharmacological support to assist patients with symptom management.

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.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools.

Staff prescribed, administered and recorded pain relief accurately. We saw evidence of this in patient records we reviewed.

Recognised pain assessment tools were in use across the service. Nurses and consultants routinely asked patients about their pain and patients told us their pain had been managed appropriately. The notes we reviewed showed that patients had been given necessary pain relief when required. However, there was discrepancy in the scores used on the computer system and the patient notes and paper records. While the computer system used a scale from 0-3 paper records used a 0-10 numerical scale. Although staff were aware of which scale was being used at each time this could lead to potential errors in pain management.

At each treatment assessment, patients were assessed on pain symptoms. A pain score was then captured on the electronic system and medical notes were updated accordingly. If a patient arrived with acute pain, a nurse and RD assessment would take place and pain relief would be administered as quickly as possible.

Complementary therapies were also available to patients to help manage symptoms and side effects. The complementary therapies team offered reflexology and massage to patients as part of their treatment plan. Patients that we spoke with were satisfied that their pain was well controlled.

Competent staff

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

Outstanding ☆

Medical care (Including older people's care)

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

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 at 100%. In addition to this, nurses had a mid-year assessment carried out against their objectives to measure their performance and progress.

Clinical practice facilitators were on hand to provide clinical supervision to both new nurses and nurses who required additional assistance in their training and development.

Managers gave all new staff a full induction tailored to their role before they started work. We saw there was an induction learning and competency folder that defined the induction process their role required. New nursing staff had a mentoring system provided by more experienced nurses. This ensured that new staff worked alongside the more experienced nurses and that competency checks were signed off appropriately. The matron for the service had the final sign off for the competencies.

Revalidation for nurses was well supported through the service's human resource platform.

The service encouraged nurses to pursue special interests and deepen their expertise in areas of care. We saw how leads encouraged nurses to take ownership of roles such as link nurses and champions.

The clinical nurse specialist team provided teaching and training to staff on the different cancer types and the specific needs of the patients in relation to their diagnosis. Additionally, staff received specialist training in the cardiac wards such as blood transfusion, medicines management, cardiac study days and electrocardiography training.

Resident Doctors (RDs) received revalidation at the Harley Street Clinic if required. RDs felt supported in their education and were provided with funding to attend conferences. The RDs we spoke with had a high level of training and worked whilst also undertaking research. All RDs had a designated mentor.

The service ensured consultants had the right competencies and training. Permanent consultants had designated responsible officers and for consultants who were under practising privileges there was a provider level annual review of practising privileges, including scope of practice and activity. We saw the appraisal rate for medical staff was 100% completion.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. We saw staff newsletters that contained links to meeting notes and recordings.

Staff had access to relevant information that contributed to their competency and ability to carry out their work safely. We reviewed notes from a range of staff meetings. The meeting notes we reviewed contained detailed information in a clear and simple format. They included a range of topics from shared learning to hospital and ward updates as well as governance updates. The service also ensured that any staff who did not attend the meeting read and signed a record sheet stating they had updated themselves with the information shared.

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

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

Medical care (Including older people's care)

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. They told us that they enjoyed working with their colleagues and were complimentary about the support they received from each other. We observed good working relationships between all grades of staff and all professional disciplines.

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Daily morning huddles were attended by all staff in the service including nurse, healthcare assistants, RDs, pharmacists, patient administration officers, and allied health care professionals. These huddles included staff from across the whole service, both clinical and nonclinical. Staff were able to discuss their day and it was an opportunity to allocate tasks and discuss the patient list. We reviewed the last 3 huddle meetings and saw staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patients receiving wellbeing treatments that day were discussed and the wellbeing consultant attended meetings when they were based at the service.

A broad range of MDT meetings were held regularly and there were clear terms of reference for each meeting. For example, oncology meetings were carried out on a weekly basis and cardiology MDTs took place on a bi-weekly basis. Other specialist MDT's also took place with regular intervals and assured all specialisms and staff had a regular platform to update and review their practice. Staff we spoke with were proud of MDT working across the department and of the collaborative nature of the department.

As part of the inspection, we attended daily handovers and ward rounds. Each of these meetings included multidisciplinary input, as well as consideration of the individual needs of each patient from each clinical discipline. We reviewed patient records as part of the inspection and found that the daily meetings reflected input from disciplines across the wards.

Seven-day services

Key services were available to support timely patient care.

Staff received support from other services, for example when they were concerned about a patient's general health. Staff could call for support from consultants and other disciplines such as specialist nurses when needed at all times.

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 RD on duty for updates on patients.

Patients had access to support from staff at any time. They were provided with a card that had an out of hours number on it. This number directed patients to the out of hours triage line. We spoke with a patient who had used this number and said that it was "Excellent, really set my mind at ease when I had symptoms". The 24-hour triage service allowed patients and family members to contact a trained nurse team member for advice on symptoms related to toxicity, side effects from

treatment, medication advice and emotional support. The service also helped co-ordinate any admission to an inpatient facility with the patient and consultant's consent if required. If a patient was triaged as being acutely unwell, the triage line would ask the patient to call an ambulance to access emergency care. The service would then ensure safe handover to the admitting hospital and follow up to ensure advice or treatment plans were followed. The 24-hour line provided access to specialist advice by a specialist nurse and consultant oncologist/team.

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.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support available. There were leaflets about cancer and cardiac conditions and other support services on request. Leaflets were available in different languages.

The service had a significant amount of information available to patients, but staff also promoted healthier options and health advice during treatment. Information was supported by leaflets and staff could direct patients to online links to read more about the issues at matter.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. Staff also knew how to access local policies and procedures and who to contact for advice if they had any queries.

Staff made sure patients consent to treatment was based on all the information available. Patient information leaflets and records included information that helped patients provide informed consent. Staff gained consent from patients for their care and treatment in line with legislation and guidance. The service had an up-to-date consent policy which was comprehensive and referenced best practice guidance. We saw that consent was clearly recorded in the patients' records.

When patients lacked capacity to give consent this was also recorded in the patient record. Due to the daily and close interaction with patients, staff felt they developed close relationships with patients that enabled them to be alerted to changes in their capacity. This further supported staff to understand how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, considering the patient's wishes, culture and traditions, as well as input from family members.

Staff were clear if they had concerns about a patient's capacity, they contacted their doctor, or the RD, for support. They also told us the patient notes could always be reviewed to understand if this was new or a previously known lack of capacity.

Outstanding ☆

Medical care (Including older people's care)

Staff described and knew how to access the local policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. There was a Mental Capacity Act and Deprivation of Liberty Safeguards policy, which was up to date.

The service had a designated mental capacity lead at provider level. We spoke with staff who told us they would contact them if they had any concerns. Staff also said they would make their designated line manager aware of any concerns.

Is the service caring?

Outstanding ☆

Our rating of caring stayed the same. We rated it as outstanding.

Compassionate care

Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People thought that staff went the extra mile and care and support exceeded their expectations.

The relationship between people who used the service, those close to them and staff was caring, respectful and supportive. Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff talking with patients about how their treatment was affecting them so they could monitor this. We saw staff taking time to discuss patient's lives outside of treatment and things they had been doing. Patients told us this made them feel cared for as an individual.

Patients said staff treated them well and with kindness. We spoke with a patient who told us they felt staff 'could not do enough' and had fully supported them through their treatment. Patients felt that care and support exceeded their expectations. We saw patient feedback for areas of improvement often stated they felt nothing required improvement.

The patients we spoke with were exceptionally positive about staff. They provided examples of how staff supported their health and wellbeing. Comments included, "I feel safe when I'm there. They show a huge amount of compassion and empathy", "I genuinely feel they care about me as a person" and "They make you forget how difficult the treatment is. I don't think they could do anything better."

We observed interactions between staff and patients prior to, during and following treatments. Interactions throughout the inspection were seen to be positive, caring and patient led.

Staff followed policy to keep patient care and treatment confidential. During the two days of inspection no conversations about patient care, individual names and treatment plans were discussed in open areas. Staff were conscious of closing meeting rooms and waiting for doors to close before starting private conversations.

Patients were called by first name only or if requested by surname and title. Conversations to confirm identify details such as date of birth and address were held only once in a private area. Patient reviews took place in private rooms and conversations in these rooms were not overheard.

Outstanding ☆

Medical care (Including older people's care)

Patients' individual preferences and needs were reflected in how care was delivered. This helped patients feel relaxed during treatment with a patient leaving a comment thanking staff for the music. Additionally, the service completed a holistic needs assessment which assessed any additional physical and mental health needs for each new patient. At this assessment the cultural, social and religious needs of the patient were taken into consideration.

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: final wishes, making arrangements to attend family events and catering needs.

The inpatient dashboard for the hospital between January 2022 and December 2022 indicated that 97% of patients felt they were always treated with respect and dignity and that they were given enough privacy.

Emotional support

Staff empowered people who used the service to realise their potential. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We heard stories of how staff listened to patients and took time to get to know them and support their emotional needs in a human and compassionate way.

Staff gave patients and those close to them help and emotional support and advice when they needed it. Patients' emotional and social needs were seen as being as important as their physical needs. As an example, patients receiving cancer treatment benefitted from wellbeing support services such as reflexology, counselling and relaxation techniques

Patients' families were also entitled to supportive services such as mindfulness and relaxation, this helped further support the patient by ensuring their families were given tools to be mentally able to support them.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. There were quiet rooms, which could be used if a patient became distressed and needed additional support. The service had designated wellbeing rooms for patients to use if they were distressed. This room was designed to be comfortable and soothing and to not feel clinical. Treatment areas were also separated from waiting areas so any distress during treatment was kept confidential.

Staff demonstrated empathy when having difficult conversations. As part of their development staff completed training which supported difficult conversations. They were also supported by policies and training offered by specialist nurses and the practice development nurses.

The clinical nurse specialists (CNS) provided a personalised service for each patient. The CNS's were present during clinics with consultants throughout the patient journey. CNS's assisted patients with a variety of things relevant to care they were receiving e.g. receiving complex care in the community and discharge coordination. The CNS team were key to ensuring people had a positive experience of care.

Staff provided all patients with a contact number for outside of admission if any support was required. Staff told us this made patients feel supported and that staff cared. We also heard how patients away from home said it made them feel less isolated.

Outstanding ☆

Medical care (Including older people's care)

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Consideration of people's needs was consistently embedded in everything staff did. Patients told us they valued their relationships with staff.

Staff made sure patients and those close to them understood their care and treatment and supported them to make informed decisions about their care. Patients and families we spoke with told us they felt fully involved in planning their care, and in making choices and informed decisions about their future treatment. They said staff explained things in plain language to help them understand and gave them enough information about different treatment options. All patients told us they felt able to ask questions of those caring for them and felt listened to by their doctors and nurses. One patient told us, "They always talk things through with me".

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. The service accessed printed information in an 'easy read format' and signers were available to support patients if needed.

All patients we spoke with said that they were provided with the out of hours triage number if they had any concerns whilst the service was not open. Patients informed us that they were provided with adequate information throughout their treatment plan. If in doubt, patients could contact their consultant directly and discuss treatment plans or test results.

Patient feedback was overwhelmingly positive in nature. Patients used terms such as kindness, compassion and professionalism routinely when referring to the service. This was reflected in the hospital's inpatient survey which stated that between January 2022 and December 2022, 83% of people said they had a very good experience of care and that 90% were extremely likely to recommend their consultant.

We reviewed patient compliments for the three months prior to inspection and saw that patients praised staff and the support they gave. One patient compliment stated, "Thank you for looking after me and being a friend in difficult times" and another "Thank you so much for everything you have done and all your support throughout".

The hospital held support groups for patients receiving treatment. 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.

The service provided information and support with payment of fees. All patients we spoke with informed us that they were aware of the cost of treatment prior to starting.

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.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Outstanding ☆

Medical care (Including older people's care)

Service planning and delivery to meet the needs of the local people

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

The complex and differing needs of individuals were central to the planning and delivery of the tailored service that the hospital provided.

Facilities and premises were appropriate for the services being delivered. The service was accessible to patients who used a wheelchair or had mobility limitations. The service also addressed the needs of people with dementia and learning disabilities.

The service had systems to help care for patients in need of additional support or specialist intervention. Specialist nurses reviewed patients regularly. Staff told us they contacted the patient's clinical consultant if patients requested specialist intervention not provided by the specialist nurses.

Pre-admission procedures would be offered over the phone to facilitate the process for patients travelling from a distance for treatment, those from abroad or those with impaired mobility. Managers had processes that ensured that patients who did not attend appointments were contacted.

The corporate provider's overseas office managed all aspects of care for international patients. This service was designed to meet the needs of a large demographic of international patients that the hospital received. They oversaw the full referral process form pre-admission, obtained visas and organised follow-up care, amongst other duties.

Meeting people's individual needs

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

Managers undertook their own ward rounds to talk to patients individually, suggesting additional support and to ensure their needs were met. Nursing staff told us that the established nurse to patient ratio meant that they could spend enough time with patients to cater for their individual needs.

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 often offered 1:1 nursing care and family members and carers were encouraged to be involved in their care as much 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 a national dementia charity, were used if required. This helped all the hospital staff know how to make patients with communication difficulties feel comfortable.

Staff were proud to always make patients' needs a priority. For example, staff told us about a patient whose cultural needs meant they required a female workforce as to not make them uncomfortable. They highlighted that on assigning duties they ensured the same staff cared for the patient all the time.

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 if possible. We also heard how the service met individual religious needs such as allowing late night visitations, during Ramadan, for example.

There were in-house interpreters for Arabic, Russian and Greek international patients. Most interpreters had a medical background to ensure information, treatment options and clarity at the point of care was well understood. 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.

Patients whose first language was not English accessed interpreting services and all information leaflets were as needed, produced in an alternate language. Arrangements were also made for patients who required signers to attend for British Sign Language (BSL) translation. The service also had a hearing aid loop available for those who wore a hearing aid.

Psychological counselling services were available for oncology patients suffering from anxiety, stress or pain. Other complimentary therapies like massage were also offered.

The service had access to information leaflets available in languages spoken by the patients. We saw a variety of leaflets on information related to cancer and cardiac diseases on the wards.

Access and flow

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

Between October 2022 and December 2022, the number of patients for oncology services, including admissions and day cases, was 259, while the number of patients for cardiology, including admissions and day cases, was 222. Radiotherapy fractions had 2805 cases and the cardiac catheter laboratories had a total of 357 cases for the same period.

All patients admitted to the hospital were admitted under the care of a consultant, either employed or with practising privileges. The admitting consultant provided a booking request form with the patient demographics, expected length of stay, procedure and any specialist requests. We saw the hospital admitted adult patients from the age of 18 and there were clear inclusion/exclusion criteria.

The oncology admission pathway followed the provider's admission policy and was also available for patients having active treatment at another HCA UK facility. Patients had access to a 24-hour triage service provided by a dedicated team of oncology nurses. The team provided this service off site out of hours and at weekends, and on site in normal hours weekdays. The service was accessible to all patients undergoing systemic cancer therapy. All patients were given an alert card with in-hours and out of hours numbers and an explanation of how the service worked.

The service was in the process of arranging online booking capability across the provider. In the meantime, the service had implemented an online registration for patients. This meant that once a patient had an appointment booked, they were able to register online prior to their arrival at the service making their experience more seamless.

For some procedures a pre-admission nurse for cardiac and cardiothoracic patients called patients 2 days before any planned admission for an initial assessment. 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.

Outstanding ☆

Medical care (Including older people's care)

Patients flowed seamlessly between services in the hospital. We saw arrangements and planning to ensure there was bed availability and that all parts of the admission process ensured a safe flow for patients being admitted for care and interventions. As an example, oncology patients could be admitted as outliers on the cardiology ward if there were no oncology beds.

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.

Patient individual needs and preferences were considered in the delivery of tailored services. Treatment times could be amended, and specific times requested. Senior staff told us there were no waiting lists for procedures in the cardiac catheter laboratory or the oncology department.

The service had no did not attends for all services provided. However, should a patient not attend an appointment the service had a policy in place to assure they were contacted and follow up appointments arranged as soon as possible. The policy also supported any safeguarding processes that needed to be made.

The hospital was an independent sector hospital and as such there were no waiting times for referral to treatment or delays in accessing oncology and cardiac services. Waiting times to access services were driven by patient choice. Between January 2022 and December 2022, 98.8% of weekdays saw patients access services where the booking reservation was taken on the same day. This demonstrated that the service was responsive in facilitating urgent access for patients.

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 hospital.

Each patient was assigned a cancer specialist nurse who coordinated all necessary discharge arrangements for oncology patients. This reduced delays for patients with complex discharge needs. The 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.

Staff completed treatment summary letters and sent these to the patient and their GP.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they knew how to raise a complaint. They felt confident that if they complained, they would be taken seriously and treated compassionately. Patients also told us they did not feel they needed to raise any complaints.

Outstanding ☆

Medical care (Including older people's care)

The service clearly displayed information about how to raise a concern or complaint in patient areas. There were leaflets for patients in the waiting area which explained the complaints process clearly. The provider also gave guidance on making a complaint or raising concerns on their website.

The service had a clear, in date, complaints policy which outlined the expected way complaints were to be investigated. Staff were all able to access this policy if they needed. The policy referred to the independent resolution of the complaint through the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if a patient felt their complaint had not been investigated appropriately by the service.

Between January 2022 and December 2022, the service received 13 formal complaints. Two of those formal complaints were referred to the provider chief executive for internal review and resolution. No complaints were referred to ISCAS.

Staff understood the policy on complaints and knew how to handle them. All staff we spoke with were clear about their responsibilities when patients complained. They told us they offered the patient advice on how to complain formally and made their senior manager aware.

Managers had the overarching responsibility for investigating complaints. We reviewed the 3 most recent complaints investigations completed by the service. We saw these had been investigated in line with provider policy and the responses were appropriate and compassionate.

The service investigated complaints and identified themes. Staff told us themes were communicated at provider level to ensure learning was shared across the provider. Complaints were discussed and learning points shared in meetings such as hospital clinical governance and medical advisory committees.

Managers shared feedback from complaints with staff and learning was used to improve the service. As an example, the service received a complaint that the choices on the food menu were too small for a specific dietary requirement. As a result, the service reviewed their menu and introduced a dietary check in the pre assessment stage to ensure specific dietary requirements could be met with greater options.

We also saw examples were concerns raised by staff were addressed where new equipment was suggested by staff and the service provided new scalp cooling equipment, new electrocardiographs and a new bladder scanner.

Is the service well-led?

Outstanding ☆

Our rating of well-led stayed the same. We rated it as outstanding.

Leadership

Leaders had the experience, capacity and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. There was an embedded system of leadership development and succession planning.

Outstanding ☆

Medical care (Including older people's care)

There was compassionate, inclusive and effective leadership at all levels of the organisation. Managers within the service including those operating at a more senior level were highly skilled, motivated and experienced. They provided services and support which were highly effective, responsive and person-centred. Patients and staff consistently expressed their satisfaction with the performance of the service.

All staff knew management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management. The nursing and medical leadership teams worked closely together to plan and deliver care, and staff from across all disciplines were positive about the working relationships within the service.

All leaders we spoke with had comprehensive and successful leadership strategies in place to ensure and sustain delivery. They had a deep understanding of issues and challenges and priorities in their service and how these integrated with the rest of the hospital services being provided.

Staff we spoke with stated that the clinical leads and nursing leadership were visible and were available to staff when needed. Frontline staff stated that the managers had an open-door policy, and we observed staff interacting well with the service leadership during the inspection.

Staff said they were well supported by their consultants and medical leadership on the wards. Consultants we spoke with were also positive about the support of their colleagues and stated there was a collaborative working relationship between medical staff on medical and surgical wards.

Patients told us they felt valued and listened to by staff and managers at all levels of the organisation. Staff were equally positive and told us they were respected, appreciated and supported by the organisation to develop their knowledge, skills and competencies. We saw examples of staff development and promotion throughout the inspection. Leaders ensured patients and staff were reminded of what the service did well through their 'Reasons to be proud' initiative. As part of this initiative posters were displayed that summarised key achievements each month.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The vision and strategy had supporting plans and objectives which were innovative and achievable.

The service had a clear strategy that focused on creating a seamless system, working as a united team while committing to the care and improvement of their patients' lives. This strategy was measured against the service's values and had clearly defined action plans to achieve their targets. These included implementing a physician team to support oncology admissions, providing seamless patient support, maintaining a sustainable business and developing exceptional people to deliver their services.

The hospital objectives were clearly stated against the proposed strategy. As an example, the service had the objective of applying for cardiac institute status within the wider HCA Healthcare organisation and expand therapies, palliative and supported services integrated within the multidisciplinary teams. We also saw clear targets against seamless patient support such as implementing the patient portal, optimising the oncology triage service and addressing and improving feedback and patient satisfaction response rates and scores.

The service had clear benchmarks for achieving the vision and staff had highlighted those they had achieved to celebrate their progress. As an example of developing exceptional people within their service all nurses were offered the systemic anti-cancer therapy training course after their first year of employment. This training helped specialised nurses expand their knowledge on drug treatment types which may include chemotherapy, immunotherapy, targeted therapy, hormonal therapy or a combination of these.

We also saw how progress against delivery of the strategy and local plans were monitored and reviewed at a more senior level. There was a strategy document developed by the management team which was highlighted to show the areas the service had achieved. This had been shared with staff, so they understood and supported the vision, values and strategic goals and understood how their role helped in achieving this.

Staff told us they were happy working at the service and were a close team. Staff were passionate about providing high quality care and treatment to all their patients and their families. All staff spoke of a sense of working together and towards a common goal. Staff were aware of the values of the service.

Culture

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

All staff we spoke with told us they enjoyed and were proud to work at the service. Staff were asked what they were most proud of and most staff told us it was the team that they worked in and spoke highly of the culture. Staff in all areas spoke of good collaboration, team-working and support across all the service. There was a common goal on improving the quality and sustainability of care and people's experiences.

We found a good working relationship between doctors, nurses, allied health professionals and all other staff caring for patients. Staff were very positive about their colleagues and we observed a collaborative working culture in place between the various clinical disciplines.

