

HCA International Limited

The Wellington Hospital

Inspection report

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

Ratings

Overall rating for this location

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

Overall summary

The rating of the core service inspected improved. We rated it as outstanding because:

Patients were protected by a strong comprehensive safety system with a focus on openness, transparency and learning when things went wrong. The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, 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 seven days a week.

Patients were truly respected and valued as individuals and were empowered practically and emotionally as partners in their care. 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.

Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility choice and continuity of care. The service made it easy for people to give feedback. People could access the service when they needed it and did not have to wait for treatment.

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

Summary of findings

Our judgements about each of the main services

Service

Rating

Summary of each main service

Surgery

Outstanding



Our rating of this service improved. 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 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. Key services were available seven days a week.

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

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

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

Summary of findings

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Summary of this inspection

Background to The Wellington Hospital

The Wellington Hospital is the largest private hospital in the United Kingdom (UK), it is owned and provided by Hospital Corporation of America (HCA) International Limited. The hospital is located in St Johns Wood in the London Borough of Westminster. The hospital has an urgent treatment centre but does not provide an Accident and Emergency service, however there are several NHS services within a four-mile radius. Services are provided from four buildings, three of which are located on Wellington Road; the North, Central and South buildings and one on Lodge Road called the Platinum Medical Centre.

The Wellington hospital is registered for the following regulated activities:

- Treatment of disease, disorder, or injury.
- Surgical procedures.
- Diagnostic and screening procedures.
- Management of blood and blood derived products.
- Family planning Services.

The Wellington Hospital provides services to both UK and international patients with medical insurance, patients sponsored through their respective embassies, self-funded treatments and a small number of patients referred through NHS contracts. In the year 2022, the surgical services attended to a total 4704 patients with private medical insurance, 1278 self-paying patients, 922 NHS patients and 233 patients through their respective embassies.

There were 73 theatre staff employed at the hospital, 26 employed consultants and 424 consultants with practising privileges.

Data requested from the hospital was from the period March 2022 to February 2023, as data from March 2023 was still in the process of being collated and validated and not available until April 2023. Therefore, the reporting period referred to in the report represents data from March 2022 to February 2023, unless stated otherwise.

The number of surgeries carried out in the reporting period was 5724 and the number of cardiac catheterization laboratories (also known as Cath Labs) in the same reporting period was 1470. The top three surgeries performed at the hospital were spinal, orthopaedic, and general surgery. Other surgeries performed at this hospital included, cardiothoracic surgery, gastrointestinal, hepatobiliary, gynaecology, ears, nose and throat surgery, oral and maxillofacial surgery, breast surgery, and much more. There were 12 operating theatres to facilitate the surgeries.

How we carried out this inspection

We inspected this service using our focus inspection methodology, inspecting the core service of surgery only as part of our routine inspection programme. We carried out the unannounced inspection on 21 March 2023.

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>.

Summary of this inspection

Outstanding practice

We found the following outstanding practice:

- There was a strong culture of shared learning when things went wrong and incidents were discussed formally and informally, encouraging strong staff participation in learning, and sharing. Processes were adapted and changes were made quickly to avoid repeat incidents and all staff had knowledge of incidents that happened outside of their immediate working area through news bulletins, posters, and feedback Friday.
- Training modules that occurred in house were adapted to suit the needs of staff, patients, and the service. The Practice Facilitator was a certified trainer in key skills and was able to train staff directly for their job role. Staff were continually trying to improve and better their training to provide the best care for their patients.
- The service had focused on pain management effectively and utilised different aids and technology to manage pain well. Patients had access to pain consultants and clinical nurse specialists for pain. More than 99% of patients surveyed on surgical wards reported that their pain was managed to their satisfaction. The hospital supported national pain awareness month and held events to improve knowledge and communication around pain.
- Patient outcomes were positive for example the national survival rate for cardiac surgery was 96.7% and HCA UK had a survival rate of 99.2%.
- There was effective multidisciplinary team working, that occurred daily, weekly, and monthly. Staff were invested in providing the best care and service to their patient.
- The hospital ran health awareness events for the general public, including educational events and patient health talks to care for their local community.
- Staff thought about the wellbeing and comfort of patients even after they had been discharged from the hospital and sought out equipment that could be purchased online to ease a patient back in their home environment.
- There was a strong well-known vision and strategy at the hospital. Staff wellbeing and patient care was at the height of the hospital's own strategy. Committees and mechanisms were in place to support the strategy and deliver the vision. Strong leadership was found at all levels and staff spoke highly about all staff and of working at the hospital.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	<div>☆</div> Outstanding	<div>☆</div> Outstanding	<div>☆</div> Outstanding	<div>☆</div> Outstanding	<div>☆</div> Outstanding
Overall	Good	Good	Good	Good	Good	Good



Surgery

Safe	Good
Effective	Outstanding
Caring	Outstanding
Responsive	Outstanding
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.

The mandatory training was comprehensive and met the needs of patients and staff. Staff received and kept up to date with their mandatory training. Mandatory training included but was not limited to fire awareness, equality and diversity, health and safety and safeguarding adults and children level one and two.

Mandatory training was monitored by the Practice Facilitator twice a month and alerted staff when they needed to update their training. Completion rates for training were monitored and we saw that staff received emails to remind them of upcoming training modules due for completion. Staff also stated that reminders were given to them verbally at the daily morning safety huddles.

The service had set a 85% mandatory training compliance target. We reviewed training records which showed completion rates for training was 92%. The Practice Facilitator explained that some staff were on long term sickness however, the training compliance remained above target.

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

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.



Surgery

All staff received training specific for their role on how to recognise and report abuse. HCAUK set out an 85% compliance target to complete safeguarding training. We saw evidence that the overall compliance rate for safeguarding training for surgical staff, including on the wards and in theatres was 96%. This training included safeguarding children level one and two and safeguarding adults' levels two and three. The named safeguarding lead had completed training up to safeguarding children level 4.

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

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could give examples of abuse found in the safeguarding policy and knew the name of the safeguarding lead within the hospital. Staff followed the managerial hierarchy and would initially report safeguarding concerns to their manager.

We found the safeguarding policy kept in a folder within theatres. It was up to date and included reference to modern slavery, female genital mutilation, PREVENT and other forms of abuse. The folder was easily accessible to all staff in theatres. The policy was also located on the hospital's electronic policy library.

Cleanliness, infection control and hygiene

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

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

Staff used records to identify how well the service prevented infections. Patients with known infections were last on the list, or if scheduling commitments allowed, the patient would be treated in an unused theatre that day. Data showed low rates of hospital acquired infections such as Clostridium Difficile (C.Diff), Methicillin-Resistant Staphylococcus Aureus (MRSA), Escherichia Coli (E. Coli), and COVID 19. There were no cases of C. Diff reported in 2023 and one case of MRSA, E. Coli, and COVID 19 in the months of January and February 2023.

We observed staff using alcohol gel between patient contact, entering patient rooms and when moving around the hospital. Hand hygiene audits consistently showed positive results, showing 97% compliance on average for the last 12 months.

We observed staff wiping down keyboards and the computer mouse after use. Staff cleaned equipment after patient contact. Porters assisted with theatre cleaning postoperatively as per the cleaning policy. Daily cleaning was overseen by the theatre lead nurse.

Staff followed infection control principles including the use of personal protective equipment (PPE). Infection Prevention Control (IPC) was a mandatory part of training for all staff. We observed all staff using PPE and all staff complied with bare below the elbow guidance. We saw surgical staff wearing scrubs, clogs, hair coverings, masks, and gloves whilst in theatres.



Surgery

Staff had access to a sharp's injury kit. We observed checks on this kit had been undertaken from January 2023 to March 2023 to ensure the kit was in date and fit for use.

We observed good practice for sterile item checks, for items such as tracheal tubes and laryngoscope blades.

Staff worked effectively to prevent, identify, and treat surgical site infections. We observed staff using sterile fields in surgery. A sterile field is an area created by placing sterile surgical drapes around the patient's surgical site and on the stand that will hold sterile instruments and other items needed during surgery. The hospital had an effective Central Sterile Service Department (CSSD). We looked at service records for equipment used for sterilisation which were well completed and up to date. The hospital had recently invested in new equipment to enhance the CSSD. We observed staff checking sterile items were all in date and sterile before use.

The Wellington Hospital had low rates of surgical site infections. There were seven surgical site infections in the reporting period March 2022 to February 2023. We saw that the hospital had a robust governance process for surgical site infections and investigations including a post infection review process which was discussed with the relevant consultant. The reviews were discussed at the quarterly infection prevention committee and monthly medical governance committees. Surgical site infections rates were benchmarked against Private Healthcare Information Network (PHIN) data.

We looked at the daily cleaning schedules in theatre and observed all checks were completed daily for the month of March 2023.

The hospital had a monthly bug brief for infection control news and staff were encouraged and reminded to read the bug of the month during the morning theatre brief. The March '23 bug of the month was Staphylococcus. The brief also contained information and updates on policies and training.

Recovery areas in theatres had disposable curtains which was dated 28 February 2023.

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 was visibly clean and dust free. All doors within departments were intact and were kept closed adhering to fire safety regulations. The lighting was good, and the floor was clear of clutter.

The design of the environment in the theatre and wards were well designed and followed national guidance such as the Health Building Note Guidance. 10 out of the 12 theatres had laminar air flow which was managed by the in-house estate team. There was a single air flow system per theatre so that issues could be isolated, and interruptions could be minimised.

Staff carried out daily safety checks of specialist equipment. We saw safety daily checks had been carried out on the resuscitation trolley, theatres, and fridge temperature. We saw theatre daily checklists were completed and thorough and included theatre lights and table attachments.

We observed the equipment in recovery was tested and documented such as the emergency alarm test. Temperatures were monitored and recorded, and daily safety checks were documented and completed.



Surgery

Staff disposed of clinical waste safely. We observed consultants disposing of sharps in sharps bins that were signed, dated and not over full. We saw domestic waste being separated from the clinical waste and placed in appropriately labelled bins. We found the sluice room to be clean with suitable storage and items were not stored on the floor. Equipment we saw in the sluice room, for example a biohazard spill kit was in date.

All patients had private rooms with ensuite at the hospital. Patients could reach call bells and staff responded quickly when called. We observed staff attending to patients within a minute of a call bell being activated. We observed call bells close to patients whenever we visited a patient inside their rooms. Call bells were encased with a material that gripped onto surfaces and had an extendable cord to reach patients at different points in their room.

The service had enough suitable equipment to help them to safely care for patients. We looked at a range of medical devices and found that all equipment had been electrical tested. This included: syringe drivers, ultrasound machines, anaesthetic machines, and screens in theatres.

The service had suitable facilities to meet the needs of patients' families. The patient rooms were large, each with a bed, two chairs, a table and television. Patient privacy could be well maintained at all times.

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

There was a well-documented exclusions policy for patients attending the hospital for surgery. This included but was not limited to children and young adults under 18 years of age, women in labour or over 20 weeks' gestation presenting with obstetric problem, bariatric patients with a weight above 159kg.

The service had a robust process in place for assessing patients prior to admission. All patients had their patient history taken in detail, including pre-existing conditions during their pre-assessment appointment; medications such as blood thinners were noted and the patients' general health.

All patients had a pre-assessment appointment to ensure they met the inclusion criteria for surgery and to identify any risks that may lead to complications during the anaesthetic, surgery, or post operative duration. Only patients going for major operations were seen for pre-assessment face to face. Patients undergoing minor procedures had their pre-assessments taken over the phone.

Staff completed risk assessments for each patient on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with any specific risk issues. Patients had a Venous Thromboembolism (VTE) assessment documented, a water-low risk assessment – which calculated the risk of pressure ulcers developing – and a pregnancy status documented in their records.

We observed a surgeon checking the patient's pregnancy status and any known allergies. We also observed the surgeon asking the patient if there were any concerns before commencing with the procedure.

Morning theatre huddles included all necessary key information to keep patients safe. We observed a morning theatre huddle and saw the theatre manager hosting the meeting and keeping staff engaged within the meeting.



Surgery

Staff shared key information to keep patients safe when handing over their care to others. We saw shift changes; safety briefings and handovers included all necessary key information to keep patients safe. Information was shared during the morning briefing and discussions held included patients requiring additional support. Handovers were designed around the 'big four' which were safety, policies of the month, training, and incidences.

We witnessed good communication within theatres to ensure the safety standards and national guidance had been met. For example, the service developed Local Safety Standards for Invasive Procedures (LocSSIPs) that were compliant with National Safety Standards for Invasive Procedures (NatSSIPs). The service also followed and adhered to the World Health Organisation (WHO) Surgical Safety Checklist.

We observed good practice and adherence to the count and check policies. We saw staff using a surgical count board to count swabs, tags, blades other medical consumables used in theatre.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The hospital used the National Early Warning Scores (NEWS) to assess for deteriorating patients and we saw that there was good record keeping of NEWS in patient notes. Patients had access to emergency care 24 hours a day seven days a week (24/7). Staff could call the outreach team for patients that deteriorated. The outreach team was available 24/7 with intensive and high dependency care specialities.

First aid kits were available on all the floors of the building and kits were in date and complete.

Staff had access to a one stop care kit that provided a range of glucose products for patient use in case of low blood sugar. All products were in date.

The service had robust processes for the recognition and management of sepsis. There was a sepsis six folder, pathway, algorithm, and screening tool to help identify a patient developing sepsis. The tools used were audited and reviewed by the outreach team.

All staff knew where their nearest resuscitation trolley was located. We looked at two resuscitation trolleys and saw that a copy of the resuscitation council guidelines was available in a folder on the trolley, the trolley was sealed and clean, the oxygen cylinder was secured, and full and daily checks had been completed.

Care plans were added to patients records if required to aid recovery. We saw patient records had extra care plans added in, such as a drain in the surgical area to remove excess fluid and reduce the risk of an infection.

All referrers were sent a copy of the clinic letter including the patients' GPs (General Practitioner).

We observed a routine fire alarm and saw that barriers were suspended over the lift doors to deter patients and their relatives, as well as staff from using the lift in case of a fire. Routine resuscitation simulations were completed regularly. Staff identified gaps in learning and actions to improve the service were put out in all communications bulletins to all staff.

Nurse 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.