Staff and teams worked collaboratively to deliver good quality of care. We observed daily handover and discharge meetings during the inspection and found this to encourage contributions from all staff attending. Care that we observed and meetings we attended showed that staff considered the holistic needs of all patients and their surrounding support network.

Staff were proud of the work they carried out. Staff stated they enjoyed working at the hospital and were enthusiastic about the care and services they provided for patients. Staff we spoke with told us that there was a no blame culture relating to safety and they were encouraged to report incidents. Staff said that they felt valued and respected by their colleagues.

Staff at all levels were actively encouraged to speak up and raise concerns, and policies and procedures positively supported this process. The service had an up-to-date whistle blowing policy and staff knew how to raise concerns with managers. The policy outlined the responsibilities of staff and managers when concerns were raised.

The culture promoted support for equality and diversity in both the patient and staff groups. Some examples included the patient user group 'Us for you', the colleague council and specialist interest groups such as the blood management and quality improvement interest group. Information and learning were readily available to staff to improve their knowledge and understanding of the needs of people with protected characteristics.

Staff had access to the wellbeing service that also supported patients.

Patients told us they knew how to raise concerns and would feel comfortable complaining if they needed to. They all told us they had no reason to raise a concern.

Governance

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

There were extensive systems and processes in place to monitor safety, quality and performance. At provider level there was an executive board with committees that covered medical governance, clinical governance, information governance and health and safety and risk governance. These reported to the overall provider quality and safety board.

Each element of the governance structure was supportive of the organisational strategy and service objectives. There were clear lines of responsibility and accountability throughout the structure. For example, we saw records of the governance committee minutes and saw they discussed complaints, incidents, key performance indicators (KPIs), training, staffing levels, audits, and any other clinical issues. Actions to address concerns or outstanding issues were identified and monitored through the team meetings. The meetings were minuted for dissemination to other leaders who were not able to attend or to staff who wanted to review the findings of the meeting.

The provider also used a variety of other governance meetings in the form of sub-committees to support the overarching board committees. Examples of these were: the combined medical advisory board, the risk management, radiation protection, health records forum, clinical audit and effectiveness, mortality and morbidity sub-committees. In addition, there were independent committees such as the ethics and compliance and nursing strategic council which further informed the board. We reviewed meetings minutes and there was clear accountability and lines of reporting throughout the meeting minutes as well as clear terms of reference for each sub-committee. As an example of this we saw that the medical advisory committee (MAC) advised on matters such as the granting of practising privileges, scope of consultant practice, patient outcomes, clinical standards and implementing new and emerging professional guidance. The MAC ensured there was a process for overseeing and verifying doctor revalidation, continuing practice development and reviewing practising privileges. The scope of practice for doctors with practising privileges was available for other clinical staff to check to ensure they were not working outside of their area of expertise. Staff were able to show us where to find practising privilege information.

Staff had access to critical data and reports and were aware of their roles and responsibilities to escalate concerns. We saw minutes of multidisciplinary meetings involving staff and managers at all levels where information of concern was discussed and action to improve practice was agreed and completed.

Staff recognised the value and importance of effective governance processes and contributed accordingly. Managers used meetings and other methods to ensure there was regular feedback. Staff contributions and successes were routinely recognised and celebrated.

There were clear communication processes to make staff aware of incidents both locally and across the whole provider. Locally staff were told either in person or over an email that there had been an incident and what changes to procedure were required.

Management of risk, issues and performance

Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. They had plans to cope with unexpected events.

There was a clear approach to audit and performance management at the service. The audit programme was thorough and clearly laid out timescales for audits to be repeated to ensure compliance. The results of the audits were fed into the provider leadership team to allow for benchmarking across all sites.

The service carried out environmental risk assessments. The health and safety representative carried out regular walkarounds to ensure there were no new environmental risks.

There were regular safety and quality meetings which covered a variety of topics and included appropriate members of the organisation.

The service reviewed their performance regularly. An example of the service being proactive towards managing their performance and key outcomes to the sustainability of the service was outlined with the introduction of the Complaints, Litigation, Incidents & Patient Experience meeting (CLIP). CLIP was introduced in January 2023 and was used as a weekly meeting where all summary data and actions were tracked from complaints, litigation, incidents and patient experience. This enabled the provider to have refreshed triangulation of data, quicker identification of emerging trends, clarity of escalation and oversight and supports to prompt learning across the service.

The service managed risk well. A risk register was maintained and kept up-to-date by the risk management committee. 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. In addition to the risk register the service provider used a risk dashboard which provided fast access information regarding live risks as well as a risk register summary for quick access to information on outstanding and ongoing actions, highlight greatest active risks and prompt actions when deadlines approached.

The service was responsive and practical in their approach to risk management. As an example, they introduced a permanent learning and development superintendent as a result of risks and feedback from the radiotherapy service concerning working relationships, recruitment and retention of staff. This resulted in identifying clear areas of improvement for this area of the service, improving staff induction and redesigning the competency framework. This resulted in a decrease of incident trends in the last 4 months in the department whilst maintaining a good reporting culture.

Information Management

Outstanding ☆

Medical care (Including older people's care)

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

Authorised staff could access information in accordance with their roles and responsibilities. Staff told us they had all the information needed to provide safe care and treatment. Most of the information systems that the provider operated were computerised. There was a comprehensive information governance policy and framework in place which was aligned with relevant legislation.

The service complied with information protection laws and local policies. As an example, we saw that all members of staff were careful to lock computers when they were leaving the area to make sure patient data was kept private and secure. The service worked consistently to meet the standards established by the General Data Protection Regulation 2016.

All staff had access to their work email, where they received organisational information on a regular basis, including clinical updates and changes to policy and procedures. Meeting minutes were also made available to staff if they were not able to attend meetings, meaning they were able to keep up-to-date with changes.

Data was collected and used by the service to monitor and drive improvement. We saw that data was collected in reliable and accurate formats and was well used by the service and governance process to ensure effective measures were taken to address findings. The collection of data also assured the service that auditing processes and review of data was consistent and repeatably reassessed throughout time to monitor the implementation of improvement strategies.

Data and information were shared internally through secure systems. It was only shared externally as required by legislation. For example, when providing statutory CQC notifications. Personal data was redacted or coded to ensure confidentiality was maintained.

Leaders told us that policies approaching a review date were flagged to the author and then reviewed in line with new guidance. Once authorised by relevant governance processes these were flagged to staff and updates in huddles, team meetings and other information pathways were provided.

The service submitted data to the Private Health Information Network (PHIN) to allow them to benchmark against other organisations nationally.

Engagement

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

Managers and staff recognised the value of engagement in support of safety and quality improvement. They also recognised engagement as a key component of their vision and strategy. Patients and other key stakeholders from the local health community were actively encouraged to engage with the service and the wider organisation to provide feedback through a range of formal and informal mechanisms including surveys and questionnaires. There was clear evidence of these views being acted on to improve the service for example, through the ‘Us for you’ patient user group.

Outstanding ☆

Medical care (Including older people's care)

The service actively asked patients for feedback while they were using the service. In addition to the comment feedback the service began a work stream in 2020 to develop ways to engage with oncology patients in quality improvement initiatives. From this the patient group “Us for you” was established for patients, carers and families to ensure their voice was heard in all aspects of care. As a result of this group members were consulted on refurbishment plans, development of oncology documentation for patients and establishing support partnerships for newly diagnosed patients.

The service also engaged with patients through video sharing and explaining treatment pathways and patient experience. Media content was shared openly for patients to view on social media and the service’s website. Other forms of engagement and information sharing included leaflets and easy to access literature. The hospital published a booklet called "bedtime stories" which contained patients' experience testimonies who had received treatment in different areas of the hospital.

The service also engaged well with staff through publication of magazines, a monthly newsletter and consultant update. The service also offered freedom to speak up information and had guardians assigned in different areas of the hospital.

The latest staff survey from October 2022 used a 10-parameter assessment to determine staff engagement levels. Some parameters included but were not limited to caring, meaningful conversations, growth and resources. The survey showed that overall staff engagement in the cardiac and oncology wards was high with engagement levels of 68% and 77% respectively. Despite this the overall staff engagement level for radiotherapy and cardiac catheter laboratories were still scoring low at 38% and 34% respectively. We saw evidence of how the staff surveys were being acted on to improve overall engagement by the leadership team and how staff comments were taken seriously to improve satisfaction, engagement and staff retention.

The service further engaged with staff through the diversity, equality and inclusivity committee and colleague council. In addition, patients, their families and colleagues could nominate a staff member for the daisy awards, which were designed to recognise work that staff did above and beyond for patients. Nominations could also be made for the ‘Employee of the Quarter’ awards. Other specialist interest staff groups and forums also contributed to support staff engagement.

The service engaged well with the wider provider as well as the corporate provider. This was evidenced well in the governance documents we reviewed and by how staff spoke of working relationships with the wider provider.

The service also engaged well with external providers and partner organisations. Examples of this were the services long standing relationship with a specialist cancer charity service. In addition, the service also engaged with other external charities such as the British Heart Foundation and several NHS hospitals.

Learning, continuous improvement and innovation

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

The provider had a governance structure to oversee research and development, and any activity only took place with prior approval. There was robust oversight of any research activity through the MAC and the Corporate Research Review Committee. All staff demonstrated a commitment to the process of continuous improvement.

Outstanding ☆

Medical care (Including older people's care)

Systems, processes and organisational values provided an effective foundation for the review of practice. The provider used established methodologies to deliver quality improvement. Leaders and staff continued to participate in recognised accreditation schemes and projects to improve practice and the patient experience. For example, following a period of research, an application had been submitted to a major drugs company to trial the use of a specialist product for a different type of cancer.

The service encouraged innovation and participated regularly in clinical trials of new treatments and contributed to research in the medical care area. For example, between January 2022 and December 2022 the service participated in 6 research projects. These included but were not limited to participation in the British Heart Foundation PROTECT study and pilot, the imperial college and cancer research project to investigate new methods to diagnose stomach and oesophageal cancer and independent research such as the audit of impact minimal residual disease results in multiple myeloma/ amyloid light chain amyloidosis patients.

Staff at all levels were supported and encouraged to access learning and development opportunities for their personal and professional development as well as that of the wider organisation. For example, the oncology ward had weekly breakfast teaching sessions.

Staff we spoke with were passionate about driving improvement and felt positive about working in an environment which promoted innovation. Staff said they were encouraged to present ways to work which improved the patient experience.

Good

Services for children & young people

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

Is the service safe?

Good

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

Mandatory training

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

All staff had a learning profile allocated to them by the hospital's Learning Academy. Mandatory training compliance could be reviewed through reports provided to line managers.

Mandatory training was a combination of e-learning and some face-to-face modules, which included PILS (paediatric immediate life support) training. The matron for the service received the report and discussed with individual members of staff and provided protected time to complete required training. This included training on sepsis, medical gas, and learning disability & autism.

The amount of protected time given for mandatory training was reviewed on an ongoing basis. We were told by the Outpatients matron the first two weeks for newly employed nurses were dedicated to mandatory training, whilst they were supernumerary.

Staff were 87% compliant in Paediatric Basic Life Support training and were 88% compliant in Paediatric Immediate Life Support training. Staff were between 98% and 100% compliant for all other required mandatory training modules, which included: Moving and Handling, Infection Control & Sepsis, and Learning Disability & Autism Training Level 1.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Good

Services for children & young people

Staff completed a minimum of Level 3 safeguarding training for children and young people, which was completed as an e-learning module. There was a 98% completion rate for this training. The chief nursing officer for the hospital was required to have the knowledge, skills and attitude to practice safeguarding level 4 training. They had completed this training.

There had been no safeguarding referrals made in the last 12 months, but staff were aware of the escalation and referral process for reporting a safeguarding issue. All safeguarding referrals would be escalated up to the senior sister and matron, but the chief nursing officer would lead on the referrals.

Female genital mutilation (FGM) awareness training was also included in staff training in safeguarding training modules levels 2 and 3 and child sexual exploitation training within level 3 modules. There was also an additional bespoke FGM e-learning module available for staff to complete. Awareness of FGM was included in the hospital's safeguarding policy and staff were trained to follow the safeguarding escalation flow chart for any safeguarding concerns. Staff also had access to safeguarding yellow information folders which had all the relevant FGM information contained within it.

For non-British nationals, the safeguarding process would be followed through with embassies. The service had processes in place to manage procedures requested that were not legal in the U.K, such as FGM.

If there was a child or young person with a history of safeguarding concerns, they would have a flag on their file. When clinic lists were loaded for the day, it would be highlighted, and the service would alert the consultant and the nurse covering the clinic. If the patient was known to the service, staff would be extra vigilant when they were examining the patient. If there was any further input that needed to be done, that would be completed by the nurse in charge.

Cleanliness, infection control and hygiene

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

Senior staff completed weekly observations of the clinical areas to ensure compliance with infection, prevention and control (IPC). There were monthly IPC audits that were completed to ensure compliance with IPC. The audit looked at clinical areas, curtains, and waste disposal.

Infection, prevention and control meetings took place every quarter with all the heads of departments, where the service could report if they'd had any MRSA, c. difficile cases, or any other major infection concerns. The service would complete a report on any known cases and a full report would be sent to the IPC Lead.

The service undertook hand hygiene audits which also looked at compliance amongst staff with the dress code of being bare below the elbow and not wearing nail varnish. Staff followed infection control principles including the use of personal protective equipment (PPE). The service provided staff with personal protective PPE such as gloves and masks.

The service set themselves a target of 100% for their IPC audits. If this was not achieved, then an exception report would be generated for the governance team with an associated action plan put in place. The matron told us that an action plan could be around introducing further training and providing additional support to staff around IPC. Any actions or learnings as a result of the exception reports would be shared in team meetings.

Good

Services for children & young people

The service performed well for cleanliness. The service had a contract with a cleaning company, which included the cleaning of reception, waiting areas, and consulting rooms in the evening. Waste management was also handled by the same contractor and clinical waste was collected from the service's clinical waste store by the porters.

Staff working in the service checked consultation rooms each morning to ensure that cleaning by the external cleaning company had taken place. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. The service completed cleaning checklists.

Environment and equipment

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

The service had enough suitable equipment to help them to safely care for children and young people. Staff had enough space for consultations to be carried out safely. There were 36 consultation rooms in the building where children and young people outpatient services were being delivered.

At the time of the inspection the waiting room used for children was not wholly adapted to the needs of children. The waiting room was of mixed use for both children and adult patients. However, the service had put in place mitigation measures to reduce the risk to children. The waiting room was not used for adult clinics at the same time as for children's clinics. Children using the waiting room had to be accompanied by their parent or guardian. Furthermore, we saw the service's improvement plans which included a re-design of the area to be an exclusive children's waiting area.

Consultation rooms were fitted with call bells. The nature of the service meant it would be rare a child or young person was left alone and needed to use the call bell. However, the system was maintained as a best practice safety measure. Consultation rooms were furnished with clinical trolleys and there were resuscitation trolleys on each floor of the building, which were checked at regular intervals.

The design of the environment followed national guidance. Staff demonstrated how they had access to evacuation routes and emergency equipment. There was a fire evacuation procedure and staff were informed of this procedure during their induction. All staff completed training in fire safety and knew how to respond in the event of a fire. The service had fire safety equipment which was checked regularly.

An annual electrical safety visit was carried out each year by a certified contractor to capture 100% of available non-medical devices. Failed items were labelled 'do not use' and rendered unusable. Passed items had a dated label added. The safety records were stored by the Estates Department in their compliance system. The annual visit was last conducted in October 2022 for The Harley Street Clinic. All new equipment brought onsite between the annual visits was tested and labelled by trained estates engineers.

Due to the size and design of the adult outpatient and paediatric outpatient services, health and safety and call bell audits were not split but completed as a whole for the two services.

Across all outpatients' departments there were mandatory daily checks for all consulting rooms, such as: replenishment of all PPE; checking all clinical equipment was in working order, with necessary safety testing labels in date; checking that computer, phones and printers were in working order; ensuring all clinical trolleys were compliant with specific speciality requirements; and checking for any confidential information. Daily checks of call bells and the cleaning of clinical equipment for the month of November, showed 100% compliance.

Good

Services for children & young people

Staff disposed of clinical waste safely. Clinical waste and non-clinical waste were correctly segregated and collected separately. Sharps bins were not overfilled, were signed and dated when brought into use, and had a disposal date listed.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

For a deteriorating child, there were resuscitation trolleys available which had guidance for paediatric emergencies, including paediatric early warning score charts (PEWS). Paediatric escalation pathways as recommended by national guidance were on the crash trolleys. Attendance for a resuscitation or emergency event would consist of all cardiac bleep holders – resident doctor (RD), paediatric nurse, adult nurses, cardiology and radiology bleep holders, resuscitation lead and duty manager, who were all paediatric trained. Depending on the nature of the emergency event patients would be transferred to the Portland Hospital as per policy, or the closest NHS hospital. Patients were transferred to HCA hospital only if the patient was stable and it was safe for them to be reviewed at this hospital.

Clinical staff used a 'Safeguarding Flag' on the electronic patient record system to identify a child or young person with any safeguarding concerns or previous safeguarding history. Any child or young person with learning disabilities would also be flagged on the system so the service could be sure to provide the necessary special attention and care. If a flag had been placed to alert staff to those additional needs, nursing staff ensured that appropriate additional care steps were provided into the child or young person's pathway in advance, to maximise their experience and have successful outcomes. Those steps included the extension of appointments to allow the child and parent extra time to convey their health concerns, or any other additional services that would need to be provided as part of the consultation or procedure.

The nurse-in-charge checked the safeguarding flag on the electronic patient record system daily during the morning huddle and nursing staff and consultants for the particular clinic would be informed to make any necessary adjustments.

The service ensured that paediatric patients had a parent or guardian with them, making sure the paediatric patient's paperwork was completed on arrival, signposting them to the necessary waiting areas and ensuring the paediatric nurse was available to support.

The service worked to a gold standard – a local HCA initiative – to ensure that there was always a paediatric nurse on site to support patients where there was a safeguarding risk or concern, throughout the patient's episode of care, within consultations and examinations.

Staffing

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

The service had enough staff to keep patients safe. The hospital utilised a tool called 'Facility Scheduler', which was a planning and scheduling tool for the staffing rotas. Facility Scheduler allowed for facilities and workforce planning (WFP), to create scheduling and reporting functionalities to address forecast and actual census, along with appropriate 'staffing grids' at the guidance of the local clinical leadership team.

Good

Services for children & young people

Staffing included healthcare assistants, nurses, consultants, and management. The number of clinical staff working in the service was based upon both capacity planning and based on risk assessment. The service were data driven with regards to their clinical staffing.

There had been a full-time paediatric nurse working in the service, but they had left in December 2022. An agency paediatric nurse was currently covering the role until a new full-time paediatric nurse started in their role on 6 February 2023. There were 28 adult nurses working in the adult outpatient service who were all PILS trained and could be used for chaperoning.

Apart from the staffing rotas, which were planned in advance, medical staffing levels were monitored closely on a daily basis by the head of resident doctors. The hospital had a team of resident doctors who covered the outpatient department alongside the paediatric nurse, nurses and healthcare assistants. Medical rotas accommodated the hours of 9am to 5pm with multiple clinics and procedures running including specialties such as dermatology, ENT, and plastics.

There were 1200 consultants working in the business with practising privileges, working across adult and paediatric outpatients. For continuity of care, patients would see the same consultant for their follow up care and consultants held regular clinics. Those consultants carrying out CYP activity were paediatric trained.

Records

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

Patient notes were comprehensive, and all staff could access them easily. Staff used electronic records to document patient's episodes of care. We reviewed 10 sets of records and they were all fully complete with the date, name and signature of person treating. Consents were documented where required.

Every consultant had different expectations of observations. We saw that all the cardiologist's patients had height, weight and vital signs recorded, including blood pressure, heart rate. However, we found that the service was not routinely recording children, and young people's centile (this can be an indicator of a problem or of a child experiencing stress). Recording the centile using centile charts would be an effective indicator of growth in CYP patients, especially very young children, as it indicates if there are other stressors affecting growth.

Records were stored securely. All patient's data, medical records and results were documented on a secure electronic record system. The service performed audits in patient documentation and electronic records patient access.

Medicines

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

Clinicians reviewed each patient's medicines regularly and provided advice to children, young people and their families about their medicines. Only clinicians were able to prescribe and give advice to patients about medicines.

For more information on medicines, please refer to the Outpatients report.

Incidents

Good

Services for children & young people

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

Staff knew what incidents to report and how to report them. They used a system called Datix to report an incident, and this was accessed via the intranet portal. Newly inducted staff were shown how to access the incident reporting system.

Staff raised concerns and reported incidents and near misses in line with the service's policy. The service had not had any serious incidents, never events or hospital transfers, and hadn't yet had to notify CQC of any significant events. Incidents were discussed at monthly governance meetings.

Staff received feedback from the investigation of incidents. Debriefs occurred following an incident and learning was shared amongst staff in governance meetings and regular team meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff understood their responsibilities and could give examples of when they would use the duty of candour. Staff also described giving duty of candour over the phone to patients and their families when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. This means providers must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.

Is the service effective?

Good

Our ratings stayed the same for effective. We rated it as good.

Evidence-based care and treatment

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

Staff followed up to date policies to plan and deliver high quality care according to best practice and national guidance. Policies were written based on best practice and amended as needed. Policies were reviewed in the event of a change in guidance, which could result in the change of a standard operating procedure, in line with new guidance and local risk assessment.

Any changes to National Institute for Health and Care Excellence (NICE) guidance would be sent to all teams/staff by email and changes in NICE guidance would also be discussed at the governance meetings. The matron and senior sister would regularly update policies and procedures when necessary; however, the chief nursing officer would have the final sign off on any policies.

All policies were dated, and version controlled to ensure they remained up to date. Policies referred to national guidance to ensure the service were adhering to best practice. Policies were supported by standard operating procedures to guide staff in delivering the highest quality care.

Pain relief

Staff assessed and monitored children and young people regularly to see if they were in pain.