Surgery

The service had enough nursing and medical staff to keep patients safe. We were told that bank and agency staff were used but managers limited their use of bank staff and only used agency staff that were familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service. The induction included a thorough orientation to their area of work and included emergency numbers, policies, incident reporting and clinical skills competencies. There were no bank staff used in the last 12 months. There was low agency use in the service over the last 12 months; data showed that there was 6.7% and 5% of hours worked in theatres and the wards respectively was via agency staff.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. All theatre lists were pre-planned and therefore the number of staff required for each shift on the ward and in theatres could be pre-determined.

Vacancy rates across theatres during the reporting period have been minimal; for the month of February 2022 (the most recent month for which reportable data was available), theatres were fully staffed and there were no vacancies. There was a recent successful recruitment drive for Operating Department Practitioners (ODP).

The service employed clinical nurse specialists in seven fields, including spinal, cardiology, and breast care.

The service had low sickness rates and turnover rates and the wards had reducing vacancy rates.

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.

All consultants with practising privileges had a bi-annual review which looked at credentials, training and revalidations. This was overseen by the Chief Executive Officer. There was a total of 750 consultants with practising privileges at The Wellington Hospital. Data from the Patient Reported Outcome Measures (PROMs) was used to support consultant annual medical appraisals.

The service had practising privileges with internationally renowned spinal experts offering integrated clinical Multi-Disciplinary Team (MDT) care for patients, including distinguished consultants who held parallel senior clinical research posts at leading London teaching hospitals. The service also had practising privileges with world leading cardiologists and cardiac surgeons.

Consultants spoke highly of Resident Doctors working at the hospital. Resident Doctors were described as very competent and were confident to call the Consultant managing the patient's care with any problems that required escalation.

There was also 24/7 Resident Doctor cover, (during the day there was one Resident Doctor per floor of the hospital). There was also a 24/7 on-call speciality consultant rota and the hospital was working towards being able to offer anaesthetist 24/7 cover through the HCA Anaesthetist Hub. Staff had access to a 24/7 Intensive Care Unit consultants for patient review if required.

The hospital had access to two consultant anaesthetists employed by HCA who they could call upon if required.

Records



Surgery

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

Records were stored securely; paper notes were locked away and electronic records were password protected.

The systems used to manage and share information needed to deliver effective care treatment and support were coordinated, provided real time information across services, and supported integrated care for people who used the services. We saw how easily staff on the wards could access patients' real time theatre notes allowing staff to prepare for the patients return to the ward, including meal preparation.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients were able to transition seamlessly between services as there was advance planning and information sharing between teams. Different forums and avenues allowed staff to communicate patient needs, and electronic records facilitated this.

Patient notes were comprehensive, and all staff could access them easily. Records we reviewed included relevant patient assessments such as VTE assessments and known allergies were clearly documented. Documented consent processes covered pregnancy status checks, initial consent at the initial consultation and reconfirmation of consent on the day of surgery, in line with good practice.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff performed surgery under general anaesthesia. We observed good handling of medication by anaesthetic staff and the ODP. We saw that medication was prepped, labelled, capped, and stored in drug trays ready to be administered to the patient. Before administering the medication, we saw that the medicine was doubled checked by the anaesthetist and an Operating Department Practitioner.

Staff completed medicines records accurately and kept them up to date. We observed staff checking medication expiration dates in theatres. Controlled drugs (CD) are those medicine which require additional security and recording measures because of their potential for misuse. We observed CDs were safely stored and observed the logbook checks were completed between October 2022 and March 2023.

Staff followed national practice to check patients had the correct medicines when they were admitted, or when they moved between services. We observed 'stop before you block' posters in theatres, which was a campaign aimed at reducing the incidence of inadvertent wrong-sided nerve block during regional anaesthesia.

Staff stored and managed all medicines and prescribing documents safely. We observed fridge ambient temperature and room temperature charts that were completed for every working day, initialled and within range. Charts encouraged staff to log actions taken if temperatures were outside of range. We observed monthly expiry dates checked and logged for all medications for the months of January 2023 to March 2023.

Incidents



Surgery

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.

There was a genuine open culture in which all safety concerns raised by staff and people who used the service were highly valued as integral to learning and improvement. Staff knew what incidents to report and how to report them. Staff were told 'that if something does not look right, it probably isn't right'. Staff were given the responsibility and encouragement to speak up and advocate for their patient.

Staff reported serious incidents clearly and in line with the providers policy. Staff raised concerns and reported incidents and near misses in line with their provider policy.

The service had not reported any never events on any of the wards in the reporting period.

All staff were open and transparent and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the level of harm and near misses which provided assurance of a robust picture of quality. There were no serious incidents or never events reported in the period 1 March 2022 to 8 February 2023 in theatres. Data from March 2023 was still being collected and could not be validated until April 2023. The severity of theatre incidents was reported as 80 incidents as no harm, 42 as low harm, two as moderate and no severe harm incidents in the same reporting period. Surgical wards reported 179 incidents as no harm, 60 as low harm, one as moderate and zero as severe harm. Cardiac catheter laboratories reported 37 incidents as no harm, six as low harm and two severe harm incidents. These incidents were reported to the Care Quality Commission.

There were no wrong site surgeries in the reporting months between February 2022 and March 2023.

Staff received feedback from investigation of incidents. Staff met to discuss the feedback and look at improvements to patient care. Feedback Friday was recently introduced to the hospital to ensure a dedicated focused time to discuss incidents that had occurred in the last week. The meeting gave staff a chance to contribute, share, learn and improve by discussing incidents, complaints, and notable events. A representative from the surgical team attended the meeting and fed back information at the morning theatre brief. Clinical and non-clinical staff were invited to participate in this meeting. Incidents from other departments were shared in the morning briefings.

We saw evidence on learning from incidences in the hospital, for example, information, learning and change in practice had occurred from a recent near miss on blood safety. Staff could view this information displayed in staff areas on the ward. On the back of this, the '3C's' were introduced which stood for Check, Confirm and Clarify. This poster was displayed in the staff room and reminded staff to conform to this way of working. This also provided evidence of integrated learnings from incidents throughout the hospital.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We looked at the two unexpected deaths in the Cardiac catheter laboratories and reviewed the incident report. We saw that the consultant had ensured that the patient had been aware of the risks of the procedure during the consent process. We saw that the consultant had personally delivered the news to the patient's family members. We saw lessons learnt and recommendations and arrangements for shared learning. Actions from the report had been assigned to senior medical staff and were completed. Both incidents had been discussed at the mortality and morbidity review. Staff involved in the incidents were debriefed and offered emotional support.



Surgery

Staff understood the duty of candour. Information on the duty of candour was displayed on the wall to remind staff of this duty to all patients. Staff were open and transparent and gave patients and families a full explanation if and when things went wrong. We saw that a duty of candour had been exercised and well documented. We also saw that managers debriefed and supported staff after any serious incident.

Is the service effective?

Outstanding



Our rating of effective improved. We rated it as outstanding.

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.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Hospital policies reviewed were up to date and had gone through the necessary governance processes. The policies were developed in line with national guidance such as the National Institute of Clinical Excellence (NICE).

Staff were able to give examples of latest NICE updates including ensuring patient temperature was at least 21 degrees Celsius before, during and after surgery. The providers policy had already referred to this NICE guideline but reemphasised this to staff and upgraded their warmers.