Due to the nature of the service being an outpatient function, the service was not routinely recording pain score for children and young people. However, there were conversations with the child or the parent regarding pain. If there was any observation or communication that the child was in pain, an assessment would be undertaken in line with the service's pain management policy.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The service was not participating in any national audits.

Managers and staff carried out a comprehensive programme of repeat audits to check improvement over time. In August 2022 a new audit reporting tool and interactive audit dashboard was launched. Each month, every department received their audit results and a summary of any areas of non-compliance. This enabled staff to identify any areas for improvement and they reported the actions to be taken to address non-compliance. Audit results, actions required, and learning were shared by heads of department with staff at team meetings and displayed on departmental quality boards.

Actions required and learning from the audit programme were discussed and shared at The Harley Street Clinic clinical audit and effectiveness committee. This committee reported into the corporate HCA clinical audit and effectiveness committee. This enabled learning to be shared across the organisation.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children and young people. This was checked as part of pre-employment checks. To apply and be accepted for practising privileges at the service, consultants had to fulfil several criteria including: having the correct certification; completion of practising privileges forms; and completion of application forms.

Managers identified poor staff performance promptly and supported staff to improve. Staff performance was managed on a continual basis through probation review meetings, appraisals, one to one meetings and clinical supervision. Poor performance would result in an extension of the probationary period. Probation and appraisal meetings served as opportunities to discuss poor performance. The service managed performance improvement by providing additional training or developed an action plan to address improvement. Staff were open to giving feedback on their colleagues.

Managers identified any training needs their staff had and gave them the protected time and opportunity to develop their skills and knowledge. Staff training needs were identified though one-to-one monthly meetings and clinical competency assessments. Appraisals were used as a forum to discuss continuous professional development plans. If professional development plans were required, then the service would support this financially.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. All staff were subject to a probationary period where managers could identify needs for development and celebrate progress and outstanding practice. Appraisals occurred twice a year, which served as an opportunity to provide support and highlight opportunities for development and staff progression and development.

The paediatric nurse working in the service was an agency worker so was not included in the appraisal figures data. However, all staff working in the service were 100% compliant in completing their appraisals for the period. The matron would oversee all the appraisals for nurses.

There was a 100% completion rate for end of mid-year performance review and the end of year performance reviews were due for March 2023.

Consultants had a review every year, where the senior leadership team went through complaints, incidents and mandatory training as part of it. The senior leadership team would oversee this and ensure practising privilege consultants had up to date information on their files.

We were told that the permanent paediatric nurse due to start in February 2023 would be supported through their three-month probation period. There would be access to resources for them to progress with leadership and governance training to lead the service for CYP. The post was rotational with a sister to assist with pre-operative assessment and development of knowledge and skills for patients undergoing surgery. The safeguarding sister at Harley Street Clinic's sister hospital would provide safeguarding supervision and would be available along with the other heads of department to support with any complex concerns regarding CYP.

Paediatric consultants had to hold a substantive NHS post. The hospital completed checks that consultants were on the General Medical Council (GMC) specialist register and required a copy and reviewed their CV and experience as part of the application process. The hospital also reviewed a completed Paediatric Scope of Practice which included consultant's recent activity and was countersigned by their NHS Clinical Director.

New starters needed to complete mandatory training within their three-month probation period. They would be given an induction booklet, which included safeguarding flowcharts, process flow charts, a map of the buildings, competencies, where resuscitation trolleys were located and information relating to general data protection regulation (GDPR). New starters received a mentor group and buddy support.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

The Harley Street Clinic had a comprehensive multidisciplinary team (MDT) meeting infrastructure in place and MDT's were managed in line with the hospital's corporate MDT Policy.

Seven-day services

Good

Services for children & young people

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

The service was open from 9am to 5pm Monday to Friday. The service was not currently offering paediatric services on a Saturday.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

Consultants ensured that health promotion was provided to all paediatric patients during consultations and any further referrals were made regarding obesity, diet and exercise.

Health promotion posters were displayed in the waiting areas, which included: 'Staying safe in the sun', 'Healthy eating', 'Keeping families active', and 'Using an inhaler'.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff were 100% compliant in Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS).

There were paediatric consent forms. Gillick competence were used by consultants depending on the age of the patient. The consultant would negotiate these conversations where appropriate. Fraser guidelines are used to decide if a child can consent to contraceptive or sexual health advice and treatment.

Staff gained consent from children, young people and their families for their care and treatment in line with legislation and guidance. We observed three consultations where consent was gained from children, young people and their families for examinations they were about to undertake.

Mental health assessments were carried out and patients were referred to a psychologist within HCA or their GP, as appropriate. Consultants could also link in with other services across the HCA network.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Good

Services for children & young people

Staff were discreet and responsive when caring for children, young people and their families. Consultants and the paediatric nurse took time to interact with patients and their carers/guardians in a gentle, respectful and considerate way. We observed several very positive interactions between staff, patients and their carers/guardians which demonstrated kindness and patience.

Staff followed policy to keep patient care and treatment confidential. We observed discreet interactions that protected patient's personal information.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. The main touch points for paediatric patients and their families to receive emotional care was with their consultants. The service was committed to imparting empathy and caring when things were not going well. There were doctors with different specialisms who could provide different support systems.

Staff described how they approached difficult conversations with paediatric patients and their families, such as by ensuring they were in a private environment and offering time and space for questions. The paediatric nurse would employ calming methods and distraction techniques when paediatric patients became distressed.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. We observed members of staff who talked with a 6-year-old at an appropriate age-related level of understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We observed staff were proactive in engaging with patients about their experiences and frequently asked how they were doing.

Patients gave positive feedback about the service. Patient feedback from September to October 2022 showed that 94% of parents thought that their child received excellent or very good care whilst visiting the service. 97% of parents also felt that their child was given enough privacy during their consultation. 100% of children and young people using the service felt that their doctors and nurses were friendly and 94% stated that they would revisit the service again if they needed to.

The service provided information and support with payment of fees.

Good

Services for children & young people

Is the service responsive?

Good

Our rating for responsiveness stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. The Harley Street Clinic (THSC) business development managers and the chief operating officer (COO) had led on listening sessions with doctors and received consultant engagement in order to visualise a new service requirement. An example of this was illustrated in 2022, whereby a service pioneered in the NHS between a paediatric consultant and consultant breast surgeon, to offer a service to adolescent breast patients, was ceased in the NHS due to the Breast Surgeon retiring from the NHS. This created an opportunity to launch and offer this service at THSC.

The Harley Street Clinic chief nursing officer (CNO) met with all other HCA UK CNOs at monthly intervals and discussed with the peer CNO at a neighbouring women and children's hospital offering services for children, any learnings, governance issues and updates to best practice and service provision. Service level agreements were in place between the neighbouring hospital and The Harley Street Clinic to ensure service provision safely met the needs of patients.

Essential and regular activity reviews occurred to ensure any changes in demand were identified along with bi-monthly reviews of patient and parent feedback.

The Harley Street Clinic outpatients department appointed a substantive paediatric nurse following interview involvement and expert advice from a neighbouring women and children's hospital on the panel, and secured some rotational work for the new incumbent in another HCA hospital pre-assessment service to ensure regular opportunity to work alongside other paediatric nurses for professional collegiate peer support.

Consultants met with children and young people and their parents at the Devonshire Street Outpatient Department. A paediatric registered nurse was present for all planned consultations and was available directly for patient care as required when an examination was indicated, or a procedure was booked.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Waiting areas were bright, airy and well ventilated with comfortable seating. Waiting areas were equipped with fresh drinking water, tea, coffee and snacks. The waiting areas had toys and a play table for patients visiting the service.

Good

Services for children & young people

The waiting room facilities for children, young people and their families were at the time of our inspection being shared with adult patients. However, the waiting room facilities were currently under a design upgrade review with the intention of providing an age appropriate visually pleasing environment, enhancing privacy in the waiting rooms throughout the buildings at 13-19 Devonshire Street. Meetings had occurred in 2022 with a HCA designer to explore the potential for a much improved environment to be developed in 2023.

Design mood boards had been shared following discussion between the CNO, matron and estates management. Patient representation from the CYP population would be sought to provide feedback on the new plans when a full design was worked up and ready to be shared.

For young people transitioning into adulthood, there was no change in the environment or consultant, enabling a seamless transition into adult services. The only exception to this was for phlebotomy services. All adult bloods were taken at the same location as the consultation as opposed to another HCA hospital for CYP patients. All young adults were advised of this as part of their transition. For young adults with long-term conditions introductions were made ahead of any future appointments to the hospital's team of clinical nurse specialists or other staff members where indicated.

Patients could be supported with a hearing loop upon check-in and throughout their journey within the centre. The service had an agreement with language line which provided patients with access to translation services. The service had signs and notices in Arabic as the service had a large Arabic speaking patient population. The Hospital had an international relations team who looked after this demographic.

Where a paediatric nurse was no longer required, chaperones were available to all the service's patients.

Information outlining confidential help and support was accessible to young people across the Harley Street Clinic campus via the Young People Card, which had contact numbers for organisations such as: Childline, Mind, Hopeline UK, and the Samaritans.

Feedback from patients received and acted upon included comments identified that adolescent service users were not keen on completing patient feedback forms embellished with images that they did not relate to, such as jungle animals. The feedback form was currently being reviewed to see how the service could enhance their response rate with this patient cohort, which would be monitored via the hospital's patient experience committee.

Access and flow

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

From 1 January 2022 to 31 January 2022 the service experienced 108 did not arrive (DNAs) out of a total of 2,175 booked outpatient appointments for the period. Any DNAs were flagged as a safeguarding concern, and cancellations were flagged back to secretaries to rebook. The service had a DNA policy which also referenced the Safeguarding Policy with regards to how to manage DNAs.

The service was participating in waiting times audits and results showed good compliance.

The hospital did not have online booking capability for CYP services at the time of our inspection. The hospital was in the process of exploring the feasibility of implementing a robust online booking system for outpatient appointments.

Good

Services for children & young people

The hospital had implemented online registration for patients, therefore once a patient had an appointment booked, they were able to register online prior to their arrival at the facility making their experience more seamless. The system had been redesigned with the patient in mind, enabling patients to view and amend existing information, as well as add new information. It was accessible on all device types such as: mobile, desktop computer or tablet device. The patient could therefore complete their online registration at any point before their appointment.

Learning from complaints and concerns

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

Complaints were handled by the head of department. Learning from complaints were discussed with their teams during team meetings and huddles and were displayed on departmental quality boards. All actions as a result of a complaint were monitored at the weekly complaints meetings, attended by heads of departments and the lead complaints investigator.

All learning outcomes were shared and discussed via the Quarterly Clinical Operations Report (QCOR), the Monthly Board meeting, the Patient Experience Committee and the Medical Governance and Quality Committee. Sharing of learning to and from other HCA facilities also occurred at the Heads of Governance meeting monthly.

The service received 1 formal stage one complaint between 1 January 2022 and 31 December 2022. The complaint was received from a patient's mother regarding an appointment with a consultant, which lasted for only 5 minutes and not for the scheduled 20 minutes. The consultant had informed the patient that as the consultant's clinic was running late, they did not have time to review the patient, but had offered to call the patient back and book a follow-up appointment.

The key learning to come out of this complaint was that consultants should ensure paediatric patients and their families were communicated to effectively when their clinics were running late. Patients should also be given the opportunity to reschedule if they were not going to receive the full appointment they had attended for. Continuous monitoring of consultant outpatient practice and punctuality of the clinic was to be reviewed by managers in the outpatients department and addressed directly with the consultant, should this continue to recur.

The matron for the service shared with us that some of the lower level complaints related to fees not being made transparent in consultations. When we spoke with the patient access head and patient access officer who took payments in the Business Office, they told us one of the issues they were experiencing was that patients didn't always realise there was a shortfall to pay against what their insurance companies paid. We were told consultant's secretaries were only informing patients about the consultant's fees but not the hospital fees. The Business Development team were working on a consent form for patients to sign for any procedure they would need beforehand, which would have information about all costs, with the hopes that this would eliminate the current issue.

Is the service well-led?

Good

Our rating for well-led stayed the same. We rated it as good.

Good

Services for children & young people

Leadership

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

The service was overseen by a matron and a senior sister, who were also responsible for the adult outpatient service too. Within that structure, there was a paediatric nurse who reported to the matron. There was a hierarchy of reporting, with the matron reporting to the chief nursing officer. The matron would also meet regularly with the CEO.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The Harley Street Clinic's values were to be unique and individual; have kindness and compassion; to be honest, have integrity and fairness; and to be loyal, have respect and provide dignity.

The service's seven objectives fed into the corporate objectives of The Harley Street Clinic. These were: 'Exceptional People Exceptional Employer'; 'Partner with Outstanding Consultant Team'; 'Sustainable Business; Prove Our Value'; 'Routes to New Patients'; 'Seamless Patient Support'; 'Geographical Growth'. The service hoped to achieve the 'Exceptional People Exceptional Employer' objective through a number of different initiatives. These included: developing an exceptional standard of outpatient nursing knowledge and skills for the new paediatric nurse who was due to start on 6 February 2023; ensuring the daily huddle was relevant for paediatric services and that the information received was triangulated via that communication method rather than via email; and asking for regular input from the paediatric nurse as to how the service could improve and further develop their services for children and young people.

Strategic plans were initially discussed via the service's paediatric representative for the Medical Advisory Committee (MAC), who was also their MAC Chair. The representative was a consultant in ENT (ear nose and throat)/head and neck surgeon and professor of otorhinolaryngology. Potential development ideas and changes were worked up by The Harley Street Clinic business development lead, the chief operating officer (COO), the chief nursing officer (CNO) and service management heads of departments.

Culture

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

The culture in the service, was one which was positive and was demonstrated in the examples that we were given by staff working in all disciplines. The matron and senior sister told us they had an open-door policy for staff to be able to approach them about any matters concerning them and that they too could approach their managers about any matters concerning them.

Good

Services for children & young people

Staff described the service as having a culture of acting on feedback as well as a culture of quality improvement and wanting the service to be safer for patients. Nurses were described as working very closely together, with some nurses having worked in the service for 5-10 years.

(HSC) nursing staff completed “Living the HCA Way” as part of their annual mandatory training which incorporates specific modules on equality and diversity. On a daily basis, nursing staff advocate HCA values and behaviours to ensure that all CYP regardless of age, gender, ethnic background, culture, sexual orientation, or mental status have the right to their privacy and dignity being maintained at all times.

Governance

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

The matron attended several different meetings. There were quarterly meetings for: infection prevention control, resuscitation, health and safety, air and ventilation. All CYP related matters were integrated into the governance committee structure.

The matron would meet with the chief nursing officer monthly and provided a quality assurance report. Within that report, mandatory training and vacancies, staff performance concerns, service level problems were discussed, including any main incidents of the month and any general concerns for the department.

There were monthly complaints huddles where informal and formal complaints were discussed.

Department level financial performance was reviewed for all departments at monthly Department Financial Review (DFR) meetings held with the finance team and heads of department. These meetings covered cost management, including staffing and supplies, charging compliance and other operational and financial performance measures.

Department performance was presented to The Harley Street Clinic board, which was held monthly.

Management of risk, issues and performance

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

The service had one red, amber, green (RAG) rated risk on the risk register, owned by the matron for the service, which was closed off on 20 January 2023. The title of the risk was, ‘Missing Child Simulation’, described as a risk assessment to identify the risk of a missing child event. The hazards were noted as: 1. Suspected/actual missing child 2. The reputational damage and adverse publicity; 3. The loss of confidence from patients/clinical staff; and 4. A breach relevant Care Quality Commission (CQC) standards and Health Care Act 'Working Together to Safeguard Children'.

The controls that the service had in place to mitigate this, were: for all staff to be familiar with the missing child flowchart and how to activate an urgent response; for the flowchart to be discussed in regular team meetings, morning huddles and

for a copy to be placed in the nurse in charge folder for easy access; for access to departments/buildings to require security access; for all children/young persons to be accompanied by an adult when arriving to the department; a Corporate Management of Missing Child Policy that outlined the process on what staff need to do; and security systems in place (CCTV) that can be used to search for a missing person.

The matron attended a bi-monthly corporate risk management committee meeting, which had a standardised agenda for these meetings. The risk management committee meeting reviewed new risks that had been added to the risk register during the preceding two months; reviewed and monitored all extreme risks to ensure robust actions/mitigations were in place to manage/reduce the risk; received assurance that each department maintained its risks via the risk register module (Datix); considered and challenged risk prioritisation as provided by the risk owners including discussion of any perceived discrepancies; and championed and promoted highly-effective risk management practices, ensuring that the risk management process and culture was embedded throughout the facilities.

Information Management

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

The service had an Information Governance Policy, which was owned by the data protection officer (DPO) and chief information security officer and was due to be updated on 6 September 2024. All staff had to complete, as part of their induction, HCA's mandatory Data Protection and Security training, with existing staff refreshing their mandatory training on an annual basis.

The DPO monitored compliance with the Data Protection laws and provided advice to the information governance board (IGB) and all staff working across HCA.

Inappropriate sharing of personal data and security incidents were reported as an incident via the reporting system. Staff gave us examples of what constituted as a reportable incident, such as: the sharing of passwords; leaving personal data or confidential information unattended in public area; sending personal data to a third party in error and/or where there is no justification; and clicking on a link in a phishing email.

Engagement

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

Children, young people and their families were encouraged to fill out patient feedback forms following their visit. We saw an example of where a child had rated their experience with their consultant and their time spent in the reception area as "brilliant". We saw evidence of how the service would use the good or bad feedback it received to make improvements in the service.

Feedback that the service received from children, young people and their families was continually positive about the way staff treated and cared for them. Feedback comments ranged from 'staff going the extra mile' and 'their care and support exceeding their expectations'.

Good

Services for children & young people

Staff engagement data for children and young people's services was collated with outpatient data. Results showed that for October 2022, over 75% of staff felt that they received care, meaningful conversation, growth and support working in their departments. However, less than 55% of staff felt that there was adequate retention, belonging, communication and involvement working in their department. The matron told us when there had been several nursing vacancies, staff morale had dipped below normal levels but then improved when those vacancies were eventually backfilled.

The diversity and inclusion committee provided visible leadership on equality issues across the hospital. Its purpose was to help shape the future of the health system from an equality, diversity and inclusion perspective, and to improve the access, experiences, health outcomes and quality of care for all patients, service users and the workforce.

Learning, continuous improvement and innovation

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

The hospital was operating a 'Talent Beyond Boundaries' Programme where pre-registered nurses from Lebanon came over in June 2022, an initiative to give nurses in under-privileged areas a better quality of working and personal life. The matron informed us that two nurses had come over, with one having already completed their nursing and midwifery council (NMC) registration and receiving their PIN.

Critical care

Good

Outpatients

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

Is the service safe?

Good

We rated it as good.

Mandatory training

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

All clinical and non-clinical staff received and kept up to date with their mandatory training. Mandatory training included moving and handling, fire awareness and infection control and sepsis. All staff were trained in basic life support (BLS) and nurses and doctors were trained in immediate life support (ILS).

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. All staff completed level 2 learning disability and autism modules as part of their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff. At the time of our inspection 99% of staff were up to date with all mandatory training.

Staff told us there were learning pathways for each job role and core modules depending on what staff members roles were.

New starters were required to complete mandatory training within their three-month probationary period. They were given an induction booklet with a safeguarding flowchart, process flow charts, maps of the buildings, competencies that were required to be completed and information about where to find the resuscitation equipment. Each new starter was provided with a mentor to facilitate the induction process and provided the new starter with support.

Staff told us the new staff induction included mostly e-learning modules and some face to face learning such as basic life support (BLS) training.

The senior leadership team (SLT) monitored mandatory training compliance for consultants. Consultants had the option to complete their mandatory training over a full day or over a period of time.

Good

Outpatients

Managers monitored mandatory training and alerted staff when they needed to update their training. All staff had a learning profile allocated to them by the HCA UK Learning Academy. Regular reports of compliance with the completion of mandatory training were provided to line managers who took action to ensure staff were up to date.

Safeguarding

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

Nursing staff received training specific for their role on how to recognise and report abuse. All staff were trained in safeguarding at a level appropriate to their role. All clinical staff had safeguarding adults and children level 3 training as part of their mandatory training. The chief nursing officer and corporate safeguarding lead had completed safeguarding level 4. There was also a requirement for the named safeguarding doctor to complete safeguarding level 5 training, however this role was vacant at the time of our inspection. The named safeguarding doctor was not employed by HCA and was contracted to do this specialist role.

Safeguarding policies and procedures were in place. These were available electronically for staff to refer to and staff we spoke with knew how to access these. We saw the safeguarding adults at risk policy was version controlled and in date. There were also safeguarding flow charts visible in the staff offices that provided guidance to staff.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. The outpatient service had not reported any safeguarding concerns in the last year. However, staff we spoke with were aware of the process and how to report a safeguarding concern.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff told us if a safeguarding referral was made, the senior team audited adherence to the pathway and guidance.

The nurse in charge completed daily checks to identify any safeguarding flags on the electronic patient record system. They would alert the nursing staff or consultant for the particular clinic or procedure, to ensure they made any necessary adjustments.

There was a chaperone policy and we saw posters throughout the outpatient service advising patients how to access a chaperone should they wish to do so. Staff told us Arabic was the most common language other than English spoken by the patients attending the outpatient clinics, therefore the chaperone posters were also displayed in Arabic.

Cleanliness, infection control and hygiene

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

Clinical and non-clinical areas we visited were visibly clean and tidy. They had suitable furnishings which were clean and well-maintained. Clinical staff cleaned the consultation rooms at the beginning of the day and the house keeping cleaning team cleaned each room every evening. We saw the cleaning checklists had been completed.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All public areas had cleaning checklists which had been completed in full. We reviewed checklists from October to December 2022 and found them to be up to date.

The service generally performed well for cleanliness. The service completed hand hygiene and Infection prevention and control (IPC) principles and practice monthly audits. Between January and December 2022, monthly IPC audits found 99% compliance and monthly hand hygiene audits reported 100% compliance.

There were policies and protocols in place for the prevention and control of infection. Staff followed infection control principles including the use of personal protective equipment (PPE). We saw all staff adhered to "bare below the elbow" guidelines. Hand sanitisers were located at reception and around the service. There were hand washing facilities including hand washing basins, hand wash and hand sanitiser and we observed staff being compliant with the recommended hand hygiene practices.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment we checked had an 'I'm Clean' label attached and was visibly clean.

There were disposable curtains in all treatment and consulting rooms with a date on when they were put up. The curtains were changed every 6 months in the consultation rooms and 3 months in the treatment rooms. All the curtains we checked were in date.

The infection prevention and control (IPC) committee was held quarterly and reviewed the previous quarter's departmental exception reports, data, surveillance, audits and progress on the IPC annual plan.

Environment and equipment

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

Consultation rooms were fitted with call bells. The nature of the service meant it would be rare for a patient to be left alone and needed to use the call bell. However, we were told that the system was maintained as a best practice safety measure. There were also emergency call bells in every toilet, however one toilet we observed did not have a reachable call bell. Therefore, in the event of an emergency the patient would not have been able to call for assistance.

Each consultation and treatment room we visited had an electronic heating and cooling system to ensure the rooms were at a comfortable temperature. Consulting rooms were all equipped with examination beds and individual medical consumable storage trolleys.

Patient waiting areas were clean and had enough seating for patients and relatives to meet the needs of those attending the clinic. The seating was wipeable to reduce the risk of cross infection.

Staff carried out daily safety checks of specialist equipment. Emergency resuscitation equipment was in place in all areas we saw and followed national resuscitation guidelines. Trolleys we reviewed were checked on a daily and weekly basis. Staff carried out resuscitation trolley audits for September 2022 and October 2022 which showed all equipment was in date and all expired items had been removed and replaced.

The service completed environmental, health and safety audits. The audit from January 2022 to December 2022 was 98% compliant.

We saw risk assessments completed for Control of Substances Hazardous to Health (COSHH). These were for all clinical departments and was next due a review in December 2023. There were no recommendations and concluded risks were reduced to an acceptable level.

Across all outpatient departments there were mandatory daily checks for all consulting and treatment rooms. These included checking that clinical equipment had an in date biomed check label and appropriate stock levels of PPE. All checklists were completed and scanned to the provider's shared G Drive for auditing purposes.

All patients were required to confirm their appointment at the building's main reception desk. They were then directed and or if they required assistance were escorted to the appropriate clinic by one of the provider's porters.

Equipment servicing was conducted annually by certified engineers contracted by HCA. Failed items were labelled 'do not use' and rendered unusable, once an item had been checked and was fit for use a dated label was added showing the date the check was completed. The Portable appliance testing (PAT) records were stored by the estates department in their compliance system.

All new equipment brought onsite between the annual visits was tested and labelled by the trained estates engineers. The maintenance service log for PAT tested equipment indicated the last date the equipment was PAT tested.

Fire risk assessments were completed by a certified external assessor every 24 months for each location and all areas of the service. We saw fire risk assessments for the outpatient service which were all up to date.

Legionella risk assessments of the water system were completed by a certified external assessor every 24 months for each location. The last legionella risk assessment we reviewed for one of the locations was undertaken in August 2022 and showed the work that was completed to ensure the water system was compliant with water supply regulations.

Staff disposed of clinical waste safely. 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 every three months or immediately when full. The service completed quarterly sharps and waste handling audits which showed 100% compliance.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient's health. The nature of the service meant this was a rare occurrence and staff-maintained training to ensure they were prepared.

The department had a range of appropriate emergency equipment readily available. The outpatients service had a service level agreement (SLA) with a local NHS hospital and transfer policy. The service had an SLA with another hospital for patients with a suspected stroke. All other patients would be transferred to the nearest NHS hospital. Staff we spoke with knew the emergency process outlined in the SLA.

Staff told us a risk assessment was completed for each patient at the start of each consultation using a recognised tool and this was reviewed regularly. Staff told us the consultant would also complete a mental health assessment if required.

Staff used a World Health Organisation (WHO) safety checklist and were 99% compliant in the WHO checklist audit.

All staff were trained as chaperones and this could be requested, by the patient at short notice. The service completed monthly audits for chaperone documentation. Between January 2022 and December 2022, the service achieved 100% compliance.

Staff shared key information to keep patients safe. The outpatient service ensured patients saw a named clinician at a pre-planned time. Patient notes were scanned onto the electronic system and could be accessed by the wards and other departments where required.

Staffing

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

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants (HCAs) needed for each shift. Staff told us there were adequate staffing levels to enable the clinics to run effectively.

HCA Healthcare had a planning and scheduling tool to calculate the staffing rotas based on a forecast. The staffing rotas were planned in advance and staffing levels were also monitored on a daily basis by the senior clinical staff or matron to ensure staffing levels met the service's needs.

The Harley Street Clinic outpatients' department had a team of adult registered nurses and healthcare assistants who regularly worked on the staff bank to provide cover for staff sickness and any other absence. The outpatient department did not currently use agency staff for the adult nursing service. We saw a bank and agency induction checklist which would be completed prior to any bank or agency staff member starting their first shift in the service.

The service had some staffing vacancies at the time of our inspection. This included 1 gynaecology clinical nurse specialist, and a specialist sister/charge nurse post. The service was in the process of interviewing to fill the specialist sister/charge nurse post. The service had recently recruited a senior staff nurse and two staff nurses to fill vacancies.

Medical staffing

The service had enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough medical staff to keep patients safe. There were approximately 1200 consultants with practising privileges across the whole of the service. The turnover for doctors leaving the service was low.

Good

Outpatients

We saw the practising privileges policy which was in date and version controlled. Practising privileges were processed centrally by HCA with the CEO and the medical advisory committee (MAC) providing approval of practising privileges, oversight and reviewing all practising privileges annually.

Consultant availability was driven by demand and planned according to the timeslot's consultants were available.

Records

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

Patient notes were comprehensive and all staff could access them easily. We reviewed 5 sets of patient records in the outpatient's department. Patient records were both paper and electronic. The patient records we reviewed had the relevant information within them.

Paper patient notes were completed by the consultant during the consultation. Managers told us it was the consultant's responsibility to remove the patient's consultation notes from the consultation room and give this to the secretary to scan onto the system. During our inspection, the electronic system was secure, and only authorised staff members could access the system with their staff logins.

Patient notes were generally kept securely in locked cupboards. However, during our inspection, we found a box of patient notes (3 ring binders) stored in an unlocked cupboard in an unlocked consultation room. Managers removed the box of patient notes from the consultation room and raised an incident.

When patients transferred to a new team, there were no delays in staff accessing their records. Staff used an electronic patient records system that could be accessed at any of the provider's sites. This enabled staff to readily access consultation and treatment notes at any time. This also enabled authorised clinicians to access records where care and treatment plans were shared or transferred.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Very few medicines were stocked in the outpatient areas and those available were stored in locked cupboards. The keys were held by the nurse in charge. All medicines we saw were in date.

There were no controlled drugs (CDs) kept or administered in outpatients.

We saw temperature checks for the fridges were completed daily. The completed fridge temperature checks showed that the fridge was within the required temperature range.

Staff stored and managed all medicines safely. Medication audits were undertaken by the pharmacist, these showed minimal drug errors and staff were trained in medicines administration.

Incidents

Good

Outpatients

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

We reviewed the corporate Incident and serious incident management policy. This was in date and version controlled. The policy included incident management, serious incidents, never events and the support available to staff involved in an incident.

Staff raised concerns and reported incidents in line with the service's policy. They knew what incidents to report and how to report them. Staff could give examples of incidents they would report and how they would do this. All staff we spoke with were confident in reporting incidents. Managers told us incident reporting including how to complete the incident reporting system had been included in the new starter training and induction.

The provider had not reported any never events in the last year. Senior staff maintained a policy for sharing information and learning in the event of a never event or serious incident occurring

Between January 2022 and December 2022, the service had reported a total of 155 incidents, 148 of which were no harm, 6 low harm and 1 moderate harm. A review of these incidents by the service identified that some patients had duplicate patient numbers. No harm had been caused by this but the importance of staff registering patients onto the system and the need to double check all the systems using the 3-point checking of the patients was highlighted to ensure a duplicate patient number was not created.

Staff understood the duty of candour. Staff could explain to us the duty of candour process when we requested them to.

Staff received feedback from the investigation of incidents, both internal and external to the service. We saw evidence of this in the staff meeting minutes we reviewed, which included reviewing incident reports and sharing the lessons learnt or areas identified for improvement. Information about incidents was also shared in monthly governance meetings. Managers told us they shared information about incidents across sites to facilitate learning.

Staff learned from safety alerts and incidents to improve practice. Managers told us safety alerts learning from incidents were sent from the senior team to all managers. This information was shared with staff in the morning team huddles and monthly meetings. It was also visible on the quality boards.

Is the service effective?

Inspected but not rated

We do not currently rate effective in outpatient services. However, we found:

Evidence-based care and treatment

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

Good

Outpatients

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. A monthly quality and effectiveness bulletin was sent by the corporate governance team to all staff via email to keep staff up to date with national guidance, including NICE. All staff also had access to the policy library on the HCA portal to ensure they were up to date with recent local guidance. Staff told us there were regular updates to policies and guidance. The revised policies or guidance's were shared with teams via email.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff told us mandatory training included mental health training to ensure staff had the necessary skills and knowledge to complete a mental capacity assessment when necessary. Staff we spoke with knew how to refer patients who needed mental health support and how to contact the support services i.e. psychologist.

Nutrition and hydration

Staff gave patients enough food and drink.

Staff told us that patients were not generally offered food as they were only in the department for a short period of time. However, those patients whose procedure lasted longer than 3 hours, would be offered food.

Patients were offered coffee, tea and biscuits before their appointment. In every waiting area we saw coffee and tea making facilities were available.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff told us outpatient patients did not routinely require pain relief. As part of the general care provided by the consultant, an assessment would be completed prior to the patient's procedure, to decide whether pain relief was required. Where pain relief was required, paracetamol and local anaesthetic were available in the treatment rooms.

Staff prescribed, administered and recorded pain relief accurately. Staff told us only the consultants would prescribe, administer and record pain relief.

Patient outcomes

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

The outpatient department did not currently participate in any national outpatient audits. However, they participated in several of the provider's audits including nursing record keeping, transportation of specimens and WHO documentation checklist.

Managers and staff carried out a comprehensive programme of repeat audits to check improvement over time. In August 2022 a new audit reporting tool and interactive audit dashboard was launched. Each month, every department

received their audit results and a summary of any areas of non-compliance. This enabled staff to identify any areas for improvement and they reported the actions to be taken to address non-compliance. Audit results, actions required, and learning were shared by heads of department with staff at team meetings and displayed on departmental quality boards.

Managers used audit results to improve care and treatment. Actions required and learning from the audit programme were discussed and shared at The Harley Street Clinic clinical audit and effectiveness committee. This committee reported into the corporate HCA clinical audit and effectiveness committee. This enabled learning to be shared across the organisation.

Managers and staff used patient feedback to improve patients' outcomes and experience. The service obtained patient feedback which was collated into a monthly report and shared with staff. The service aimed to implement any suggestions from patients for example patients had requested clinical bins to be placed in the bathrooms in the urology area. This had been actioned by the service.

The Harley Street Clinic endometriosis centre was accredited by the British Society of Gynaecological Endoscopy (BSGE). We were told that they held this accreditation since 2018 and were one of eight centres in London that held this accreditation.

Competent staff

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

Managers gave all new staff a full induction tailored to their role before they started work. We saw the staff induction handbook. The induction handbook included information about the department, useful contacts and operational information. All new staff were supernumerary for the first two weeks, were expected to achieve set competencies relevant to their role and allocated a buddy to provide support. Competencies were signed off as being achieved.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers and staff told us performance and practice were assessed during their one to ones, at mid-year reviews and end of year appraisal. Staff told us they participated in regular appraisals and used this process to establish goals for the rest of the year and it was motivational.

The matron oversaw all the appraisals and received an automated notification to inform them a mid-year review or appraisal was required. The staff member would then be alerted and required to complete their self-assessment, and this would go to the manager to be discussed at their appraisal. We saw evidence that the appraisal completion rate for outpatients' staff was 100%.

We were told that consultants had an annual review with the senior leadership team (SLT). At this meeting the consultants working under practising privileges reviewed with SLT any incidents and complaints that had been made against them and their completion of mandatory training was also reviewed.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Team meetings occurred every week and included information about any incidents, patient feedback and upcoming training. Staff told us daily morning huddles occurred in the outpatient department. At which they were advised who the nurse in charge was and who had each bleep.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke with confirmed they were encouraged to undertake continual professional development and were given opportunities and supported to develop their skills and knowledge. They told us they were encouraged to identify training opportunities and present these to the senior team for consideration. Senior staff were focused on staff development as part of a strategy to maintain stability and staff retention amongst the team.

Staff told us they had identified study days they wanted to attend and had been supported to do so.Managers told us internal and external study days were available for all staff. For example, there was an internal tissue viability study day. Staff told us every Thursday there was an opportunity to complete training or attend a governance meeting.

Managers made sure staff received any specialist training for their role. We saw staff had completed dermatology courses and a senior staff nurse was due to complete an institute of leadership and management (ILM) level 3 accredited qualification in leadership and management. Information obtained from these courses was shared with the wider team during teaching sessions.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us there was a formal process for managing poor staff performance which included support from a dedicated human resources team. This included meetings being held with the individual staff member who were not performing to the required standard and an action plan would be put in place to facilitate the staff member to improve, which had a clear review date. We were told any poor staff performance within their probationary period would be managed by holding a review meeting and their probationary period may be extended.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. The Harley Street Clinic had an MDT meeting infrastructure in place and MDT's were managed in line with the HCA corporate MDT policy. Staff worked across health care disciplines to care for patients. Decisions regarding patient care were made by a group of specialist clinicians during these meetings which included referring for surgery and or intervention or management on a treatment pathway as appropriate. The Harley Street Clinic (THSC) endometriosis centre held regular MDTs twice a month to discuss complex cases and a database of the cases discussed was maintained.

Staff referred patients for mental health assessments when they showed signs of mental ill health, including depression. Mental health assessments were completed by medical staff and a referral was made to the psychologist if necessary.

Seven-day services

The service was available Monday to Friday 8am to 8pm. Consultants worked from 8am until 8pm Monday to Friday and 9am until 5pm on weekends. The service did not operate out of these hours and did not have an on-call service.

From September 2022 the service had been offering a Saturday service between 9am to 5pm for consultations, walk-in or post consultation bloods and dressing changes.

Health promotion

Good

Outpatients

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

The service had relevant information promoting healthy lifestyles and support in patient areas, which were available on request in other languages. We saw health promotion posters around the patient reception areas we visited. These posters had a QR code to easily access this information. The posters included information about losing weight, optimising nutrition and getting active.

Staff assessed each patient's health at every appointment and provided support for any individual needs to live a healthier lifestyle. We were told consultants ensured health promotion was provided to all patients during their consultations and any further referrals were made regarding smoking cessation, obesity, diet and exercise.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Where patients did not understand information given or asked about care and treatment, or they demonstrated reduced capacity to consent, staff carried out a mental health assessment.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff worked in line with the provider's overarching corporate consent and capacity to consent to treatment policy. The policy was in date and version controlled, it included information about the types of consent, the consent process and the withdrawal of consent.

Staff made sure patients consented to treatment based on all the information available. They clearly recorded consent in the patient's records. We reviewed 5 sets of patient records in the outpatient's department, we could not see the consent forms in the files. However, we were told the consent forms had been completed but had not been uploaded to the system.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of our inspection 100% of staff were compliant with this training. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and they knew who to contact for advice.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Good

Outpatients

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff's interactions with patients and found them to be polite, friendly and helpful. The porters were visible and available to assist patients and their families during their time at the service.

Patients said staff treated them well and with kindness. 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. The patients we spoke with were positive about the way staff looked after them.

Staff followed policy to keep patient care and treatment confidential. 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.

Staff understood and respected the individual needs of each patient and showed an understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. The department did not provide a dedicated mental health service and staff referred patients to other specialists and services when needed.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. For example, staff recognised the different communication needs of people based on their age and culture and delivered care accordingly.

The 10 patients we spoke with were satisfied with the overall experience of visiting the outpatient service.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff considered the needs of patients and this was reflected in the care that was delivered. We observed staff were reassuring and comforting to patients.

We observed staff supporting a patient who became distressed in an open environment and helped them maintain their privacy and dignity. Staff told us how they provided practical and emotional support to patients when required. Staff described how they would approach difficult conversations with patients, such as by ensuring they were in a private environment and offering time and space for questions.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff we spoke with stressed the importance of treating patients as individuals with different needs and accommodating those needs.

Understanding and involvement of patients and those close to them

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

Good

Outpatients

Staff made sure patients and those close to them understood their care and treatment. The nature of the service meant patients were attending for an outpatient appointment and would rarely require admission for other procedures.

Staff spoke with patients, families and carers in a way they could understand. 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 and their families could give feedback on the service and their treatment and staff supported them to do this. Staff encouraged each patient to complete a feedback form online following their appointment. Patient feedback forms were located also in all the waiting areas we observed. We did not see patient feedback forms were in any other languages.

The outpatient's senior sister acknowledged there were lower return rates 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 gaining feedback on electrical tablet devices.

Patients gave positive feedback about the service. We observed staff were proactive in engaging with patients about their experiences and frequently asked how they were doing. In the December 2022 the patient satisfaction survey indicated 92% of patients said they were treated with care and compassion.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of people accessing the service. Staff demonstrated a good understanding of patients who used the service. Staff told us the consultant's secretary would assess if language translation services were required when booking patient appointments.

Facilities and premises were appropriate for the services being delivered. We saw there was disability access at the outpatient locations. Lift access was available at all sites and larger lifts were also in place for bariatric patients or patients using a wheelchair.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff told us if patients required wheelchair access, their appointments would be scheduled on the ground floor to ensure ease of access.

There was no specific provision made for bariatric patients such as bariatric wheelchairs and seating in waiting areas. Staff told us that arrangements would be made for individual patients to meet their individual requirements, such as the consultant seeing the patients on the ground floor.

Managers monitored and took action to minimise missed appointments. The service called the patient 24 hours before their scheduled appointment to confirm their appointment. Staff told us patients would be charged a fee if the patient did not attend their appointment and or if they did not cancel within 24 hours of their appointment.

Managers ensured that patients who did not attend appointments were contacted in line with the 'did not arrive' (DNA) policy. Staff we spoke with understood the process and explained patients who did not attend their appointment would be contacted by the specific team's secretary or personal assistant.

Missed appointments data was presented at monthly staff meetings and each case reviewed to ensure there were no safeguarding concerns or serious clinical implications. Staff told us if there were safeguarding concerns then a safeguarding referral would be taken according to the safeguarding policy. If there were clinical implications action such as rebooking the appointment would be taken. The service was flexible, and staff planned appointments on patients' wishes.

The service did not have an online booking system for outpatient appointments. HCA Healthcare UK were exploring this option. There was an online registration form for patients to complete prior to attending their appointment. From August 2022 patients had been able to register online prior to their arrival at the facility. Patients without IT access were not required to complete the online registration form, they could attend for their appointment as normal and inform the receptionist.

The service relieved pressure on other departments when they could treat patients as a day case. Staff told us they would accommodate, as far as possible, any additional procedures where they had the required skills, equipment and capacity.

Meeting people's individual needs

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

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. We saw there were hearing loops at all reception desks and in clinical areas. There was clear signage in each reception area across the service to identify hearing loops were available. Some of the hearing loops were built into the reception counters and some were portable to allow them to be moved to clinical areas where necessary. Staff told us reception staff were trained to use the hearing loops.

Staff told us although they rarely treated patients living with dementia and learning disabilities, this would be flagged prior to the appointment and communication aids would be used to support the patients. The service completed mandatory training for learning disability and autism training level 1 which had 100% compliance.

The service had information leaflets available in Arabic, the second most commonly spoken language by their patients other than English. This assisted in tailoring care to meet the ongoing needs of the Arabic patients attending the service.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us language translation services were available for all patients and the need for this service was identified during the booking stage.

Good

Outpatients

The service had access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. Staff told us they were able to refer patients to psychologists that worked within HCA. They also told us consultants were able to link in with other services across the whole network to ensure the patient's needs were met.

Access and flow

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

In 2022 the service had developed a one stop gynaecology service which guaranteed no waiting times for appointments with specialists. The service's focus was on a holistic approach to assessing, planning and delivering care and treatment to gynaecology patients. This service enabled patients to quickly access the care and treatment they needed, accessing a range of services including MRI and ultrasound at one location and frequently within a single visit.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes. 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. Patients we spoke with told us waiting times were minimal.

When patients had their appointments cancelled by the provider at the last minute, managers made sure they were rearranged as soon as possible. If the patient could no longer attend their appointment, the service would rebook the appointment for a later date. If a patient cancelled their appointment, the service would make every attempt to fill that appointment slot with another patient to fully utilise the service's capacity and reduce waiting times for those patients willing to attend at short notice.

Managers and staff worked to make sure patients did not stay longer than they needed to. Nurses assisted to streamline the flow of patients. If patients did not require any further follow up, this was explained to the patient.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with told us they knew how to make a complaint if needed. The service clearly displayed information about how to raise a concern in patient areas. The patient waiting areas had "A patient's guide to making a complaint" which was clear, concise and easy to follow.

We saw the patient complaints policy which was in date and version controlled. Staff understood the policy on complaints and knew how to handle them. Initial complaints were handled informally by staff in the outpatient service in an attempt to resolve issues locally. However, if this was unsuccessful staff escalated it to the governance team who would then start the formal complaints process. We saw evidence that all formal complaints were logged, and action was taken in a timely manner. Staff logged verbal complaints by completing the standard complaint's form. Verbal complaints were managed in the same way as written complaints.

Good

Outpatients

Managers investigated complaints and identified themes. The outpatients service received 14 formal stage 1 complaints between January 2022 and December 2022. The outpatients service received 2 formal stage 2 complaints which were referred to HCA's President/CEO for internal review and resolution. The outpatients service did not receive any stage 3 complaints.