Clinical leads were responsible for policies and received email notifications and reminders to update and revalidate policies. The service had clear and robust standard operating procedures (SOPs) and policies which were available on the electronic policy library. Staff knew how to access these policies on a computer.

The clinical governance committee monitored performance in relation to policies, procedures, standards, and guidance through the completion of regular audits. Theatre scrub nurses undertook these audits and were also known as audit links. These audits included hand hygiene, the WHO checklist and documentation compliance, consent and much more. There was a yearly audit schedule to follow for surgical wards, theatres, and the Cardiac Catheter Laboratories. Audits had been completed in line with the schedule.

There were two types of WHO audits that were conducted monthly. One was an observational checklist audit and the other was a documentation checklist audit. The compliance target for both audits was 100%. Latest audit results showed that the surgical services were 100% compliant for both audits.

The latest audit for consent showed 100% compliance.

Audit results that fell below expected compliance rates were repeated monthly. Clear action plans were put in place to improve compliance and data showed improvements had been made once actions had been met. This was evident in the nasogastric tube position audit, the sepsis audit and the VTE risk assessment audit. Action plans included moving audit completion and ownership from nursing staff to Resident Doctors, increased access to information and education.



Surgery

At handover meetings we observed, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

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

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

The hospital followed best practice set out by NICE guidelines for patients waiting to have surgery kept nil by mouth. Patients did not experience excessive periods without food and drink. The hospital followed a nil by mouth policy for food for six hours and fluids for two hours prior to surgery.

Patients with difficulty swallowing were provided with softer foods.

Patients' religious and cultural needs were met when it came to dietary requirements for example patients were offered halal and kosher food options.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Patients' postoperative pain plans were discussed during the sign out stage of the WHO surgical checklist.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. The service used verbal ratings to monitor pain on a zero to 10 scale. Staff used the Pain Assessment in Advanced Dementia (PAINAD) scale to assess pain in patients living with dementia.

Patients reported very little pain and told us that pain was managed well. Cold therapy treatment was used to help manage pain. Patients we spoke to said that pain was more manageable once they had used the cold therapy treatment machine.

Patients received pain relief soon after requesting it. Staff prescribed, administered, and recorded pain relief accurately.



Surgery

There was a pain nurse specialist that provided a monthly clinical training programme for nurses, allied health professional and medics. This was delivered in structured classroom interactions and followed up with clinical competencies at patient bedsides and included training on medical devices. Training for pain management could also be done via a virtual whiteboard, which was created on videoconference technology. Pain link champions and super users supported pain competency-based education in clinical areas.

The pain CNS represented the hospital nationally on The Pain Nurse Network and the British Pain Society Acute Pain Specialist Interest Group.

Patients had access to three pain consultants to help with the management of pain. 100% of patients said that the hospital managed pain to their satisfaction.

Three out of the four patients we spoke with reported no pain, two patients had surgery the day before and one patient had surgery on the day of the inspection.

The hospital marked the National Pain Awareness Month in September 2022 and the pain CNS held mini events in the clinical areas during this month. Events included quizzes, pain stickers, posters, and information. There was also a 'lunch and learn' in the canteen where the pain CNS shared more information on pain, displayed posters and highlighted resources available for patients. Learning cards and tests were designed to encourage staff engagement and promote discussion. Similar pain events were planned for September 2023.

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 hospital had participated in Patient Reported Outcome Measures (PROMs) audits, however due to COVID 19 the data across the hospital was limited. Data usually collected covered procedures of the shoulder, foot and ankle, elbow, hip arthroplasty, hip arthroscopy, knee arthroplasty and knee arthroscopy. PROMs data was presented at the hospitals orthopaedic unit meeting.

The service participated in submitting data to the National Joint Registry and outcome data was submitted individually by surgeons to the British Spinal Registry.

The hospital actively engaged in national outcome benchmarking and published their outcomes internally and externally. Outcomes for patients were positive, consistent, and met expectations, such as national standards. The national survival rate for cardiac surgery was 96.7% and HCA UK had a survival rate of 99.2%. The hospital also developed a cardiac surgery outcomes tool to analyse data and benchmark results; to be able to submit data to the National Cardiac Audits and registries in the future.

Managers and staff used the results to improve patients' outcomes. Data we looked at showed very low rates of patients returning to theatre. Return to theatres rates were monitored as part of the hospital Key Performance Indicators (KPIs) and logged as incidents. When patients did return to theatre a robust review was undertaken which included an examination of the medical notes and conversations with the relevant surgeon all findings were reviewed by the medical lead for governance.



Surgery

The service had low unplanned readmission rates. These were presented and examined as part of the KPI (Key Performance Indicators) data at the Medical Governance Committee, Medical Advisory Committee (MAC), Patient Safety Quality Board, and corporately at the Quality Clinical Operating Report Meeting (QCOR). Improvement was checked and monitored. The Medical Governance Lead discussed cases with operating consultants and where required sought out independent expert review. Data and findings were then presented at MAC and final oversight and assurance was delivered by QCOR.

There were 36 unexpected returns to theatre in the reporting period, two of these cases were booked in as an emergency and the remaining 34 procedures were planned.

Managers shared and made sure staff understood information from the audits. Managers and staff carried out a comprehensive programme of repeated audits to check for improvement over time. Audit schedules were in place for the year and audit links were in charge of completing audits. Managers used information from the audits to improve care and treatment. Action plans were developed where audits yielded lower than expected results to drive improvements. Audits were then repeated to assess improvements made.

Physiotherapy labs were accessible through the ward and patients were able to use these facilities to aid recovery. We saw patients using cold therapy machines soon after surgery to reduce swelling and pain.

CNS conducted spinal audits on a weekly basis, the data was sent monthly to the matron for review.

The service was accredited by the International Organisation for Standards (ISO). The central sterilisation services department held ISO for medical devices (ISO13485:2016) 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 supplemented their basic training with additional courses to enhance their skills and knowledge specific for their role. Staff were required to complete annual refresher training and demonstrate their competencies where necessary. This was overseen by either the Practice Facilitator, the team leader, or a senior staff member. This additional training included but was not limited to training in accountable items, performing surgical checklists, use of tourniquet for limb and digit surgery, and theatre scrub competencies. We looked at the training matrix and saw that all staff had completed their additional training within the last 12 months.

Training was adapted to meet the needs of the service. The Practice Facilitator was a certified trainer in basic life support, bloods, accountable items, and manual handling. This meant that these training modules could be delivered in-house. This also meant that training was personalised to individuals, patients, and suited the needs of the service. For example, in robotic surgery the surgical table was higher than standard practice and on a tilt. Therefore, when staff were trained for manual handling the Practice Facilitator incorporated training exercises involving a raised table on a tilt whilst supporting the patient and the equipment together. The Practice Facilitator was working with another Practice Facilitator from another local HCA Hospital to adapt and specialise their training further.



Surgery

Managers gave all new staff a full induction tailored to their role before they started work. Staff were given an orientation handbook which consisted of useful information, essential competencies, essential E-learning, and medical devices competencies. The handbook was specific to The Wellington Hospital. New staff had a three-month probation period which could be extended up to six months to facilitate individual needs. The Practice Facilitator supported the learning and development needs of new and existing staff.