The service looked at key learning and trends and themes from complaints. Themes identified from complaints included rushed clinics and patients leaving with unanswered questions. Managers told us specific doctors were named. To mitigate any further complaints the management team discussed these concerns with the consultants.

The service implemented changes as a result of complaints, for example they received some complaints regarding transparency of the cost for blood tests. The service made improvements by including prices being shown on blood test request forms.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint was concluded. When a formal complaint was received, managers would contact the patient within 72 hours (three working days) and offered either a face-to-face meeting or a video call. Managers told us they would attempt to resolve complaints at the informal stage. If this did not resolve the concerns, an acknowledgement letter would be sent to the patient within three working days. The head of department would review all the information and investigate the concerns. This included obtaining witness statements and undertaking a comprehensive review of the issues raised. A formal response would be sent to the patient within 20 days of receiving the complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Details of complaints were discussed with staff in monthly team meetings. We saw minutes of meetings that demonstrated learning from complaints had taken place; and action had been taken to address the issues in a timely manner.

All learning outcomes from complaints were shared and discussed via the quarterly clinical operations report (QCOR), the monthly board meeting, the patient experience committee and the medical governance and quality committee. Progress against learning was monitored in future meetings.

Is the service well-led?

Good

Our rating of well-led went down. We rated it as good.

Leadership

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

The service had a clear leadership structure. The outpatient service manager, an experienced nurse, oversaw the day to day running of the service. The outpatient service manager reported to the chief nursing officer. Senior provider-wide leaders were frequent visitors to the sites and were easily accessible to local staff.

The leadership structure meant staff felt well supported. All staff we spoke with told us that the CEO and other executive members did regular walk rounds and were very approachable. All staff we spoke with were positive regarding their local managers and the CEO. Staff told us the local and service wide leadership had rapport with staff members. Staff told us the senior leadership team (SLT) were open to feedback and involved staff in decision making. Staff said there was an open culture to feedback, and they felt valued in their role.

Staff were encouraged to develop their skills and progress to more senior roles. Leadership training was available and encouraged for staff to develop their skills and progress within the service.

Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture.

Vision and Strategy

The service had a vision for what it wanted to achieve and an overall strategy to turn it into action.

The service had a vision for what it wanted to achieve and a strategy to turn it into action developed with all staff and was embedded into the service's culture. All outpatient areas we visited had a clear service wide vision, which was to create one seamless system by working together as one team and living their values, being committed to the care and improvement of human life. All staff we spoke with were aware of their local and service wide vision.

The strategic objectives for all services originated from the overall HCA Healthcare UK Plan of 'One HCA'. Underpinning that the strategic objectives were supported by measurable outcomes which were reviewed at departmental and board meetings. These had been developed around 7 pillars of service, there were exceptional people, exceptional employer, partnering with outstanding consultant teams, proving our value, sustainable business, routes to new patients, seamless patient support and geographical growth.

Culture

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

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures we saw positively supported this process. 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 and action would be taken.

Staff told us there was an open, transparent culture where the emphasis was on the quality of care delivered to patients. 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 service as a whole.

Staff told us morale was at its highest and they felt they were financially rewarded for their hard work. There was a financial incentive to meet yearly objectives and a regular pay review.

Staff told us equality and diversity training was part of their mandatory training. The service had a diversity and inclusion committee. Its purpose was to help shape the future of the health system from an equality, diversity and inclusion perspective, and to improve the access, experiences, health outcomes and quality of care for all patients and the workforce.

The service had a corporate health, safety and wellbeing policy. The policy included information about the occupational health and safety management system, risk assessments and training and development.

Governance

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

There were effective structures, processes and systems of accountability to support the delivery of good quality and sustainable services. In January 2023 the governance committee structure was reviewed, and the medical governance committee and patient safety and quality committee were amalgamated to form a monthly medical governance and quality committee. The medical governance and quality committee first met in January 2023 and was attended by senior staff members, service leads and service managers. The meeting included discussions of patient safety, risk management, clinical effectiveness and patient experience. It was planned this meeting would be held monthly.

Oversight of mandatory training compliance was monitored at complaints, litigation, incidents and patient experience (CLIP), medical governance and quality committee, and escalated to the monthly board meetings, and via the quarterly clinical operations report (QCOR).

There were monthly meetings with the matrons and the senior nursing officer (SNO) to discuss quality assurance reports, mandatory training, staff vacancies and performance, service level problems and the main incidents of the month.

We saw a monthly WHO documentation checklist from January 2022 to December 2022 which had an average of 99% compliance.

Management of risk, issues and performance

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

We saw the risk management strategy included information on how to prevent risk and identify risk to patient safety. The strategy included risk management priorities for the period 2022 – 2025. These priorities included developing a risk trajectory tool for extreme risk, enhancing the risk register ensuring transparency across the division and reviewing and improving the risk escalation process to the quality and safety board.

The risk management committee convened bi-monthly. The purpose of the risk management committee was to provide oversight across the facilities for all categories of risk in order to ensure processes were in place to identify, assess and manage significant risks. The standardised agenda included reviewing the risk register summary report, reviewing new risks that had been added and discussing top risks identified.

Good

Outpatients

Information Management

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

There was an information and data management policy in place which aligned with legislation and supported staff to manage information and data safely.

There was a clear strategy to improve integration and utilisation of IT software systems. Implementation of the IT strategy was monitored at board level. Staff we spoke with were complimentary of the IT systems. Staff could easily access the IT systems and upload and retrieve information when required.

Information governance training formed part of the mandatory training programme for the service, and staff we spoke with were able to discuss their responsibilities in relation to information management. Data protection and security audits across all outpatient departments were regularly undertaken.

The service had an information governance policy which was implemented by HCA Healthcare UK. The policy included information on their governance framework and the roles and responsibilities of those involved in the governance processes.

Engagement

Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

Managers told us the CEO held monthly meeting called the “Town Hall” where all staff were welcome to attend and raise any concerns directly with him. If staff were unable to join in person, they were able to join remotely via a computer link.

Staff told us they could approach and talk to the CEO or other executive members at any time. The senior team had an open-door policy where they could feedback issues and they were confident action would be taken. Staff told us there was a CEO inbox called “Ask Will” which allowed staff to put comments to the CEO via email.

Staff said they felt involved in the service and appreciated the regular communication that occurred across teams and with managers.

Managers told us that patient feedback questionnaire return rates were lower than they would like. To facilitate increased feedback there were plans to introduce electronic tablet devices for patients to use to complete the feedback forms while in the outpatient department.

Staff surveys were completed twice a year, in May and October. We saw the staff surveys were positive and managers collated the information for their area and disseminated the feedback among their teams. Action plans were developed to address the staff survey feedback results and make improvements. For example, following feedback about the number of nursing vacancies, seven nursing vacancies were filled by the matron over the past year which had resulted in improved morale.

Learning, continuous improvement and innovation

Good

Outpatients

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

Staff told us there was a quality improvement culture in which the service aimed to make the care they provided safer for patients and also assist in the retention of staff. We were told about several corporate projects which were underway or planned for the future. Projects included the new employee recognition programme called “Because of You”, launched in January 2022 to show appreciation to colleagues incorporating the services values. To increase awareness of this initiative it was publicised in the corporate and local induction. Colleagues nominated other colleagues who had delivered exceptional customer service. Nominated staff names were published in the dedicated Because of You weekly bulletin. Each week up to 10 nominated colleagues would receive points. These points translated into vouchers which could be spent at high street shops.

We saw multiple corporate projects were planned or currently in place which included Project X to streamline processes and make them more efficient. For example, to eliminate billing complaints from patients.

Good

Diagnostic imaging

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

Is the service safe?

Good

This is the first time we rated safe at this service. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. We reviewed evidence of mandatory training records provided by the provider. We found all diagnostic imaging staff groups were above the mandatory training target for 85% compliance.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training modules provided to staff included intermediate life support training for all clinical diagnostic imaging staff groups, safeguarding adults levels two and three, safeguarding children levels one, two and three, Equality and Diversity, Fire Safety, and learning disability and autism training level one. Mandatory training was a combination of online and face to face training.

Managers monitored mandatory training completion though supervision and the online training system, and alerted staff when they needed to update their training. Staff stated they were informed by managers when they needed to undertake or update their mandatory training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. All staff had received safeguarding level three training for adults and safeguarding level two and three for children. They also had access to staff who were trained to level four safeguarding children. The service had a safeguarding policy which was up to date and reflected the best practice and all required national guidance.

Good

Diagnostic imaging

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of when they would need to raise a safeguarding concern and what specific issues they may need to look out for, such as child abuse, domestic violence, and female genital mutilation (FGM)). The service had a section within its safeguarding policies relating to FGM, and what procedures to undertake if this was identified. Staff we spoke with were able to tell us how to make a safeguarding referral and who to inform if they had concerns.

The provider had a up to date and in date chaperone policy, which staff were able to tell us about.

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

Staff followed safe procedures for children visiting the diagnostic imaging service. Children were accompanied by a parent or carer and the parent or carer were able to wait with the child for their scan. Parents and carers were also able to accompany their child into the scan room and left when radiation was present.

Cleanliness, infection control and hygiene

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

Clinical areas were visibly clean and had suitable furnishings which were visibly clean and well-maintained. The communal patient and staff areas as well as clinical rooms in diagnostic imaging areas we visited were visibly clean. Patient changing areas were cleaned between patients and were free of dust. There were clean gowns for patients to use when changing.

The service generally performed well in audits for cleanliness. The diagnostic imaging service provided evidence of their completion of a monthly divisional infection prevention and control (IPC) assurance cleaning audits. We reviewed audits undertaken between August 2022 and February 2023, and found the service consistently met over 97% compliance. The audit included standards for environmental cleanliness, decontamination, waste management, and staff practice. Where the audit identified standards were not met, the audit tool included an evidence of area not met column and an action plan to be completed to improve practice within agreed deadlines.

Radiographers were responsible for the cleaning of the diagnostic equipment. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. IPC audits included assurance sections on equipment decontamination, and staff ensured that clinical equipment was appropriately cleaned between uses.

Each clinical area had foot operated clinical waste bins, sharps bins present were visibly clean, not over filled and secure.

Ultrasound probes were cleaned in line with best practice, however, the cleaning process was not documented and audited.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed cleaning logs on site which showed that cleaning was completed with daily and weekly checklists.

Good

Diagnostic imaging

Staff followed infection control principles including the use of personal protective equipment (PPE). All clinical staff we saw on inspection were bare below the elbows and washed or sanitised their hands between patient contacts. Hand sanitiser was available for staff and patients throughout the diagnostic imaging service.

Environment and equipment

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

The environment design and layout of the various diagnostic imaging rooms followed national guidance. The layout of communal and clinical areas was in line with NHS England Health building notes guidance. Diagnostic imaging rooms had appropriate space for examination and scanning, and reception and communal areas were appropriate for patients and other visitors waiting for appointments.

Staff carried out daily safety checks of specialist equipment. The service-maintained equipment maintenance logs to monitor when diagnostic imaging equipment was last maintained and calibrated. On inspection we observed that imaging equipment was within its period of maintenance date. In MRI and CT there were contingency plans if equipment was faulty or not operational.

The service had enough suitable equipment to help them to safely care for patients which was serviced and maintained in line with manufacturer's requirements. There was evidence resuscitation equipment had been daily safety checked and was subject to monitoring.

Each modality had separate clinical rooms where the different diagnostic tests would be taken. Each room contained different diagnostic equipment, for example MRI scanner, CT scanner, ultrasound and X-ray. These rooms were well organised. The clinical rooms allowed private conversations to take place.

Some of the imaging equipment was more than ten years old. The service had an equipment replacement programme for the older equipment in the whole diagnostic imaging service and was planned to be completed within the next year.

Clinical areas that had medical equipment had measures in place for their safe use, in line with legal requirements and best practice for equipment safety. There was clear signage showing where equipment may be a risk to patients, and when that equipment was in use.

Lead aprons were available for use when required, these aprons were used to protect staff against radiation exposure. The aprons were well maintained and in good condition. We saw evidence that the aprons were scanned annually to check that they were undamaged and still offered full protection.

Staff disposed of clinical waste safely. Clinical waste bins had signage that indicated what was to be disposed of in them and staff we spoke with understood the process.

The diagnostic imaging service completed an annual personal dosimetry audit to ensure that employees were not exceeding annual dose limits of ionising radiation. All staff working with ionising radiation were issued with dosimeters to ensure compliance with Ionising Radiation Regulations 2017.

Good

Diagnostic imaging

MRI equipment was labelled in line with the Medicines and Healthcare products Regulatory Agency (MHRA) safety guidelines for MRI equipment in clinical use. This included clearly displaying information where items and equipment were safe or unsafe for use with MRI equipment.

The MRI areas displayed information showing the limit of the "5 Gauss line" and it was clear from the evidence provided how the risk to patients and staff was being mitigated. The 5 Gauss line shows the area around an MRI machine at which the magnetic fields are more than five Gauss, a measure for the strength of a magnetic field. This is an important safety consideration as when the magnetic field is equivalent to or over five Gauss, it can present risks to patients and staff, as it affects devices such as pacemakers and implantable cardioverter defibrillators.

Clinical areas where ionising radiation was being used had controlled access and relevant safety signs in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 and national guidance.

Local rules for radiation were displayed in the scanning areas and had been signed by all appropriate members of staff.

The service had suitable facilities to meet the needs of patients' families. Waiting areas in the diagnostic imaging service had suitable seating for visitors and refreshments were available in each waiting area.

The service undertook emergency evacuation simulations and had action plans for areas of improvement. We reviewed the training and action plans for simulations undertaken in April, May and September 2022 and January 2023 and found them to be comprehensive with action plans which included action owner, status and completion dates.

Assessing and responding to patient risk

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

Staff responded promptly to any sudden deterioration in a patient’s health. If a patient became unwell in the diagnostic imaging areas, there was a clear protocol to follow and numbers to contact were visible in communal areas. Staff we spoke with were clear on how they would escalate if a patient was deteriorating and stated that the response from the medical staff would be prompt.

Staff completed risk assessments for each patient and reviewed the suitability of the process regularly. Patients completed a screening process with staff to identify any potential risks that may impact the delivery of care or present potential harm to patients.

Staff knew about and dealt with any specific risk issues. Staff used ‘pause and check’ and we saw posters supporting this in imaging areas. Pause and check is a checklist followed by radiographers for good practice in line with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). When staff administered intravenous contrast, staff completed an individual patient risk assessment to identify risk of anaphylaxis.

MRI scans use strong magnets to produce images, these can affect any metal implants or fragments in the body. Metal objects may also interfere with the magnetic field and can cause a safety hazard. Staff in the MRI area ensured all staff and patients undertook a metal screening assessment before entering.

Good

Diagnostic imaging

Staff were clear on who the allocated radiation protection supervisors (RPS) for the diagnostic imaging service were. This was consistent across staff groups we spoke with, and information on who the RPS was for each area was readily available. Radiation Protection Supervisors told us they had completed the required training and they had been carrying out functions in relation to this role.

On inspection we saw evidence of emergency evacuation procedures for the diagnostic imaging service. We also saw consistent evidence of visible emergency evacuation information for patients in communal waiting areas.

Staff shared key information to keep patients safe when handing over their care of inpatients to other staff. When inpatients were scanned, staff provided details of procedures and any contrast medicines to the ward. When imaging was completed, scans were processed and loaded into the *picture archiving and communication system* to be viewed by consultants or radiologists.

The diagnostic imaging service used the Society of Radiographers "Six Point Paused and Checked" patient identification check prior to radiological investigations. This allowed staff to ensure patient information was accurate, that any patient risk factors that had been identified could be acknowledged, and that exposure was safe for the patient.

There was a World Health Organisation (WHO) checklist in place in ultrasound and a WHO surgical safety checklist for non-general anaesthetic procedures. The three completed WHO checklists we reviewed during the inspection were completed fully.

Staffing

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

The service had enough radiographers and support staff to keep patients safe. Staffing levels were planned and reflected the demand on the service and known treatment support needs. Rotas were completed in advance to align with activity, with short notice increases in demand for the service as required in accordance with staffing levels.

Staff were separated into teams across the clinical modalities: plain film (X-ray), computerised tomography (CT), magnetic resonance imaging (MRI), ultrasound.

The number of radiography staff and imaging support staff on the whole matched the planned numbers. Staff stated across modalities that the services were generally capable of matching staff numbers to rotas.

The service had low and reducing vacancy rates with two new members of staff having just been recruited. The service had low turnover rates. The service had a low level of sickness rates; 5.6% for the 6 months preceding the inspection.

There were four radiologists supporting the service who were employed under practising privileges. They had varying specialisms, such as, muscular-skeletal (MSK); gynaecological; neurology; vascular; cardiology and breast.

Diagnostic imaging staff we spoke with stated they felt valued and supported. Patients we spoke with were positive about the service they received from the service. Parents stated that all staff they met were supportive and appointments were patient-centred, and staff were quickly available to answer any questions or address any issues they raised.

Good

Diagnostic imaging

Records

Staff kept detailed records of patients' care and diagnostic procedures. Records were clear, up to date, stored securely and easily available to all staff providing care. Staff always had access to up-to-date, accurate and comprehensive information on patients' care and procedures.

Patient imaging records were comprehensive, and all staff could access them easily. The service used a picture archiving and communication system (PACS) to store and process images.

Radiologists reported on images on electronic systems in the service and results were securely sent to referring clinicians.

We reviewed three sets of patient records and found they were fully completed, and all staff could access them easily. Patient notes were a mix of paper and electronic records. On inspection we observed staff storing records securely in each clinical area and access to computers and electronic patient records systems were password protected.

Medicines

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

Staff followed systems and processes when safely administering, recording and storing medicines. When contrast was administered this was done under a Patient Group Direction (PGD). PGDs are written instructions to supply or administer medicines to patients, usually in planned circumstances. The PGDs were in date and had been reviewed by an appropriate staff group, there were also signed sheets demonstrating staff has read the PGD.

Staff stored and managed medicines securely in line with the provider's policy. Staff labelled contrast with the date it entered the warming cabinet, this was monitored and disposed of after 28 days, this was in line with manufacturer's guidance. The diagnostic imaging service did not use any controlled drugs. Staff followed current national guidance to check patients had the correct medicines.

In the event of an emergency, the different sites within the diagnostic imaging service had an anaphylaxis box, these were in date and secured with a number tag by the pharmacy.

Incidents

Staff recognised and reported incidents and near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. The service managed patient safety incidents. Staff knew what incidents to report and how to report them. Training on reporting incidents was given to all staff and they were familiar with how to do this.

Staff raised concerns and reported incidents and near misses in line with the service's policy. Managers discussed incidents with staff at the time of reporting, all incidents and near misses were reported. Staff reported serious incidents clearly and in line with policy. Managers supported staff in reporting incidents to ensure consistency. Managers investigated incidents thoroughly, debriefed and supported staff after any serious incident.

Good

Diagnostic imaging

We reviewed the minutes of diagnostic imaging service's meetings which evidenced discussion of incidents. Staff we spoke with stated they had an opportunity to discuss feedback from incident investigations and that actions were taken to make improvements to patient care. There was evidence that changes had been made as a result of feedback.

Between January and December 2022, the diagnostic imaging service reported no serious incidents or never events.

There were systems in place for radiation related incidents to be escalated to and investigated by a medical physics expert.

Staff we spoke with understood duty of candour. They were open and transparent and gave patients and families a full explanation if or when things went wrong.

Is the service effective?

Inspected but not rated

We do not currently rate effective in diagnostic imaging services. However, we found:

Evidence-based care and treatment

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

Staff followed policies to deliver high quality care according to best practice and national guidance. The service had policies in place to support good practice and these were available electronically. Changes in national guidance was communicated by the leaders in the service to be implemented at a service level.

Guidance from the Royal College of Radiologists, the College of Radiographers and the National Institute of Health and Care Excellence were available to staff via the intranet.

The service provided care and treatment based on national guidance including the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R). Policies were aligned with and referenced the Ionising Radiation Regulations 2017. The Ionising Radiation Regulations 2017 are regulations concerned with the protection against exposure to ionising radiation as a result of work activities. The radiation safety policy and local rules for radiation safety were up to date and were available to staff electronically.

Diagnostic reference levels (DRLs) were calculated and displayed on an annual basis by the radiation protection supervisor.

We observed that all local rules were signed and dated by staff as being understood, within the twelve months prior to our inspection. Local rules were in each diagnostic imaging room. Managers checked that staff followed these.

The service managers attended all the hospital wide governance meetings and share information with their teams via the monthly staff meetings and shared learning slides.

Good

Diagnostic imaging

Pain relief

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

All patients attended as an outpatient or from a ward. Staff assessed patients' pain both before and during imaging procedures. Patients attending from home were advised to bring any medication including pain relief with them, that they might require during their attendance. Inpatients would be returned to wards as a priority if their pain was not controlled for pain relief to be administered. The service did not administer pain relief.

Patient outcomes

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

Outcomes for patients were positive. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers used information from the audits to improve care and treatment. Discussions were had between staff that were based around recent cases and learning was used to improve the quality of care provided. Managers shared and made sure staff understood information from the audits.

Managers and staff investigated discrepancies and implemented local changes to improve care and monitored the improvement over time. The diagnostic imaging service took part in the HCA wide Radiology events and learning meetings (REALMS) as suggested by the Royal College of Radiologists. These meetings were designed to anonymously discuss radiological discrepancies alongside examples of excellence in order to recommend learning and improvement. The diagnostic imaging service conducted a CT reporting accuracy audit which monitored the accuracy of CT reports and image quality, and to determine the degree of concordance between reports of different radiologists.

Peer reviews of images had a rejection target of less than 10%. Results could be broken down to individual radiographers or specialities to identify issues.

The service had only begun working towards QSI accreditation in Q4 of 2022/23. At the time of the inspection the service did not have any ISO accreditation.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff were knowledgeable and able to tell us about their roles.

Managers gave all new staff a full induction tailored to their role before they started work. New staff had a corporate based led induction and a local induction to the service. Staff were provided with a competency-based pack to complete. New staff were required to complete mandatory training within 3 months of starting their role, which was monitored by managers within the service.