Managers supported staff to develop through yearly, constructive appraisals of their work.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff attendance at team meetings were recorded and staff could also access electronic copies of the minutes for meetings they were unable to attend.

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

Managers made sure staff received any specialist training for their role. The Practice Facilitator organised competency training for new equipment. Representatives of new equipment would come in to train all staff. The service asked the representative to attend surgeries every time the new piece of equipment was used until all staff were fully competent in using the new equipment. The Practice Facilitator said that sometimes there would be up to a month gap between using the new equipment and could not deem staff as competent when they had only used the equipment twice in two months. The Practice Facilitator ensured the competency process was robust and rigorous, putting patient safety and their needs first.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. This included revalidation which was required by the Nursing and Midwifery Council every three years.

Managers identified poor staff performance promptly and supported staff to improve. The theatre manager explained clear procedures and processes on what to do when a staff member was under performing. The manager also referred to human resources for support if staff members had troubles in their personal life.

Managers thought outside the box to encourage good practice and competence. We saw signs in the ward staff room called '12 reasons why I give a great handover'. The manager explained that instead of listing working instructions on how to do the task she put a positive spin on delivering the information whilst providing staff with the knowledge to achieve good practice.

The service provided courses that staff could attend to further their career, education, and development, for example in theatres a nurse was currently attending an aesthetic course.

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 teams within the service were committed to working collaboratively and had found innovative and efficient ways to deliver more joined up care for patients. Staff held regular and effective clinical Multidisciplinary Team (MDT)



Surgery

meetings to discuss patients and improve their care. Staff worked across health care disciplines and with other agencies when required to care for patients. We attended a hospital wide operational MDT meeting called Patient Operation Safety Huddle (POSH) where all department managers attended to discuss the needs of the patients they were looking after. At the beginning of the meeting all attendees voiced the providers mission statement. The meeting was held twice daily for 30 minutes via videoconference and was chaired by the matron of operations. The meeting was established to ensure all leaders could connect and was aware of what was happening across the hospital that may directly and indirectly effect their own area. The meeting was a continuous review and daily update of operational priorities and progress to enhance teamwork daily communication, cooperative problem solving and escalation to senior teams where needed. We observed each department discuss various topics about their speciality including the number of staff members available, including how many were on sick leave and how many were onsite to provide optimal care, patient numbers, and those patients at risk of a fall. We observed the theatre manager discussing potential unplanned cases that day and maintenance and environmental factors such as issues and resolutions to the temperature controls in theatre. Information was delivered in a timely manner and staff workloads could be appreciated and understood by one another. POSH was attended by head of departments or managers from security, material department, therapies, outreach team, clinical wards, housekeeping and catering, pharmacy, outpatients (based at another location), endoscopy, theatres, estates, and radiology.

Surgical patients were under the care of a variety of health professionals. This included their consultant, their lead nurse, clinical nurse specialists, and physiotherapists. All healthcare professionals worked together as a team to provide an individual care plan to best treat their patients. Depending on the needs of the patients, other specialities could be involved in the care of a patient, including a speech and language therapist and a dietician. We observed a multidisciplinary approach for a patient handover from theatres to recovery. Staff involved, included the consultant, the anaesthetist, the theatre registered nurse, and the recovery nurse. Pain nurses were also involved in the handover of patient care to support the patient's pain needs. All communications between staff observed were polite, respectful, and thorough.

A clinical MDT schedule was organised for each week of the month, 1162 patients were reviewed in MDT in the year 2022.

Pictures and names of healthcare professionals in the MDT were displayed in the staff room and there was a sense of inclusion within the nursing team.

Staff referred patients for mental health assessments when they showed signs of mental ill health, or depression.

Seven-day services

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

Surgical services were provided seven days a week.

Consultants led daily ward rounds on all wards and visited their patients immediately after surgery.

Patients that were discharged were given emergency contact numbers should they require urgent advice or treatment out of hours.

Health promotion

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



Surgery

The hospital ran health awareness events for the general public including educational events and patient health talks with patient participation groups on topics including but not limited to, breast care, women's health, paediatric support, weight management and diabetes, managing high blood pressure, and men's health.

We saw leaflets on the ward informing patients of how to look after themselves at home post-surgery. This included information on how to take a shower and wash with confidence post-surgery and how to best recover.

The service had relevant information promoting healthy lifestyles and support on in-patient wards. This was in the form of Quick Response (QR) codes that were available at the information stand. Information was available on how to lose weight, drink less alcohol, smoking cessation, keeping fit, and nutrition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff made sure patients consented to treatment based on all the information available. Staff clearly recorded consent in the patients' records. The five patient records we reviewed had consent clearly documented. Consent audits were undertaken quarterly, the required compliance was 90% and the service achieved 98% in September, 100% in December and 99% in March. Patients told us they had been given clear information about the risks and benefits of their treatment which was explained in plain English before signing the consent form. Patients told us that they had the confidence to speak up if they were unclear of any aspect of their treatment.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. Consultants were able to record best interest decisions in dedicated forms for those patients unable to make an informed decision.

Nursing staff and managers received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Consultants received and kept up to date with their training with their respective NHS trust. Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Patients living with mental health were flagged at the pre-assessment stage, through the CNS or via the patient's consultant. This meant that ward staff and theatre staff were aware of patient's mental health conditions and needs before arrival.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Qualified medical staff had access to mental capacity assessments forms and a mental capacity assessment flowchart which included the five principles of the Mental Capacity Act.

The hospital did not treat patients for mental health, and therefore mental capacity and Deprivation of Liberty Safeguards (DoLs) concerns were not common. However, staff were equipped to treat patients requiring surgical interventions that lived with mental health. Staff had the appropriate training and held weekly mental capacity health meetings.



Surgery

We looked at the Mental Capacity Assessment (MCA) and safeguarding review meeting minutes and were assured that when there was a concern regarding capacity, this had been identified and appropriate interventions were in place to protect the patient's best interests. This included Mental Capacity assessments, completion of Deprivation of Liberty Safeguards (DoLS), completion of best interest forms, one to one care arrangements and completion of dementia 'This Is Me' passport.

Staff had a checklist for best practice for patients admitted with dementia. The checklist included a number of recognised dementia friendly tools such as 'Forget me Not' stickers and the 'This is Me' patient passport. The checklist also took into consideration the need for a DoLS referral, offering support and guidance from the safeguarding lead.

Patients with mental health were on a very clear pathway and were well managed.

Care packages were arranged and tailored to aid and support safe and effective patient discharge. Occupational Therapies (OT) supported patients and made referrals for discharge via adult social services or through a private local care agency. Patients were able to choose the option best suited for their needs. A package of care and equipment determined by the functional assessment was included in the referral process and the OT provided written information about the care needs post-surgery.

Is the service caring?

Outstanding



Our rating of caring improved. We rated it as outstanding.

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 those close to them in a respectful and considerate way. We witnessed staff knocking on doors before entering a patient's room and introducing themselves to patients and addressing patients by their preferred name.

We observed good practice when using manual handling techniques to transfer patients, ensuring the patients dignity was respected by covering up the patient as much as possible with sheets and blankets.

All patients were met at the reception by a ward nurse and escorted to their room by that nurse. This gave the nurse some time to get to know their patient and help settle them in for their stay.