Good

Diagnostic imaging

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. The staff we spoke with told us that they had access to training for their learning and educational needs.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Meeting notes were shared with staff electronically and staff had to confirm that they had read the notes.

Staff were given time during their working time to undertake training suitable to their role, when additional training was requested, this was discussed with senior managers to ensure it would be of benefit to the service. Staff who were designated as radiation protection supervisors were given the opportunity to undertake training specific to their role.

Multidisciplinary working

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

Staff and radiologist held and attended regular and effective multidisciplinary team (MDT) meetings to discuss patients and improve their care. Radiologist staff attended a variety of HCA wide MDT meetings which took place at different HCA locations.

Staff were positive about the working relationships between staff disciplines and different modalities. Staff stated they felt well supported by managers and by colleagues. We observed staff working well together as a team, the service had a positive and respectful atmosphere. Staff told us they believed there was very good lines of communication within the service.

Seven-day services

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

The service was available Monday to Friday with the occasional Saturday clinics when required, on-call support was available for diagnostic imaging out of hours and on weekends. Staff could call for support from doctors and other disciplines.

Health promotion

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

The diagnostic imaging service could access relevant information promoting healthy lifestyles and support. Staff told us how they provided materials and information on support and health promotion services.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Good

Diagnostic imaging

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

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff we spoke with demonstrated sufficient understanding of their responsibilities in regard to consent. Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. We saw evidence that consent had been recorded in line with legislation.

Staff could describe and knew how to access policies on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good

This is the first time we rated caring at this service. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and their families in a respectful and considerate way. Staff spoke with kindness and engaged with patients to make them feel they were being listened to. Patients had the time needed to allow them to ask questions and for staff to provide explanations, preparing them for their procedures.

We spoke with three patients, who stated staff were very kind, friendly and considerate throughout their treatment. Staff asked patients how they felt about the imaging procedure they were having and if they had any questions.

Staff clearly explained the diagnostic procedure and the time it would take to the patient. We witnessed staff interacting with patients before and throughout their procedure. Staff gave patients positive feedback during the imaging procedure, where appropriate and continued to ask how the patient was doing. Patients were reminded to tell staff if they wanted the procedure to stop at any time.

We saw that reception staff asked patients how their procedure had gone when they left their scan. Reception staff were kind, sensitive and caring when speaking to patients on the telephone.

Staff maintained privacy and dignity by ensuring blinds and doors were closed when patients entered the room. Chaperones were available to support patients during procedures if needed.

Good

Diagnostic imaging

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed and helped them maintain their privacy and dignity. There were quiet spaces within all the diagnostic imaging service sites where patients could wait prior to their scan for those patients that had to wait for this scan.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were given clear details of when results would be known and who to contact, we were told this reduced anxiety while waiting for results.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their diagnostic procedures.

Staff made sure patients understood the diagnostic imaging procedure they were having done. Patients were provided with details of the diagnostic procedure by the referring clinician. Fee information for patients who paid for their own care was available and could also be requested through the service's website.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff were aware of reasonable adjustments that could be made to ensure patients understood the information they were given. This included providing interpreters to support medical discussions with patients and families. We saw how patients were encouraged to ask questions about their procedures and were given an opportunity to do so.

Staff maintained constant interaction with patients throughout their scans, they talked patients through the procedure and went at a pace that suited the patient.

Patients we spoke with told us that staff had been very reassuring. They told us that all relevant details relating to their scan had been explained to them very well.

Is the service responsive?

Good

This is the first time we rated responsive at this service. We rated it as good.

Service delivery to meet the needs of local people

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

Good

Diagnostic imaging

Managers planned and organised services, so they met the changing needs of the patients it served. The service provided diagnostic imaging services to the private patients undergoing both elective and urgent care. There were also clear pathways for ad-hoc scanning for inpatients.

Facilities and premises were appropriate for the services being delivered. There were waiting areas in all diagnostic imaging service sites, with hot and cold beverages available. The waiting areas were accessible to wheelchair users either by lift or were on the ground floor.

The service had systems to help care for patients in need of additional support or specialist intervention. The diagnostic imaging service monitored patients who did not attend for treatment, the levels of patients failing to attend were low. Managers ensured that patients who did not attend appointments were contacted and asked if they wanted to book a new appointment.

Diagnostic test results were available to support timely multidisciplinary team (MDT) decisions on cancer care, treatment plans and achieve cancer waiting time standards.

The service relieved pressure on other locations run by the provider, they could treat patients on the same day if there was availability.

Meeting people's individual needs

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients accessing the service.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff were aware of how to obtain interpreters and told us they had used them. When patients were referred, staff were given details of the preferred language spoken if this was not English for interpreters to be arranged.

We were told inpatients were given a choice of food and drink to meet their cultural and religious preferences. Outpatients had access to hot and cold drinks and biscuits in the waiting areas. Inpatients had access to chaplaincy services that catered towards a wide range of religious beliefs.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to test and from test to results were in line with national standards.

Managers monitored waiting times and made sure patients could access services when needed and received diagnostic imaging within agreed timeframes. Waiting times for appointments were monitored by the diagnostic imaging service manager. Managers and senior staff looked to extend working hours to meet demand for example opening on occasional Saturdays.

Good

Diagnostic imaging

Managers monitored and took action to minimise missed appointments. Missed appointments were flagged to managers and referring clinicians to establish the cause. Managers ensured that patients who did not attend appointments were contacted.

We saw evidence that demonstrated over 90% patients were either seen on their chosen appointment or within 48 hours of a referral being made. Staff accommodated same-day slots whenever possible. Patients were able to utilise a same day walk-in service for general x-ray and ultrasound subject to availability of appointments.

The service had a 48-hour turnaround target for imaging reports. Audit results for the period October 2021 to March 2022, showed compliance within 24-hours was at 91% and 96% compliance within 48 hours.

Patients were asked about times to avoid by staff booking their procedure, to ensure they would be able to attend. When patients had their appointments cancelled at the last minute due to equipment failure, managers made sure they were rearranged as soon as possible and booked within national targets and guidance.

Routine servicing of equipment was always planned in advance to avoid disruption. The service was also able to direct patients to one of the provider's other locations if there was significant disruption to the service.

Learning from complaints and concerns

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

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. When patient feedback indicated a negative experience, this was followed up by senior leaders with patients.

Staff understood the complaint policy and were able to talk us though how they would handle any complaints they received. Managers investigated complaints and identified themes. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint had concluded.

There had been four complaints received about the diagnostic imaging service during the period January to December 2022.

The service said they would escalate complaints to the Independent Healthcare Sector Complaints Adjudication Service (ISCAS) if a patient was dissatisfied with the service's response to a complaint. The service followed the ISCAS code of complaint's management.

Managers shared feedback from complaints with staff and learning was used to improve the service. Staff could give examples of how they used patient feedback to improve daily practice. Feedback from complaints across the hospital was shared with all staff and learning and improvements took place in all areas, including the diagnostic imaging service

Is the service well-led?

Good

Diagnostic imaging

Good

This is the first time we rated well led at this service. We rated it as good.

Leadership

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

Staff said they felt leaders engaged with and listened to them. Leaders supported staff in their development and encouraged them to own their achievements both in their departments and as a wider hospital.

Leaders had an open-door policy and supported staff to raise concerns and seek out support. Staff said they felt able to approach management and discuss any concerns with them. They gave examples of when they had done this.

The service had a clear leadership structure. The diagnostic imaging service manager, an experienced radiologist, oversaw the day to day running of the service. The diagnostic imaging service manager reported to the chief operating officer. Senior provider-wide leaders were frequent visitors to the sites and were easily accessible to local staff.

Staff spoke positively of senior leaders and those leaders expressed confidence in the people who they managed. Staff were supported to develop into senior roles through leadership training provided through online Harvard University leadership courses, which the provider had commissioned.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The Harley Street Clinic had a clear vision for what it wanted to achieve and a strategy to turn it into action. The Harley Street Clinic's strategy aligned with the HCA corporate 2022 growth strategy. The diagnostic imaging service had its own service goals developed with staff input which aligned to the Harley Street Clinic and HCA corporate strategies. The service reviewed progress against its goals regularly. Goals were discussed at meetings between the manager of the service and the chief operating officer.

Culture

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

Good

Diagnostic imaging

Staff consistently told us they were proud to work for the service and enjoyed their work. They felt that they work together well as a team to provide good patient-centred care. A staff member told us that the leadership team were fantastic, and they had been fully supported by their colleagues and helped to settle in with an excellent induction. Staff consistently told us they were proud to work for the service and enjoyed their work. There was a strong emphasis on the safety and well-being of staff.

Staff worked in collaborative and cooperative teams. The diagnostic imaging service had a culture which was centred on the needs and experience of the patients who use the services and had robust mechanisms to gain patient feedback and improve services as a result.

The culture encouraged staff to be open and honest within the diagnostic imaging service, including with people who use services, in response to incidents and complaints. Staff were supported to raise concerns and stated that they felt they would be listened to. The service also had a whistleblowing policy which outlined how staff could speak up.

The diagnostic imaging service had mechanisms for providing staff with opportunities for career development. For example, staff stated that the service manager encouraged them to consider their career development. Where staff had development plans from their appraisals, the manager encouraged and supported staff to achieve their goals. Staff we spoke with were positive regarding the opportunities to develop and learn within their roles. The manager told us that all staff that had requested career development training in 2022 had been approved and had their training funded by the service.

Governance

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

There were clear governance structures for the provider, the clinic and the diagnostic imaging department. We saw a diagram which detailed how the governance systems operated, including a committee structure. THSC had sub-committees that covered medical governance, clinical governance, information governance and patient safety, quality and risk which feed into the executive board. There was clear guidance on the scope and responsibilities of each committee and how they interacted with each other.

There was a corporate HCA wide Radiation Protection Framework in place and the associated Radiation User Groups (RUGs), that met quarterly to provide assurance to the local Radiation Protection Committee. THSC's diagnostic imaging service reported into the diagnostic RUG. THSC also had a radiation protection committee which reported to the corporate radiation protection committee.

Staff at all levels were clear about their roles and understood what they were accountable for.

THSC had a Medical Advisory Committee (MAC) which advised on matters such as the granting of practising privileges, scope of consultant practice, patient outcomes, clinical standards and implementing new and emerging professional guidance. The MAC ensured there was a process for overseeing and verifying doctor revalidation, continuing practice development and reviewing practising privileges.

Management of risk, issues and performance

Good

Diagnostic imaging

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

The department had two radiation protection supervisors in place. Controlled radiation area signs gave contact names and contact details for the radiation protection supervisors. Radiation Protection Supervisors were appointed for the purpose of securing compliance with the Ionising Radiations Regulations 2017 for work carried out in an area which are subject to Local Rules.

There was an overall provider level risk register which we requested from the service, however, the document provided only showed three risks, none of which were for the diagnostic imaging service. All the risks recorded were however graded according to their severity and controls were in place and documented, with actions required before the next review date. All actions had a named person who was response for the risk. Risks were regularly reviewed. Risks were discussed at departmental meetings and at the monthly board meeting.

The key risk within the diagnostic imaging service was aging scanning equipment. We saw the departmental risk register and staff we talked to were able to talk us through the local risks for the department.

The diagnostic imaging service had plans to cope with unexpected events, including adverse reactions during procedures and unexpected equipment failure. There was a risk management policy and the service undertook risk assessments, for example control of substances hazardous to health (COSHH) risk assessments.

The diagnostic imaging service's performance was reported to the board on a quarterly basis. Reporting was based on monthly performance targets across all imaging modalities.

Information Management

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

The diagnostic imaging service ensured data or notifications were sent to external bodies as and when required. We saw evidence that notifications such as serious incidents were submitted to regulators. Policies and procedures and data about performance were stored electronically.

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems. There were effective technology systems to monitor and improve the quality of care. Access to information systems was restricted to only those who needed it, and this kept patient and confidential information secure.

Electronic systems, such as to store, records and manage patient appointments, required password access. Diagnostic scan results, reports and images were stored electronically and could be accessed by staff in other parts of the hospital via a secure system when required such as during routine outpatient consultations or on the wards.

Engagement

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

Good

Diagnostic imaging

Leaders engaged with staff using a variety of methods, including annual staff surveys, team meetings, electronic communication, staff notice boards and in informal discussions. Staff felt their view and opinions were listen to. HCA held twice yearly staff surveys and we saw that action was taken in response to the staff feedback.

Staff felt well informed about what was going on within the diagnostic imaging services, the wider hospital and HCA group and received regular updates.

The service engaged with patients and sought feedback to improve the quality of the services provided. Patient feedback forms provided areas of open text for qualitative information. Patient feedback was displayed and shared with the team and used to improve the service. Staff we spoke with could give examples of changes that had been made based on patient feedback.

The diagnostic imaging service had access to the HCA wide recognition platform where senior leaders were able to award staff reward points in a recognition scheme, these points were able to be used to purchase goods and services.

Learning, continuous improvement and innovation

All staff were committed to continually improving services.

Improvement and innovation were driven at a provider wide level.

Within the diagnostic imaging service, the staff were committed to continuous improvement. For example, The CT scanner had received allocated funding for full replacement and upgrade and will also include modification of the existing CT suite to include additional space to enhance patient safety as well as new ventilation. The new scanner will support a wider range of interventional CT procedures. The new scanner would offer Dual Energy Imaging for ultra-low dose scanning reducing the current radiation dosage for patients and staff. The new system would also introduce the 4D Laser 'MyNeedle Companion' to support increased accuracy for CT biopsy procedures.

During 2021, THSC upgraded the echocardiography machine in the main hospital and the echocardiography machine in the diagnostic imaging service to improve the quality of echo studies, this was initiated following feedback from the echo physiologists delivering this service. In May 2022 the portable ultrasound scanner was upgraded to improve diagnostic image quality following feedback from consultant radiologists and department staff.

Outstanding

Surgery

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

Is the service safe?

Good

Our rating of safe stayed the same. We rated it as good.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Mandatory training modules were a mixture of face to face and online training. At the time of our inspection mandatory training compliance levels for theatre and surgical wards was 96%, which exceeded the hospital's target of 85%.

Mandatory training was comprehensive and met the needs of patients and staff. Modules included but were not limited to, infection control, sepsis, mental capacity act, safeguarding adults and children, immediate life support, basic life support, learning disability and autism and equality and diversity.

Bank staff also completed the hospital's mandatory training programme.

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

Safeguarding

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

We reviewed the service's safeguarding adult's policy. This was in date and available on the hospital intranet system. The policy detailed individual responsibilities, processes for reporting and escalation of concerns and who to contact.

All staff were trained to level 2 and 3 safeguarding adults and level 2 and 3 safeguarding children. There was a designated safeguarding lead for the service who was trained to level 4. Compliance rates for level 2 safeguarding adults was 97% and 88% for level 3, which exceeded the hospital's target of 85%. Compliance rates for level 2 safeguarding children was 98% and 100% for level 3, which exceeded the hospital's target of 85%.

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

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

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

Cleanliness, infection control and hygiene

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

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

Staff cleaned equipment after patient contact. Cleaning checklists of clinical areas and equipment were completed on a daily and weekly basis. The service had infection prevention and control (IPC) link champions who supported in ensuring the audits were undertaken and any actions were in place.

We viewed the infection control policy which was in date and accessible on the hospital intranet. Infection control was part of mandatory training for staff and compliance rates were 100%.

The service completed monthly infection control audits, which were overseen by the IPC lead.

Hand hygiene audit compliance rates in pre-assessment, surgical and cardiac wards were 100% at the time of our inspection. Although consistently 100% in previous months, hand hygiene compliance for theatres in December 2022 was at 80%. Actions were in place following the audit to further improve on aspects of the audit. This included training and education by the IPC champion.

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

If a patient was infectious, a sign was put on the door of their room to indicate this to staff and visitors. Visitors for an infectious patient were kept to a minimum and staff supported visitors to put on and remove the appropriate PPE before and after entering the patient room. We saw nurses putting on PPE prior to going into a room where a patient required barrier nursing (where extra precautions are implemented to prevent spread of the infection) for an infectious patient.

Outstanding ☆

Surgery

Staff worked effectively to prevent, identify and treat surgical site infections. There had been one surgical site infection in the last year. The service had access to a microbiologist for advice and in the case of any investigations into surgical site infections. We saw that the case was investigated thoroughly with actions and learning in place.

There had been no cases of methicillin-resistant staphylococcus aureus (MRSA), methicillin-susceptible Staphylococcus aureus (MSSA) or C. Difficile in the last 12 months for the surgical wards.

Whilst most of the theatre equipment was single use, the hospital sent all equipment that required decontamination to a facility within HCA UK. Staff told us this worked well and they had not encountered any issues with the service.

We witnessed housekeeping staff cleaning the ward areas throughout the day and the service employed an external cleaning company to carry out additional deep cleans of theatre.

Environment and equipment

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

The hospital had two wards for surgical patients on the fourth and third floor of the hospital building. The fourth floor cared for general surgical patients and the third floor cared for patients who underwent cardiac surgery. All patients were cared for in private single rooms with en-suite facilities. Call bells and emergency buzzers were in the main patient bedroom area as well as the en-suite bathroom.

The pre-assessment clinic was located on the ground floor of the main hospital building. Theatres were on the lower ground floor and comprised 4 theatre suites, 3 anaesthetic rooms and a recovery bay. One theatre had laminar flow. Laminar flow theatres aim to reduce the number of infective organisms in the theatre air by generating a continuous flow of bacteria free air. Access to theatres was by keypad locked door. There was also a patient transfer lift from theatre to wards and the intensive care unit. At our last inspection, staff told us storage space was an issue across surgical services. At this inspection, additional storage space had been sourced since the refurbishment of the fourth-floor surgical ward and improvements to the environment in theatres.

Emergency trolleys were available on each ward, in the pre-assessment clinic and in theatres. We checked the emergency trolleys on the wards, pre-operative assessment clinic and theatres and found that they were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Equipment on the top of emergency trolleys were checked daily and equipment in the drawers were checked on a weekly basis with record check sheets, which were signed to confirm checks had been made. We checked various consumables and found they were sealed and in date.

We checked and saw evidence technical equipment had been serviced and calibrated regularly. We saw safety checks had been completed and logged for anaesthetic machines. Staff told us equipment faults could be reported electronically and were seen to quickly by the equipment maintenance team.

Oxygen tanks were stored securely and were in date. We inspected three sharps bins and found them to be correctly labelled and not filled above the maximum fill line.

The medicines room was locked to prevent unauthorised entry. We checked consumable equipment and found most items we sampled were in date and packaging was intact, indicating it was sterile and safe for use in patient care. However, on the third floor we found some consumable items which were out of date and one with packaging that was not intact. The ward manager took immediate action and disposed of these immediately.

Theatres, patient rooms and clinical areas were visibly clean and uncluttered. Staff told us they had been involved in the redesign of the surgical ward and were able to make sure patient feedback on the design of the patient rooms was considered. Plans were in place to refurbish the third floor which was the cardiac ward. This required updating and had some uneven flooring in some places. To mitigate the risk of slips and trips, anti-slip strips had been placed on these areas of the cardiac ward.

The hospital had access to bariatric equipment such as bariatric wheelchairs, beds and patient rooms with wider doorways. Bariatric equipment could be requested by staff and delivered to the ward prior to a patient arriving.

Staff told us there was enough access to computers and equipment such as consumables. Resident doctors had their own dedicated rooms to use to rest when on duty overnight or between shifts.

Linen cupboards and storage rooms were appropriately stocked and tidy.

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

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

Assessing and responding to patient risk

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

Staff we spoke with were aware of escalation protocols for deteriorating patients and the use of national early warning scores (NEWS2). This is used to monitor the patient condition and included recordings of blood pressure, pulse, respirations and temperature. We checked patients' NEWS2 charts and found them to be correctly filled in.

NEWS2 was audited quarterly and the analysis was split between scores of 1-4, scores of 5-6 and scores of 7 or above. Overall compliance scores for the surgical ward was 93% and 92% for the cardiac ward. There were action plans in place which included more frequent documentation checks and spot checks.

Staff carried a portable handheld device where they could record patients' NEWS2 scores and observations. Observations were assessed and scored automatically which removed the chance of human error. The information could be accessed and monitored in real-time by the resident doctors and critical care outreach team so any indication of patient deterioration could be quickly responded to.

The use of the World Health Organisation (WHO) five steps to safer surgery checklist was embedded in practice. Audits were carried out monthly and the latest audits from October to December 2022 showed 100% compliance for WHO checklist completion.

Outstanding ☆

Surgery

Staff we spoke with said they had received training in sepsis and the sepsis six care bundle which consists of 3 tests and 3 treatments for the management of patients with presumed or actual sepsis. Sepsis training was recorded within each staff member's individual competency folder. The service also had a sepsis folder, which was kept in the nurse's station and updated regularly. Sepsis audits took place monthly. From July 2022 to December 2022, six patients were initiated on the sepsis six pathway.

Patients were assessed in the pre-assessment clinic by a nurse prior to their surgery. This was conducted face to face or over the telephone depending on certain criteria. The pre-assessment team provided advice and information to patients prior to their surgery which included ensuring any individual needs such as access to interpreters were arranged, as well as arranging diagnostic tests. The team told us they were able to contact the patient's consultant to ask any questions about the patient as well as engaging early with physiotherapists, clinical nurse specialists, theatre staff or surgical ward staff. This ensured that everything was in place for the patient when they arrived at the hospital for their procedure.

The service did not treat complex patients, such as those with mental health conditions, but did treat some patients with multiple co-morbidities, in line with the admission criteria.

The service followed National Institute for Health and Care Excellence (NICE) recommendations for pre-operative tests. We saw evidence in patient notes that risk assessments had been completed. For example, patient notes recorded falls risk assessments and patients were assessed for venous thromboembolism (VTE) risk on admission and after admission, in patient documentation. VTE risk assessments were completed for all patients and the risk was reviewed at each shift. There were no reportable VTE or pulmonary embolism following surgery in the last 12 months.

The service used the aSSKINg care bundle which stands for 'assess risk; skin assessment and skin care; surface selection; keep moving; incontinence and moisture; nutrition and hydration; and giving information or getting help' and is a tool which ensures all fundamental aspects of pressure ulcer prevention are included in patient care. The service had a dedicated tissue viability nurse who attended wards regularly.

Patients were taken back up to the wards following surgery from recovery by the recovery team so that surgical ward staff were not taken away from their duties on the ward.

There were twice daily ward rounds. Consultants reviewed their patients' condition as part of the daily ward round. The surgical resident doctor who was on site 24 hours a day, 7 days a week would conduct the second ward round and would call the consultant surgeon if they had any concerns.

We observed bed meetings where staff shared key information to keep patients safe when handing over their care to others.

Patients received a discharge information pack when they were discharged from the hospital. This included a telephone number to call the ward at any time of the day as well as a number for the clinical nurse specialist. The clinical nurse specialist also called the patient post-discharge to check that the patient was recovering well and if there were any questions they had.

All nursing staff had completed immediate life support training, all healthcare assistants had completed basic life support training and resident doctors had completed advanced life support training.

If a patient deteriorated, nursing staff would escalate for support from the resident doctor. The resident doctor would contact the patient's consultant and notify the hospital's critical care outreach team for transfer to the hospital's critical care unit or arrange for transfer to a local NHS hospital depending on the severity of the patient.

There was an on-call team which included a radiographer, theatre team and senior staff who were supported through an on-site duty manager who covered 24-hours day 7 days a week. The on-call theatre team were available for emergency returns to surgery out of hours.

There was 24-hour access to diagnostic imaging. There was access to an on-call radiographer and staff told us that they worked with the theatre manager if a theatre was required unexpectedly such as for urgent readmissions.

There was a formal on-call anaesthetist rota. The hospital followed its practising privileges policy which stated that consultants and anaesthetists retained responsibility for their patient for the patient's entire clinical pathway. Consultants were always required to be contactable by telephone and available to attend their patient in the event of an emergency. Anaesthetists and consultants informed the hospital of who would be covering them if they were not able to attend to their patient.

Nursing and support staffing

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

Staffing levels were reviewed and planned in a timely manner by ward managers using a safer staffing tool. Staff told us they received their rotas a month in advance, so they knew what shifts they were working. We saw that actual staffing levels reflected the planned numbers.

Staffing levels for the day were discussed at handovers at 7.30am and huddles at 11am and discussions including any need for cross cover across wards.

Staff in theatres, wards and pre-assessment reported generally good levels of staffing. Staff said this enabled good supervision of more junior staff and allowed staff to be able to complete documentation and audits.

The service undertook elective surgeries and was able to plan staff accordingly. During our inspection we saw there were enough staff allocated to theatres, recovery and the surgical wards.

Bank and agency staff were used on wards and staff told us they would get the same agency staff in order to maintain continuity of care to patients. All agency staff received a full induction and held the same competency folders that the nurses on the ward had.

Turnover and vacancy rates were low. Sickness rates in the reporting period were less than one percent. There were three vacancies for theatre anaesthetics staff. There was a plan in place to fill the posts in the form of weekly recruitment meetings with the hospital's dedicated recruiter, external advertisement, internal advertisement, a nursing referral scheme initiative and overseas recruitment.

Surgery

There was an information board on the ward and in the operating department which detailed the staffing level for the day, the nurse in charge, the resident doctors, anaesthetists, consultants and the types of procedures that had been planned for the day.

Medical staffing

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

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

Consultants reviewed patients daily and we saw evidence of this in patient notes we reviewed. The hospital used resident doctors who provided a 24-hour, 7 day a week service on a rotational basis. There were two resident doctors assigned 24 hours a day, 7 days a week who worked split shifts to ensure that they had time off during the 24 hours. Resident doctors attended ward handovers and daily bed meetings and had constant access to the electronic observations system so they could monitor patients and attend to them quickly.

Resident doctors and nurses we spoke with commented that if they needed a patient's consultant to attend, they were able to contact them easily. In the event the consultant was unavailable, the consultant would ensure there was another consultant who covered for them. The service had a consultant/buddy proforma that consultants had to fill in and submit with details of who was providing cover for them. The proforma was also countersigned by the buddy consultant.

The hospital also had an on-call team. This included a radiographer and an on-site duty manager who covered 24-hours day 7 days a week.

Anaesthetists were responsible for their patients throughout their stay in hospital and did not leave the hospital until the patient had returned to the ward and recovered from the anaesthetic.

The consultant surgeon also saw the patient prior to leaving the hospital to ensure they were stable. Consultant surgeons and anaesthetists were always required to be contactable by telephone and be able to attend to their patient. As part of the practising privileges agreement, consultants were required to live or have accommodation within 30-60 minutes of the hospital. They were also required to identity and ensure a buddy consultant was in place to cover for them if required.

The service also had access to on-call anaesthetists between the hours of 8.00pm and 7.30 am, seven days a week. Cardiac surgeons also provided an on-call service for inpatients that required review by a cardiac surgeon. Surgical consultants had access to support from an HCA wide consultant physicians on-call rota.

Records

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

Outstanding ☆

Surgery

The hospital used a mixture of paper and electronic patient records to record patient needs, care plans and risk assessments. Consultants sent letters to the patient's general practitioner (GP) with information around the outcome of consultations and procedures.

Patients who were admitted to the hospital would also have a discharge summary sent from the hospital and consultant to the patient's GP.

Patient notes were kept securely in locked cupboards within the nurse's station. Electronic patient records were kept on a secure server and staff had logins to be able to access the system.

Pre-assessments were completed by nursing staff either face to face or over the telephone depending on the type of surgery the patient was to have.

Pre-assessment records included the patient's medical history, medication they took, allergies, additional needs such as interpreter requirements or mobility issues and fasting instructions. We were told coloured stickers would be placed on the records of patients who for example were receiving palliative care so staff could immediately be alerted to the patient's needs.

We saw in patient records that risk assessments had been completed such as a pressure ulcer risk assessment, and a falls risk assessment.

We reviewed 10 sets of patients records and found they were comprehensive and detailed. Records noted patients' additional needs such as if a patient required additional support with regards to mobility. We saw national early warning score system (NEWS2) observations and venous thromboembolism (VTE) risk assessments had been completed.

Care plans were in place and there was evidence these were reviewed daily. Allergies were also recorded on drugs charts. We saw evidence in patient records, and from our observations in theatres, that staff completed the safety checks undertaken during procedures using the World Health Organisation (WHO) five steps to safer surgery checklist.

Operation notes were legible and postoperative plans were clearly documented. We saw there were stickers on records in order to be able to trace medical devices used. All cosmetic implants were recorded on the Breast and Cosmetic Implant Registry.

Records audits for the reporting period showed 100% compliance for the surgical ward. The cardiac ward score 86%; however, a review of the results showed some of the cases were for interventional cardiology patients and some of the questions were not applicable to the patient group which resulted in a lower score. As a result of this, the service was reviewing the audit for the cardiac ward to ensure it was fit for purpose. We were told by the provider the next audit cycle would therefore cover cardiac surgical patients only.

We observed staff logging off computers after use. Information governance formed part of privacy and security mandatory training for nursing and medical staff.

Medicines

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

Outstanding ☆

Surgery

The hospital used systems and processes to safely prescribe, administer, record and store medicines. The hospital used an automated medication dispensing system which ensured secure medication storage with electronic tracking of medicines. We saw that staff followed systems and processes when safely prescribing, administering, recording and storing medicines. The treatment room was locked and only accessible to authorised staff.

Nursing staff were aware of the policies on the administration of controlled drugs (CDs). CDs were stored in line with required legislation and recorded in a controlled drugs logbook. We viewed the logbook where staff recorded when CDs had been used and stock was checked. Two members of staff checked the controlled drug stock levels. We checked a sample of these and found them to be accurate and the medicine in date.

We saw the service had an up to date medicines management policy. All staff undertook medicines management training as part of their mandatory training.

Medicines for patients to take away with them on discharge were packed and stored securely in the medicines room prior to their discharge. This also helped ensure patients could be discharged in a timely manner.

Medicines used in patients' procedures were clearly listed in the patient records. We saw in patient records that allergies were clearly documented.

Prescription pads were kept in a locked drawer accessible only by the consultant and resident doctors.

A pharmacist visited the wards daily and checked prescription charts and controlled drug books. Staff told us they could contact the pharmacist at any time if they had any concerns regarding medicines patients were taking. There was an on-call pharmacist for out of hours requests.

Room temperatures and fridge temperatures of the treatment room were recorded daily. We checked the medicines fridge temperatures and ambient room temperature during our inspection and found them to be within expected range.

The service completed controlled drug audits and safe and secure storage of medicines audits on a quarterly basis. Surgical ward compliance was 96%, 87% for cardiac ward, 81% for theatres. Issues were mainly around documentation errors. An action plan was in place for each area which included two weekly audits, an allocation of a second nurse to help carry out audits and additional training to be delivered by pharmacy.

Microbiology protocols for the administration of antibiotics were available on the hospital intranet.

Incidents

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

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and knew how to raise concerns using the hospital's electronic incident reporting system in line with the hospital's incident reporting policy. Managers investigated incidents and shared lessons learned and feedback with the team at team meetings. There was evidence that changes had been made as a result of feedback. We viewed the minutes of team meetings which showed discussion of incidents and the learning from them.

Outstanding ☆

Surgery

In the last 12 months, there were no incidents classified as never events for surgery services. In the last 12 months, the service recorded 354 incidents. 261 of the incidents were categorised as no harm; 67 were low harm; 25 were moderate harm and one was an unexpected death due to post-operative complications. The main themes were around post-operative complications. We looked at some incident investigation reports which were detailed and showed actions and learning.

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 we spoke with were able to explain the duty of candour fully.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

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

The service delivered care in line with national clinical guidance. Staff had access to policies and procedures based on national guidance on the hospital intranet.

We reviewed a sample of hospital policies including policies for safeguarding adults, medicines management, and local safety standards for invasive procedures. These were all in date and appropriately referenced national guidance and best practice such as that recommended by the National Institute for Health and Care Excellence (NICE) and the association of surgeons of Great Britain and Ireland.

We saw the patient pathways and protocols were based on national guidance. We reviewed several patient pathways for example for neurological, breast and cardiac procedures.

The service had updated their National Safety Standards for Invasive Procedures (NatSSIP) and this was now embedded in practice. 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.

Changes and updates to policies were disseminated to staff at team meetings and by email.

The service used evidence based 'care bundles'. A care bundle is a set of evidenced based interventions that, when used together, can improve patient outcomes.

Adherence to and understanding of NICE guidelines was embedded and evidenced through the use of audit programmes to benchmark practice.

Outstanding ☆

Surgery

Patients admitted to hospital for spinal surgery were consented to have their details submitted to the British Spine Registry (BSR) in line with national standards for spinal surgery, supported by the British Association of Spinal Surgery (BASS).

The hospital also collected data for patients undergoing breast and cosmetic surgery to the Breast and Cosmetic Implant Registry.

We saw there was a formal annual clinical audit programme to evidence performance monitoring, quality measures or patient outcomes relating to surgical services. The audit programme detailed the frequency at which the audits should be undertaken and included but not limited to, audits for infection prevention and control; WHO five steps to safer surgery; medical devices; pain; hand hygiene; sepsis; falls; sharps; chaperone documentation, consent and early warning scores.

Actions and learning as a result of the audit programme were discussed and shared at the clinical audit and effectiveness committee. Actions were then escalated corporately and shared with the heads of department to be disseminated at team meetings. We saw from team meeting minutes the audits results and actions were discussed in detail.

Nutrition and hydration

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

There were appropriate arrangements to ensure patients' nutrition and hydration needs were met on the wards. The service had dedicated dietitians to support nutritional planning for patients. We saw in patient records the dietary planning included any food supplements prescribed.

The hospital had its own catering team who provided fresh food to patients. Food menus catered for different patient groups including those with specific dietary requirements such as allergies, intolerances and religious needs.

We saw catering staff replenishing water jugs and bringing hot drinks and snacks to patient rooms throughout the day.

Fasting instructions were given to patients at the pre-assessment stage and patients told us the staff checked with them that they understood the instructions. Admission times could be staggered so fasting times could be minimised.

The service used evidence-based tools to screen for malnutrition. We saw in patient records a malnutrition universal screening tool (MUST) for assessing patients' nutrition. We saw fully completed fluid charts which were used to monitor patients particularly after a surgical procedure.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. We saw in records we reviewed the patients' level of pain was assessed as part of their observation records. Patients we spoke with told us their pain had been managed appropriately and they received pain relief in a timely manner.

We saw from patient records patients had been prescribed, administered pain relief and recorded these actions accurately.

Patients' pain levels were reviewed by the anaesthetist in the recovery area to ensure they were comfortable before returning to the ward.

Upon discharge, patients were given a telephone number of the ward and their clinical nurse specialist if they had any concerns about pain.

Pain management was audited. In the last 12 months, 93% of patients felt the hospital staff did everything they could to help control pain.

Patient outcomes

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

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Actions and learning as a result of the audit programme were discussed and shared at the provider's clinical audit and effectiveness committee and then disseminated to individual department team meetings.

Audits were completed on an electronic auditing system. This allowed for results and trends to be generated and shared effectively. Staff received training in the use of the electronic auditing system at their new starter induction.

To monitor the quality of care and outcomes, the provider monitored key performance indicators such as activity reviews. These were monitored at monthly surgical service line meetings.

One of the main types of surgery performed was cardiothoracic surgery. The service collected data for two national audit standards. Cardiac surgery data was submitted to the National Institute for Cardiovascular Outcomes Research (NICOR). The latest report concluded that the adult cardiac surgical outcomes for the hospital continue to remain excellent for the 3-year reported period. The crude survival rate 99.2% (including 8.9% Redo surgery) was greater than 99% for the 3 years reported.

We reviewed the service's quarterly quality report for the period between April and September 2022 and were assured the service was providing consistently good outcomes of care for their patients. The report monitored patient outcomes on quality indicators such as unplanned readmissions within 48 hours and risk-adjusted acute hospital mortality, among others. It also monitored physiology, case mix, infection, length of stay and organ support.

In the last year, there were 22 unplanned returns to theatre, which was 0.79% of the total of procedures undertaken and no transfers out. All returns to theatre were discussed at the hospital's weekly complaints, litigation, incidents and patient experience (CLIP) meeting and the medical governance and quality committee to identify any lapses in care, trends, themes, learning and actions.

There had been one surgical death in the last six months which was assessed as unavoidable. We viewed the mortality and morbidity review and found it to be detailed and findings from the review were shared with the cardiac multidisciplinary team.

Departmental performance, including exceptions and escalations, were also presented to monthly hospital board meetings. This was where key performance indicators such as unplanned returns to theatre, unplanned transfers and incidents were discussed.

Patients were given surveys to complete including post discharge and these were collated and submitted to the private healthcare information network (PHIN). PHIN is an independent patient information network which works to empower patients to make informed choices about their care provider.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

The service used regular agency staff to ensure continuity of care. There were specific induction packs for agency staff.

New staff received a comprehensive induction and had competency folders which were signed off by senior members of staff once a competency had been achieved. Staff were required to sign to say they had read the hospital policies. New staff were also allocated a mentor so they always had someone they could go to ask any questions.

Staff told us their training needs were met, and managers were always willing to support their development. Staff told us they had been supported to access leadership courses, attend conferences or nurse associate programmes. At the time of inspection, 100% of staff in surgical services had completed their appraisals. There was a clinical practice facilitator for surgical wards and theatres who supported the development of staff.

Revalidation was introduced by the Nursing and Midwifery Council (NMC) in 2016 and is the process nurses and midwives must follow every three years to maintain their registration. Nursing staff told us they were supported with their revalidation through clinical supervision.

Several staff had taken on roles as link nurses in various specialities. For example, the service had link nurses for IPC, tissue viability, dietitian, and staff wellbeing. The service also had a team of 28 clinical nurse specialists specialising in, for example, spinal care or breast care.

All consultants under practising privileges received an induction pack which included details on what was required of them to practise at the hospital. Each application for practising privileges was assessed by the medical advisory committee (MAC) and we saw evidence of this in the MAC minutes we reviewed.

Resident doctors had advanced life support training. All nursing staff had immediate life support training and healthcare assistants were trained in basic life support. The hospital also had a critical care outreach team who supported the wards in the event of a patient deterioration. Team members were assigned specific roles daily and this was reviewed at the start of each shift. The critical care unit resident doctor, consultant intensivist and the nurse in charge were part of the team. All members of the critical care outreach team were trained in advanced life support (ALS) and were contactable by the emergency bleep system.

If a surgeon wished to bring first assistants to theatre, they were required to submit a recommendation to the provider and the first assistant would then have to have their competencies signed off by the provider before they began working at the hospital. Surgeons we spoke with told us there was a good system in place where there was a list of 10 first assistant registrars on the rota and distributed equally among surgeons.

Multidisciplinary working

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

We saw evidence of good multidisciplinary team (MDT) working within the surgical service. We saw evidence of good working relationships between nurses and medical staff.

Nursing staff said consultants and resident doctors were always available for advice and support.

In theatres we saw there was respect for each member of the team and the contribution they made.

We observed multidisciplinary approaches to care planning for patients and families. Patient records demonstrated input from the full clinical team of doctors, nurses and allied health professionals such as physiotherapists and dietitians, from pre-operative assessment through to post-operative care.

Letters were sent to a patient's general practitioner (GP) to share outcomes and discharge information. The discharge letter included contact details should another health professional require further advice about patients care or treatment post discharge.

Bed meetings were multidisciplinary and included nursing staff, resident doctors and allied health professionals. Handovers and daily huddles included the full multidisciplinary team.

We saw physiotherapists liaising with nursing staff and saw the patient records had input from physiotherapists.

There were formal multidisciplinary team meetings (MDT) held for surgical patients. The hospital held 17 MDTs which took place either weekly, bi-weekly or ad-hoc.

Staff we spoke with who attended the MDT meetings spoke of how there was a holistic discussion about the patient's needs and how communication was clear and inclusive.

Patients could be discussed at any of the MDTs held at other facilities managed by the provider to ensure there are no delays to patient treatment.

Patients received care by a multidisciplinary team. For example, records showed that patients received input from consultants, nursing, pharmacy, physiotherapy and nurse specialists.

Seven-day services

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

Surgery

Consultants led daily ward rounds on all wards, including weekends. In addition, there was a resident doctor on every shift who was available 24-hours a day, seven days a week.

Staff could call for support from doctors and other disciplines such pharmacy, and diagnostic tests, 24-hours a day, seven days a week.

Patients who had been discharged were given a number to call if they had any questions or queries. This was a direct line to the ward where nurses could give advice, or a doctor could be consulted for advice. Patients were also given the telephone number of their clinical nurse specialist if they had any questions about their condition.

Health promotion

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

Staff assessed each patient's health when admitted at the pre-assessment stage and provided support for any individual needs to live a healthier lifestyle.

The service had relevant information promoting healthy lifestyles and support on wards including smoking cessation, healthy eating, losing weight and getting active.

The cardiac ward had a patient information board with leaflets about heart health, cholesterol and other heart conditions.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

We saw completed consent forms in all 10 patient records we reviewed. We observed consent being confirmed with patients in theatre prior to anaesthetisation. Written consent including anaesthetic and surgical consent was sought from the patient. Written consent was also sought prior to surgery and on the day of surgery. The service had a COVID-19 consent form, which patients were required to sign.

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

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

Staff received training on the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) as part of their mandatory training within the consent module.

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

Outstanding ☆

Surgery

All records we reviewed showed that staff clearly recorded consent in patient records. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005 and they knew who to contact for advice.

Is the service caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Staff treated patients with exceptional compassion and kindness, respected their privacy and dignity, and took account of their individual needs. People thought that staff went the extra mile and care and support exceeded their expectations.

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

There was a strong, visible, patient centred culture within the service. Staff were passionate about their work and were focused on delivering patient centred care. Surgical ward staff described how they supported a surgical patient who had been an inpatient at the hospital several times for cancer surgery. The patient had requested to receive end of life care in the hospital on the surgical ward rather than at home or on another ward and to be cared for by the staff they had become familiar with. Staff described how they had enabled this to happen with the assistance of the hospital's palliative care team.

Staff we spoke with understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. Staff in pre-assessment were committed to ensuring patients felt at ease from the beginning of their journey. They told us they ensured input from all members of the team such as dietitians and interpreters and surgical ward staff were involved at an early stage, so patients felt at ease and their needs were met. Staff gave examples of how they tried to make sure individuals who were repeat inpatients, could be accommodated in the same patient rooms they had previously stayed in, so they felt comfortable and used to their environment.

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

Patient feedback from the last 12 months was consistently positive and showed 97% of patients felt they were treated with respect and dignity and 97% of patients felt they were given enough privacy.

Boards on the ward displayed thank you cards and messages from patients. Comments included: 'such warmth and kindness; staff let me cry, made me laugh and kept me safe'; 'thank you for looking after me so well'; 'thank you for your tenderness and positivity'.

Outstanding ☆

Surgery

Emotional support

Staff empowered people who used the service to realise their potential. They provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs and made sure this was reflected in how care was delivered.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff described to us how they had supported patients who became anxious in an open environment such as when they arrived in theatre. Throughout the inspection, we observed theatre staff, nursing staff, physiotherapists and healthcare assistants reassuring patients who were feeling anxious.

Theatre staff described how they supported an anxious patient with autism by showing them the theatres before their surgery and allowing their parents to accompany them to the anaesthetic room and then to be there in the recovery room when the patient woke up from their procedure. The theatre team also staggered the start times of the surgical list to ensure the theatre common area's atmosphere was calm and quiet to further ease the patient's anxiety.

Staff in pre-assessment described how they had spent time reassuring an anxious patient and had gone up to the wards to see how a patient was doing following their procedure, which the patient had appreciated.

During the inspection we observed staff support a patient doing physiotherapy exercises outside of their room. We saw both physiotherapy staff and nursing staff being supportive and encouraging towards the patient, saying to them they were doing well and praising their progress. Patients we spoke to commented on how encouraging staff were and how doctors helped them feel empowered, 'to look to the future' and helped them feel optimistic.