Patients were treated with kindness, respect, and compassion. We observed staff providing reassurance to patients and saw that staff had a calm approach when communicating with patients.

Staff followed policy to keep patient care and treatment confidential. We observed that patients' room doors were kept closed when being attended to and that patient records were stored securely.



Surgery

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

The DAISY award was an international recognition programme that was set up by parents on the death of their son who had suffered from 'Disease Affecting the Immune System.' They had observed the quality of the care provided by staff and wanted to create an award to celebrate outstanding nursing practice. The hospital has adopted this award scheme and created a booklet for patients to be able to freely express their opinions about staff and the care that they have received. Using the booklet, patients were able to nominate an extraordinary nurse to win a DAISY award from the hospital. The form included a box to be ticked if they would like to be contacted regarding the winner of the daisy award for that quarter. Patients were invited back to the hospital to present the award to their nominated nurse in an award ceremony and read out the reasons for why they nominated that nurse. In the last 12 months three out of the four winners of the DAISY award worked on the surgical wards.

Staff tried to fulfil patients' requests including organising a wedding in the board room for a palliative patient and making in-patients birthdays special by making homemade birthday cakes suitable to the patient's dietary requirements.

During the reporting period March 2022 to February 2023, 98% of patients rated the overall quality of care as excellent or very good in the surgical wards. There was a 96% return rate of patients experience questionnaires in this reporting period.

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 said they had the opportunity to engage with patients and gauge how they were feeling post-operatively and would provide additional reassurance and information to help the patient.

We witnessed staff providing reassurance to patients before and during the initial stages of the procedure. Staff spoke to patients during the cannula procedures about various topics including travel and pets as a distraction to try to reduce the patient's anxiety about the procedure.

During the reporting period March 2022 to February 2023 97% of patients rated their nursing care as excellent or very good.

Staff received many thank you cards from patients for getting them through their surgery. Many patients had expressed their gratitude and praise for the care that they had received.

The service ensured that a member of the relevant CNS team was present with a consultant to support the patient when they were receiving bad news. Two CNSs had completed advanced communication skills training which equipped them to deliver information effectively and with compassion to patients with a new cancer diagnosis. There was also an E-learning healthcare module available for all staff in breaking bad news, 23 staff members had completed this training so far, and more staff were due to complete this module soon.

Understanding and involvement of patients and those close to them



Surgery

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

Staff made sure patients and those close to them understood their care and treatment. Patient leaflets were available to provide information about their treatment. This included an admissions booklet, what to expect whilst at the hospital and after care information.

Staff talked with patients, families, and carers in a way they could understand, all staff had access to interpreter services for patient whose first language was not English.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We saw patient feedback leaflets in the information stand and on the concierge desk in the ward. Staff told us that patients were encouraged to complete a patient feedback form upon discharge and could do so anonymously.

We observed good communication between all theatre staff and the patient before administering medication and clear explanations were given to the patient at each step of the procedure whilst they were still awake. This included inserting the cannula and an orientation in the theatre department.

The hospital produced videos with their patients and clinicians sharing the patient pathway and patient experience so patients could view and learn about the care offered through social media and the hospital website.

Patients could access support from the hospital's website and also patient information leaflets for each stage of their journey.

At the preoperative assessment, a CNS would discuss and agree a care plan with the patient to provide reassurance and support and to answer any questions the patient may have with their family members.

On arrival to the ward each patient would be assigned a named nurse to personalise the care received and meet the needs of the patients.

Patients undergoing a catheter laboratory procedure were collected from their ward by a nurse who stayed with the patient throughout the procedure. This provided patients with continuity and reassurance and provided relatives a direct opportunity to speak to someone from the catheter lab team.

Patients told us that the costs of the care provided was given to the patients upfront and the information on costs were easy to access and follow.

Patients gave positive feedback about the service. During the reporting period March 2022 to February 2023 98% of patients said they would recommend the service to friends and family.

Is the service responsive?



Our rating of responsive improved. We rated it as outstanding.



Surgery

Service delivery to meet the needs of local people

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

Facilities and premises were appropriate for the services being delivered. The wards had individual patient rooms with ensuite bathrooms and were spacious for family members to come and visit. The rooms were large and encouraged patients to become mobile as soon as reasonably possible after surgery.

Staff knew about and understood the standards for mixed sex accommodation. Single sex accommodation could always be provided, including in recovery.

HCAUK monitored and took action to minimise missed appointments, by sending all patients reminder emails about their upcoming surgery.

Managers ensured that patients who did not attend appointments were contacted. Patients who did not attend their appointment were contacted to check their welfare and if their appointment was still required.

Patient pathways prioritised same day referrals where possible for preoperative assessments.

The hospital worked closely with other providers and the wider system to plan care including with the local clinical commissioning group.

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 had access to communication aids to help patients become partners in their care and treatment. Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff in the ward kept a vulnerable adult's box which had Makaton signs, stress balls, fidget toys, inspirational quotes, and large print signs.

Wards were designed to meet the needs of patients living with dementia. Staff supported patients living with dementia and learning disabilities by using 'This Is Me' documents and patient passports.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. The service had information leaflets available in languages spoken by the patients and local community. Where necessary, patients were provided with information in different languages and were given access to translations and interpretation services in accordance with their individual needs and preferences. This included British Sign Language (BSL) interpreters.

Patients had access to a fully equipped gym. Knee scooters were available for patients that had had ankle surgery. They were introduced as a method to help reduce the number of falls of inpatients. Patients were able to use the scooters in the ward and were able to rent the equipment to take home to aid with mobility.



Surgery

Staff thought about the needs of their patients even after they were discharged. We spoke with spinal CNSs and were told that patients were sent a website link to an online shop to purchase special drinking bottles with an extra-long straw to aid patients to hydrate that had to abide to flat best rest. Flat bed rest optimised the neutral position and patients were required to be in this position from 24 hours to five days. CNS were also looking into clamps that could be attached to a bed so that patients could attach an electrical device such as a mobile phone or tablet.

In the south building theatres were split over two levels. The surgical services manager explained that they could utilise this space to accommodate for patients who requested single sex recovery rooms, as there was a recovery ward on each level. The manager also explained that some patients requested an all-female team in theatres and that this could also be accommodated. Recovery nurses went to the preoperative ward to meet and greet their patients, this also provided an opportunity to answer any pending questions that they may have had. This nurse was assigned to the patient post-operatively and when patients awoke, they were able to see a familiar face immediately after their procedure.

Patients were seen by their surgeon in the recovery area immediately after surgery and then on the very next day on the ward. Consultants performed ward rounds whilst the patient were on the ward but had the option to utilise virtual rounding which was supported by two nurse specialists.

The nurse in charge completed rounds on the ward for every shift and completed a summary for every patient including their care plan.

All patient accommodations were single accommodation which met the single sex accommodation for patients' guidelines.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Patients were given a menu with hot and cold food choices and beverages. The menu had items that were vegan, vegetarian, halal, and kosher.

Access and flow

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

Patients could begin their surgical journey with an appointment and diagnostics centre closer to their home in a HCAUK outpatient centre and then choose when to have their surgery.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. The service exceeded the national targets for waiting times and did not have any wait times for surgery. The service did not have a backlog of patients from COVID 19, and still managed to safely perform surgery during the pandemic. The service supported the NHS with complex surgical cases and performed 892 surgeries in the reporting period on behalf of the NHS.

CNSs met with all patients going for major surgery. Staff went through the entire procedure with the patient and were able to answer a lot of questions and put patients at ease. Patients were given a direct number to contact their CNS. An out of office voicemail message was left when a CNS was on leave, advising the patient of who else they could call, best times to call and specialist evening and weekend assistance. This meant that the patients had access to help and support even when their CNS was on leave.



Surgery

Part of the pre-assessment checklist included questions on the patient's home life, to ascertain if a patient had support at home post operatively. Questions included who was living with the patients, how will they be getting home, and who will be looking after them once they were home.

CNS called all patients requiring major operations 48 – 72 hours post operatively to discuss pain management and all discussions were documented in patient records. Patients that received spinal injections or less invasive procedures were called after 10-12 days post operatively as this was the length of time it could take for the treatment to take effect. However, patients were encouraged to call the hospital at any time to discuss any concerns.

CNS reviewed patients in clinic two weeks post operatively to change or remove dressings. Surgeons saw their patients one week post operatively and this appointment was given to the patient before they were discharged.

Managers and staff worked to make sure patients did not stay longer than they needed to. Key performance indicators were monitored for first case of the day start times. The hospital strived to ensure that a minimum of 75% of the cases starting the day were started within 30 minutes of the stated start time. Data showed that January and February 2023 had exceeded the 75% target at 84%.

Management worked hard to utilise theatre capacity where the overall benefits of this were seen by patients. Realistic start times were given to patients and the proximity of consultants to the hospital were taken into consideration when setting these times. This provided better outcomes for patients and staff, who could adjust their schedules accordingly. Surgeries were scheduled back-to-back minimising excessive breaks which benefited patients and staff.

Staff supported patients when they were referred or transferred between services. All staff had access to the online theatre board which was equivalent to the white board theatre list often seen in surgical departments. This meant that all hospital staff could keep track of who was in theatre, potential waiting times for patients and prepare for arrivals of patients back to the wards post operatively.

HCA sent reminder emails to patients booked in for surgery. There were no missed surgeries ever recorded at the hospital.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and within national targets and guidance. The service had 282 cancelled surgeries in the reporting period. 220 surgeries were cancelled due to clinical reasons and 62 were cancelled for non-clinical reasons. Clinical reasons for why surgeries were cancelled included patient unfit for surgery, patient positive COVID 19 test, and patient self-isolating. Non-clinical reasons for why a surgery was cancelled included illness of the surgeon, power outage, illness of anaesthetist and patient COVID 19 test results still pending. 239 surgeries were rescheduled; however, 43 surgeries were not rescheduled due to factors including but not limited to funding issues, condition improvement and patient death. The patients were able to choose when to have their surgeries rebooked, on average patients chose to wait around seven weeks since their initial surgery date. This was due to patient choice and not hospital availability.

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.



Surgery

Patients, relatives, and carers knew how to complain or raise concerns. Patients told us that they would be confident in making a complaint if there was something to complain about. There were 29 complaints received in the reporting period of February 2022 to March 2023.

The service clearly displayed information about how to raise a concern in patient areas. There was an information stand available on the wards that had clear information on how to raise a complaint or concern. The provider's website also had detailed information on the complaints procedure and patients were informed that their complaints would be acknowledged in writing in three working days by the Chief Executive Officer (CEO). Patients were also informed that a reply to their complaint would be sent in 20 working days. Patients were given the option to escalate their complaint for an internal independent review or an external independent review if they were unhappy with the way their complaints were handled. The independent external review was handled by the Independent Sector Complaints Adjudication Service (ISCAS).

Staff understood the policy on complaints and knew how to handle them and a complaint process flow chart was included in the policy for easy reference.

Meetings were held with patients to involve them during the complaint process.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Common themes found in the reporting period February 2022 and March 2023 were around food and queries regarding the invoice processes. The catering facilities had since been brought in house and as a direct result complaints regarding the food had decreased. Queries regarding invoice processes initially started as a complaint however, these were often deescalated once reviewed and discussed with the patient.

Is the service well-led?

Outstanding



Our rating of well-led improved. We rated it as outstanding.

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.

During the inspection we found compassionate, inclusive, and effective leaderships at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent care. Highly effective, responsive, patient centred services were well executed and delivered in a safe and caring manner. Leaders happily boasted about their achievements and expressed their satisfaction with the performance of their own department. Staff were equally positive and told us they were respected, appreciated, and supported by the hospital to develop their knowledge, skills and competencies.



Surgery

Leaders at every level were visible and approachable, staff stated that they could access their manager quickly and that managers had an open-door policy. Staff reported managers acted quickly to issues and concerns that were raised. Staff reported seeing the CEO and Chief Nurse Officer (CNO) daily, knew them by name, spoke very highly of them and referred to the CEO once a week walk around.

Compassionate, inclusive, and effective leadership was sustained through the leadership strategy and developed through a program of effective selection, deployment and support processes and succession planning. For example, matrons buddied up and shared key detailed information for their ward on their staff and patients and could easily cover each other's role for annual leave purposes and for sickness. Managers we spoke with informed us of a two-step interview process. The second part of the interview process involved being interviewed by staff that they will eventually be working with. The hospital sought to effectively select the right candidates for job roles by ensuring that team members were able to work well with each other.

Comprehensive and successful leadership strategies were in place to ensure and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service and beyond. Staff described the CEO to be in arm's length distance, was open, available and would often try to comprehend a staff's point of view to drive improvement in the service. This was achieved by the 'walk in your shoes' initiative which involved most of the executive team.

Staff were able to tell us about the service's speak up policy and champions. We saw posters on the wall providing all the information staff required to access these services. Champions wore badges on their uniform so that other staff members could easily identify them if they had a concern that they wished to communicate verbally.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed HCA UK. Leaders and staff understood and knew how to apply them and monitor progress.

There was a clear statement of vision and values which had been translated into a robust and realistic strategy with well-defined objectives that were achievable and relevant.

Staff in all areas knew, understood, and supported the vision, values and strategic goals of the hospital and knew how their role helped in achieving this.

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.

There were processes in place for providing all staff at every level with the development they needed including high quality annual appraisals and career development conversations. The service provided opportunities for career development. There were a number of different courses and qualifications that staff could access. We were given examples of staff development including a scrub nurse that had been developed into a surgical first assistant. Surgical first assistants were developed and trained to perform sutures. The clinical practice facilitator was developed into their



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role as it was identified that they were good and had a passion for teaching. We were also given an example of another scrub nurse that was being developed into an operating department practitioner. This nurse had joined the hospital as an OSCE nurse, had completed her NMC (Nursing and Midwifery Council) registration and received their pin; worked as a scrub nurse for 18 months and was now training as an Operating Department Practitioner.

Medical staff described fellow physicians, consultants, and nurses as excellent. There was a network of staff to support each other, and the patients' needs.

The service had a whistleblowing policy and all staff we spoke to knew how and when to access this.

Staff described their team as diverse and supportive. There was a recent development of the hospital's local Diversity, Equity, Inclusion and Belonging strategy and action plan. This was developed with Global Diversity Practice (GDP) who undertook detailed diagnostic exercises gathering information through staff interview, focus groups and ideation workshops. Actions were developed around leadership, culture, talent and patient care and informed staff of what was going to change and how that change would look like.