Patients told us staff were respectful of their cultural needs including choice of food. Patients told us staff spent time with them understanding their needs and listening to their concerns.

Patients were given a telephone number for the ward as well as the direct telephone number of their clinical nurse specialist for advice and support. Clinical nurse specialists called patients once they were discharged to check on their progress and answer any questions or concerns they had.

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

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment. Consideration of people's needs was consistently embedded in everything staff did. Patients told us they valued their relationships with staff.

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

We observed staff in theatres checking with a patient that they understood what procedure they were having. Staff brought down their on-site interpreter to further ensure the patient was clear on the procedure.

Outstanding ☆

Surgery

Patients told us they felt informed throughout their treatment and that staff also kept their family members informed as well. Patients told us they were emailed their results of tests and they felt 'in control'.

Patients told us conversations about finances were done so with sensitivity and they had all the information they needed before deciding to proceed. Patients told us the risks and benefits of surgery were explained to them in detail and they were given time to think it through and ask questions. They said consultants were happy to repeat explanations to help them understand a bit better.

We observed a patient in theatres who appeared anxious, so staff took the time to make sure they understood the procedure they were about to have. The consultant spent time with the patient and interpreter to make sure the patient was sure they wanted to go ahead.

The hospital gathered patient feedback on several aspects of care throughout the patient journey. In the last 12 months, 97% of patients felt that consultants showed them understanding and 96% of patients felt the consultant explained everything to them in way which was easy to understand.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

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

The Harley Street Clinic provided day surgery and inpatient care for adults requiring general surgical procedures and cancer surgery. Surgical procedures included complex cardiothoracic, maxillo-facial, breast, colorectal, orthopaedics, neurosurgery, gynaecology, vascular and colorectal surgery. The hospital provided surgical treatment for private patients from the UK as well as from overseas.

In the last 12 months, 18.6% of the total surgical procedures performed at The Harley Street Clinic from 1 January 2022 to 31 December 2022 were under NHS contracts.

There was one surgical ward with 14 private single occupancy rooms and a mixed medical-surgical cardiac ward with 15 private single occupancy rooms. The hospital had four main operating theatres available seven days a week.

The service was consultant led with resident doctors also providing medical cover. Consultant surgeons and anaesthetists had practising privileges to carry out consultations, admit and treat patients having surgical procedures at the hospital.

The service was open seven days a week and admissions to the surgical inpatient wards and theatre lists were planned in advance. Urgent readmissions were accepted, and surgeons were notified of emergency admissions by the hospital's admissions office.

Outstanding ☆

Surgery

The hospital still had a service level agreement with a local NHS trust to carry out some NHS neurosurgery at the hospital to increase the trust's capacity.

Managers planned and organised the service so they met the needs of the patient population. As the hospital provided private elective surgery, appointments could be planned to suit patients' schedules.

The hospital was located in central London, with good public transportation links, making it accessible to patients from a wide geographical area.

Facilities and premises were appropriate for the services being delivered. Since our last inspection the surgical ward had been refurbished. Staff told us they had a lot of input into the design of the ward and the additions they made to the patient bedrooms for example each room now had a hand-held mirror to help patients with stoma care. Physiotherapists had input into the type of chair within patient rooms which could be height adjusted depending on the needs of the patient.

There were plans to refurbish the cardiac ward which accommodated cardiothoracic surgical patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. However, the multi-faith room was still not fit for purpose.

The service was inclusive and took account of patients' individual needs and preferences. Patient records detailed a patient's additional needs. Staff made reasonable adjustments to help patients access services. Patients were able to book surgery dates to suit their plans and commitments.

Upon discharge, patients were given a discharge information leaflet which detailed a telephone number to call at any time if they had any concerns. They were given the telephone number of the clinical nurse specialist for their condition whom they could contact with any questions they had.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us although they rarely treated patients living with dementia and learning disabilities, this would be flagged at the pre-assessment stage and patient passports and communication aids would be used to support the patients. Staff told us they had recently supported a patient with autism and worked with the patient and their carers to ensure the patients' needs were met throughout the journey from pre-assessment through to discharge such as ensuring familiar staff members and allowing the patient to visit wards and theatres beforehand.

Pull-out beds were available for carers or relatives who wanted to stay overnight with the patient. These were available free of charge. The hospital had internet (Wi-Fi) for public use. Patients we spoke with said they were able to access the Wi-Fi easily.

The hospital had on-site Arabic interpreters and used an external contractor to provide interpretation services for other languages as well as British sign language. Interpreter services would be arranged from the point of booking at the pre-assessment stage.

Leaflets we saw on the wards were in English, but staff told us patients could request the leaflets in another language and this could be provided to them.

Patients were given a choice of food and drink to meet their cultural and religious preferences. We saw food menus and saw that there was a wide range of choices for patients who required halal, kosher, vegetarian or vegan meals. The menu also catered for patients with food intolerances or allergies.

The hospital chaplaincy service was multi-faith and provided spiritual support 24-hours a day, seven days a week. Staff were aware of how to contact chaplaincy services for patients and their families. At our last inspection, we noted that the multi-faith room's environment was not appropriate to meet the spiritual needs of those using the room. At this inspection we found there was no signage to the multi-faith room and the room itself was small and not accessible to wheelchair users. The service had some mitigations in place in relation to this, for example, we were told that prayer mats could be brought to patients so they could pray in their room and clinic rooms nearby could be used should a patient prefer contemplative time outside of their hospital room.

Access and flow

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

There was timely access for surgical services at The Harley Street Clinic. There were no waiting times for referral to treatment or delays in accessing services. Admission could also be facilitated at short notice to meet patients' individual needs. Waiting times to access services were driven by patient choice and patients could be seen within days. Patients we spoke with told us they did not have to wait long for their procedure to be arranged.

In the last 12 months, 98.8% of patients accessed services where the booking reservation was taken on the same day. Admissions for surgical procedures were elective and planned in advance.

Patients requiring urgent unplanned readmissions were managed by the duty manager who was available 24-hours a day, seven days a week.

Patients were admitted by consultants with practising privileges following an outpatient consultation or a direct referral from their GP.

We followed the patient journey through theatres and found that patients were transferred from the recovery bay to the ward appropriately and without delay. Staff reported that they did not experience access issues moving patients from theatres to recovery as capacity was never at 100%. Patients had a designated room on one of the surgical wards which was reserved from admission so there were no delays moving patients back to the ward.

Bed meetings were held daily where the number of expected admissions and any other issues were discussed. There were enough beds on the wards for patients who required an unexpected stay overnight, for example patients undergoing day case surgery.

The service did not treat complex patients, such as patients with mental health conditions and bariatric patients with a weight of above 159kg but did treat some patients with multiple co-morbidities, in line with the admission criteria. The service had strict admission criteria which was outlined within their admissions policy and the consultant was required to ensure the patient met the criteria by submitting a booking request form with all of the relevant patient information, expected length of stay, procedure and any specialist requests.

Outstanding ☆

Surgery

An on-call theatre team was available in event of an emergency and consultants were required to be contactable at all times while their patient was in the hospital.

Staff told us the discharge process was effective and they had few cases of delayed discharges. Medicines to take away were prepared before discharge so a patient did not need to wait for this upon discharge.

Of the 3102 surgeries performed at the hospital in the last year, 54 (1.7%) were cancelled. The main reasons for cancellations were due to the patient being unfit for surgery.

Learning from complaints and concerns

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

The service had an up to date complaints policy which provided guidance on how to manage complaints. Complaints were overseen and investigated by the ward manager and any learnings from complaints were discussed with teams during team meetings and huddles as well as being displayed on departmental quality boards to help improve daily practice.

In the last 12 months the surgical service received 13 formal complaints. Complaints were investigated, learning was identified, and the service apologised to patients when something went wrong. The main themes from the complaints were around communication around admissions, transfers and discharge processes. All learning outcomes were shared and discussed at the quarterly clinical operations report (QCOR) meeting, the monthly board meeting, the patient experience committee and the medical governance and quality committee.

There were several ways patients and families could send feedback including filling in feedback forms. Patients we spoke with were aware of how to make a complaint and told us they felt comfortable about speaking directly with staff if they wanted to complain.

The hospital was subscribed to an independent adjudication service that investigated complaints objectively when they could not be resolved locally. The service clearly displayed information about how to raise a concern in patient areas and on their website. Patients were provided with information on how to refer unresolved complaints for independent review.

Is the service well-led?

Outstanding ☆

Our rating of well-led stayed the same. We rated it as outstanding.

Leadership

Leaders had the experience, capacity and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. There was an embedded system of leadership development and succession planning.

Outstanding ☆

Surgery

There was a clear management structure with defined lines of responsibility and accountability. There was strong collaboration and support across all departments with a common focus on driving and improving the delivery of high-quality patient centred care and people's experiences.

Day to day leadership of the surgical service was managed by the ward and theatre managers and head of nursing for the surgical service.

Leaders at all levels demonstrated high levels of experience and capability to deliver sustainable care. Leaders had a strong understanding of issues, challenges and had a good grasp of the priorities of the service for example the refurbishment of the cardiac ward.

All staff spoke highly of their managers and spoke of good teamwork and support. They commented on the friendliness and visibility of the senior leaders and of being able to approach them.

Leadership development was embedded within the service. Staff told us they were supported by their managers to develop their skills, access development opportunities and take on more senior roles. The hospital had adopted the 'nine box grid' which was an employee assessment tool that plots employees across nine key data points in order to develop tailored professional development plans to strengthen their role and prepare them for further career advancement.

There was inclusive and effective leadership at all levels. Senior staff empowered staff to develop professionally and contribute to the development of the service. Staff on the surgical ward had been upskilled by consultants to manage pituitary surgery patients. Consultants commented that they had empowered staff on the surgical ward to take care of their patients and this had a positive impact on the patients' recovery journey and without the need to go to the intensive care unit. Ward managers supported staff to develop by encouraging them to join courses and showing them how to conduct appraisals by letting them sit in on their appraisals.

Staff we spoke with knew the names of the senior leadership team. Staff told us they were visible and regularly visited the wards and attended staff meetings.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress. The vision and strategy had supporting plans and objectives which were innovative and achievable.

Staff we spoke with knew about the hospital's mission statement: "committed to the care and improvement of human life."

The strategic objectives for all services originated from the overall HCA Healthcare UK Plan of 'One HCA' building around 7 pillars of service which were: Exceptional People Exceptional Employer, Partnering with Outstanding Consultant Teams, Proving Our Value, Sustainable Business, Routes to new Patients, Seamless Patient Support, Geographical Growth.

We saw the hospital's values and objectives were displayed on staff noticeboards and staff we spoke with knew of these and their individual service objectives (theatre, surgical ward, cardiac ward, pre-assessment) and described these as forming part of their discussions in team meetings. We saw in team meeting minutes that objectives were discussed.

Surgery

The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. The hospital's objectives included a focus on improving staff sense of belonging at the hospital by creating succession plans for all heads of departments and leaders and celebrating awards programmes, staff who have provided excellent patient care and customer experience. There was a focus on audit and research opportunities across the consultant body, sharing performance results at conferences and in journals, expanding therapies and supportive services and integrating with multidisciplinary teams.

The surgical service had a clear vision and set of departmental objectives, which were focused on delivering safe, high quality, patient centred care.

Surgical service objectives included plans to increase speciality skills within all areas of the service, utilising other high performing teams from other hospitals managed by the provider and external education opportunities; tailoring professional development plans and providing mentorship to strengthen the role of band 6 and 7 leaders to prepare them for further career advancement; celebrating exceptional work and patient care through personal feedback and awards systems; working closely with consultants to perform in the top metrics for theatre utilisation to minimise on the day cancelations by ensuring robust pre-assessment and ensuring a seamless patient pathway in all areas.

The objectives also included a 5-year strategy for cardiothoracic and vascular services and ensuring nursing input in surgical service line strategies.

The service objectives aimed to reduce pressure on local NHS hospitals by continuing to work closely with consultant secretaries and NHS links by promoting theatre space and taking ownership to secure complex cases.

Staff knew and understood the values and objectives for their service, and their role in achieving them and were committed to providing safe care and improving patient experience.

Staff had a clear understanding of what the service wanted to achieve and there was a sense of motivation and enthusiasm amongst the team in all areas from pre-assessment, wards and theatres in relation to the objectives which had been set.

Culture

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

Staff were passionate about their work and spoke of good teamwork in a patient-centred environment. We observed positive and supportive relationships between leaders, consultants and staff at all levels within the surgical service and other departments in the hospital.

We found an open and honest culture and staff told us they felt supported by their managers to develop. Staff of different grades we spoke with gave examples of how they were encouraged to develop. A healthcare assistant told us they had been offered to start a nurse associate role. Ward managers helped nursing staff develop by helping them learn about how to conduct appraisals. Staff on the cardiac ward spoke enthusiastically about the cardiac study day which was held by a consultant. They told us ward managers and the head of nursing was visible and approachable. Staff commented on how they often saw senior leaders on the wards. Theatre staff told us the medical director for the hospital had visited theatres and observed procedures recently.

Outstanding ☆

Surgery

Leaders promoted a positive culture which supported and valued staff, creating a sense of common purpose based on shared values. Staff throughout surgical services were welcoming and friendly and committed to providing high quality care for their patients. Staff consistently told us they were proud to work at the hospital and as part of their team. They told us there was a supportive, 'family' atmosphere at the hospital and good teamwork and collaboration within and between all teams from the clinical staff to catering team staff.

The safety and wellbeing of staff was promoted. The hospital focused on promoting equality, diversity, and inclusion. There were various forums such as the colleague council, diversity, equality, inclusion and belonging forum which were open to all staff and highlighted the importance of ensuring everyone had a voice and felt able to contribute to the success of the service. Staff we spoke with told us they felt they were kept up to date with any changes within the department from refurbishment updates to changes in practice.

Staff told us they felt heard by the management team. As part of direct feedback from the staff group to celebrate achievements, the surgical ward had created a monthly newsletter capturing the achievements of the team including team members' birthdays, new qualifications, staff awards and training and audit compliance rates. Staff told us this had significantly helped to keep morale high on the ward and the highlights within the newsletter made them feel valued.

The service had a caring culture. Staff we spoke with told us they felt valued and were treated fairly and equally. Staff commented on how their cultural needs were taken into consideration such as being allowed time for prayer, as well as how managers were considerate of any childcare responsibilities they had. Staff told us they felt appreciated when they were personally thanked by managers when they were able to step into a shift at short notice.

There were consistently high levels of constructive engagement with staff in surgical services, including all equality groups. Staff at all levels were actively encouraged to raise concerns and told us they felt able to report concerns to their managers.

Staff, patients and families were encouraged to provide feedback and raise concerns without fear of reprisal. Staff confirmed there was a culture of openness and honesty and they felt they could raise concerns without fear of blame. They were aware of the Freedom to Speak Up champions within the hospital as an alternative route to raise concerns.

Governance

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

Staff we spoke with had a good awareness of governance processes and knew how to escalate their concerns. There were several meetings where staff could voice their concerns.

The medical advisory committee (MAC) met quarterly and reviewed clinical quality and governance matters including risks, incidents and practising privileges.

There was a responsible officer responsible for the medical practitioners and they ensured appraisals were up to date to meet the requirements of the practising privileges agreement. The chair of the MAC assessed applications for practising privileges and the applications would be discussed and agreed at the MAC meeting.

There were weekly complaints, litigation, incidents and patient experience (CLIP) meetings which were attended by staff from all departments. Minutes we reviewed included feedback from audits, incidents and learnings, complaints and patient feedback.

Ward and theatre teams held monthly team meetings to discuss incidents, audit results and safety alerts. Minutes we reviewed showed a comprehensive discussion of audit results, incidents as well as celebration of staff promotions.

Staff told us the head of nursing held a complaints huddle once a week to discuss any complaints received and learnings that could be shared. After any incident, the ward manager told us there would be a debrief and ad hoc meetings where necessary.

The hospital had committees such as health and safety, patient safety, patient experience, clinical nurse specialist, medicines management where representatives from the surgical service would attend and feedback to the team at the monthly meetings.

The hospital held monthly mortality and morbidity meetings. We reviewed the minutes from the most recent meeting which showed a comprehensive discussion of a case which was then shared with the relevant MDT.

The hospital held monthly medical governance and quality committee meetings which reported to the executive board providing an overview of governance activity and performance, assurance of compliance, learning and improvements and escalation of any issues for the board to consider.

The hospital produced a quarterly clinical operating report (QCOR). The report reviewed and monitored key performance indicators (KPI) on a quarterly basis, as well as infection control, incidents and patient experience.

Management of risk, issues and performance

Leaders and teams demonstrated commitment to best practice performance and risk management systems and processes. They identified and escalated relevant risks and issues and identified actions to reduce their impact effectively and in a timely manner. They had plans to cope with unexpected events.

The service had a risk register which was reviewed monthly. Each risk was given a score, review date, a set of control measures and allocated with a risk owner to carry out any mitigations. The issues and risks which managers identified were in line with what we found on inspection, and there was alignment between these and the risks outlined on the risk register. The top risks within the surgical services were around staffing in theatres, Wi-Fi stability impacting electronic observation systems on the cardiac ward and the environment on the cardiac ward which required refurbishment. Mitigations were in place for these and managers as well as staff were able to explain these comprehensively.

The hospital also had a risk dashboard which outlined risk status across the hospital to ensure risks could be monitored and updated continually.

There was a formal audit programme for theatres and surgical wards. Results and findings were presented at the facility audit committee, medical governance and quality committee and medicine management committee meetings and action plans were reviewed. Audit results were shared and escalated to the corporate audit working group and corporate audit committee.

Surgery

The hospital had recently introduced a new audit reporting tool and interactive audit dashboard so that each month, every department received audit results and a summary of any non-compliant questions. This supported discussions at monthly team meetings and allowed for staff to identify any gaps and take actions in a timely manner.

The service had appropriate emergency action plans for incidents such as power loss or fire. These outlined clear actions staff were to take and contact details of relevant individuals or services. The service had a back-up generator but as procedures were elective and if they were non-life threatening, procedures could be stopped, measures implemented to ensure the patient is safe and appointments were cancelled and rebooked.

Information Management

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

Staff had access to patients' health records and the results of investigations and tests in a timely manner. The hospital used systems which allowed the service to manage quality and compliance processes and ensure audit completion. The service used an electronic observation tool to help with early identification of sepsis in real-time.

There were effective arrangements to ensure the confidentiality of patient identifiable data. Paper based patient records were stored securely in lockable cupboards at the nurse's station and electronic information was on a secure server which was only accessible by authorised staff members. There were computer stations throughout surgical services and staff told us there were enough numbers of computers to access when they needed. We observed staff logging off after using computers.

Staff commented that the IT system was user friendly and showed us they could easily find policies on the hospital intranet and access various systems without issue.

The hospital had Wi-Fi for public use. Patients we spoke with said they were able to access the Wi-Fi service.

Engagement

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

Patients were encouraged to share their views on the quality of the service through the patient feedback questionnaires. The service used patient feedback to guide the service delivery and responded to any concerns raised or suggestions made by people who used the service. Patient questionnaire results were consistently positive. The hospital also had a patient user group which was an initiative, made up of lots of different patients to help improve patient experience of their care and treatment at the hospital.

The hospital undertook a staff survey which asked questions covering areas such as meaningful conversations, growth, support, retention, communication and recognition.

The surgical service was in the top five of the departments in relation to high engagement scores.

Actions from the staff survey for the surgical department included: continuing monthly meetings with the newly hired staff; having a clinical practice facilitator involved in staff development; prioritising promotion; continuing the team newsletter.

The hospital had various staff engagement forums such as the colleague council, diversity, equality, inclusion and belonging forum, and staff listening forums where all staff were invited to join.

Staff were engaged in the planning and delivery of the service and surgical ward staff told us how they were heavily involved in the refurbishment and redesign of the ward. This included improvements to equipment in patient rooms and having a dedicated staff room. The cardiac ward was next to be refurbished and staff were excited to be involved in the refurbishment plans.

Staff told us they felt able to suggest new ideas to their managers and they were listened to. Staff had suggested a monthly staff newsletter which the team on the ward were proud to showcase and continue doing every month. They had created a video newsletter and staff told us the newsletter had a positive impact on staff and brought the team together.

We spoke with an anaesthetist who told us the hospital provided accommodation at a nearby hotel for them if they were required to stay overnight unexpectedly.

Theatre staff told us they were involved in improvements to the environment of theatres. As part of the improvement, staff had requested hand cream to be available for staff in the staff room. The hospital had listened to this request and had included this as part of the improvements made to the theatre department.

Staff told us whilst social events had been limited during the pandemic, the service did arrange social gatherings and meals together. The ward manager for the surgical ward told us they brought breakfast or snacks in for staff as part of staff meetings.

There were several staff award and recognition programmes at the hospital. The surgical service had created an additional award so healthcare assistants and staff who were not nurses could also be recognised.

Staff had access to an employee assistance programme which was a telephone line, which was available 24 hours day, 365 days of the year to provide counselling following incidents and to support staff should they require additional support.

Learning, continuous improvement and innovation

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

Staff were committed to continuous learning. Staff told us they were supported by their managers to develop their leadership skills and access development opportunities. The hospital offered university accredited courses such as a masters level anaesthetics course, learning courses for healthcare assistants, nursing associate programme and university accredited management and leadership development course.

Staff had been involved in a quality improvement project to improve the electronic records system. They told us they were actively approached when new systems were being introduced so they could give feedback on them.

Outstanding ☆

Surgery

Staff also commented on consultant led cardiac study days on the ward which all staff could attend. Physiotherapists told us they were given time to take part in a journal club to critically review the current literature on topics of interest for improvement of clinical practice.

The service was actively involved in research. Surgical resident doctors were academically attached to a local university and regularly contributed to research papers and publications. Current fellows were carrying out research in novel technologies such as breath testing to detect gastrointestinal cancers. Other areas of research by resident doctors included kidney transplantation in older people.

Surgeons had introduced several innovative technologies. For example, most recently, the service was able to provide minimally invasive cardiac surgery using a three-dimensional camera system.