The hospital employees were made up of 72 different nationalities. Different cultures and festive celebrations were celebrated, and the hospital used food in the canteen as a nod to the different cultures at various times in the year. The hospital recognised and celebrated black history month, had a Notting Hill Carnival and USA Independence Day themed lunch and there was Greek, Filipino and Thai themed lunch menus. Posters informing employees of staff observing Ramadan were put up in the hospital and dates were left in the staff room so that staff could break their fast.

Staff wellbeing was important to the services and leaders. Mental health awareness posters were in staff areas and information displayed included how to get access to support.

Wellness Wednesdays were introduced in the surgical ward for staff. This involved a dedicated morning for staff to have a safe space for an easy access opportunity to talk to their matron. The matron would bring in sweet treats such as pastries and doughnuts and would encourage staff to discuss any issues or troubles that they were having. Staff would share good news in these meetings and request shift swaps to accommodate lifestyles and family commitments. Managers accommodated shift swaps and encouraged a healthy work life balance.

Staff were thought about during the scheduling of surgeries, avoiding excessive breaks during the day, and ensuring a good home life balance by appropriately scheduling surgeries around sensible start times and finish times.

The hospital ran a staff engagement survey twice a year and created action plans from the results of the survey. Following the survey results a 'Walk in Your Shoes' initiative commenced where senior leaders had an opportunity to understand staff perspective and individual roles in caring for patients, including the CEO and the CNO.

The staff on the surgical ward participated in the 12 days of Christmas to boost morale over the festive period. This included winning generous prizes in a raffle in the days leading up to Christmas such as an electronic tablet, wireless headphones and multi cooker.

Staff reported receiving support and personal well-being checks after a sudden loss of one of their team members. Staff reported tactful handling from senior staff members and a minibus had been arranged so that staff could attend their colleague's funeral.

Governance



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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.

We observed a highly established and effective governance structure, which encouraged the flow of information, feedback, and accountability both ways. There was a robust and comprehensive oversight of safety, quality, risk, and patient experience. There was a Patient Safety Quality Board (PSQB) which reported to the Corporate Quality Board and a Medical Governance Committee. The PSQB provided the executive board with assurance of high standards of care, of adequate and appropriate governance structures, and of processes and controls that were in place throughout the hospital; the board met quarterly. We looked at meeting minutes from September and November 2022 and saw in-depth patient experience intel followed by patient safety intel which included: incidents, infection prevention control, surgical site infections, shared learning from both The Wellington Hospital and other HCA facilities, notifiable incidents, risk register, quality audits, policy updates and mandatory training.

KPIs were processed by the governance team and validated at the bi-weekly Validation of Incidents and Hospital KPIs Group. Unplanned returns to theatre were presented and examined as part of the KPI data at the Medical Governance Committee, Medical Advisory Committee and Patient Safety Quality Board, and also with the corporate team at the Quarterly Clinical Operating Report Meeting.

Robust governance processes were in place to share information and stay connected with other departments in the hospital, preventing silo working and encouraging a holistic approach to care. Twice daily 30-minute huddles were conducted morning and night to share information to all department leads.

Meeting findings were fed back to executive level. For example, a weekly summary escalation report was generated from the daily POSH and was recorded in the executive report.

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 senior team was demonstrably focused on best practice performance and the effective use of risk management systems to drive a highly functional organisation. Departmental managers were aware of their departmental risks and could give examples of what was on their risk register.

We reviewed the surgical comprehensive audit programme and corresponding actions plans. The clinical governance committee met monthly to discuss audit results, on how to improve and how to increase compliance. This demonstrated a clear follow through on any audit exceptions which included discussion within team meetings and actions required to make the required improvements.

Handovers were structured to include key and essential information to be passed between staff. This included the 'big four' essential information sharing on; safety, policies, incidents and training.



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We looked at meeting minutes from theatres and surgical wards. We saw that there was a good attendance rate and that ward meetings followed a 12-point structure to cover various topics such as incidents, complaints, alerts and guidance, the risk register, clinical audit updates, feedback from senior staff and recruitment. Actions from previous meetings was a priority in each meeting.

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.

Systems for storing and sharing information were compliant with the Caldicott principles which meant sensitive or personal information was stored securely. Staff told us that they had all the information needed to provide safe care and treatment. Staff always had access to up to date, accurate and comprehensive information on patients' care and treatment. Patient records we reviewed were of an excellent standard.

Personal patient information was kept secured at all times and was password protected.

Data was collected and used by the department to monitor and drive improvement. Personal data was redacted to ensure confidentiality was maintained when sending information externally i.e., when providing statutory notifications to the CQC (Care Quality Commission).

We saw that the hospital had a range of methods to share information amongst staff, such as emails, team meetings, briefing, huddles, bulletins, and newsletters. During the inspection we saw copies of newsletters and bulletins on staff notice boards.

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.

Senior leaders told us about ways in which they constructively engaged with staff members to improve the service. Managers and staff recognised the value of engagement in supporting safety and quality improvements. Staff were kept informed about engagement opportunities and provided with feedback regularly and through a variety of different methods. For example, the hospital had a '3 + 1' newsletter for all staff which provided three clinical updates and one patient story review or feedback.

Patient feedback was actively sought through various methods, with a focus on improving patient outcomes and experience.

HCAUK introduced a wellbeing guide for staff showcasing the different types of wellbeing services available to them. They were divided in four categories so that staff could easily identify preferred options. These were financial, physical, mental, and social. Through this guide staff had access to a range of services including the employee assistance programme, and could access discounts on travel, meals, and gyms. Staff could also access free private healthcare, financial help and help with phone and technology payment plans.



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HCAUK introduced a new initiative for staff which was run in conjunction with Mental Health First Aider (MHFA) England. The MHFA's were formally accredited by MHFA England. They provided a point of contact for staff who were experiencing a mental health issue, emotional distress or simply needed someone to talk to. Clear information on how to access the service was available to staff in many forms including the hospital news bulletin, posters, and the intranet.

Annual leave for staff was extremely flexible and suited the needs of staff from overseas. Staff reported being able to take two months off at a time to go visit family abroad.

The hospital actively sought to recognise staff through awards of distinction, colleague of the year and shout outs, in line with their hospital strategy.

Staff were actively encouraged to apply for job promotions within the hospital and were supported in doing so. 'People' was the third pillar in the hospitals strategy and set out to retain staff among other objectives. Senior management organised conversations with staff who were thinking about leaving the hospital at the earliest date possible in order to strengthen staff retention as much as possible. The conversations had been effective and staff retention was very high.

The Bold, Relevant, Authentic, Valuable Education (BRAVE) committee was introduced as a method to create a safe space with a structured opportunity for staff to discuss issues concerning concerns, fears, hopes, challenges, blockers, equality and diversity, listening, bias and understanding. The BRAVE committee had a direct link to the mission statement, 'above all else we are committed to the care and improvement to human life', which extended to both patients and staff at the hospital. The committee met quarterly to identify opportunities for staff not feeling confident to speak up in front of executive members. The BRAVE committee was launched by the CEO following the passing of George Floyd and Ahmaud Arbery and is included as part of the induction process.

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.

There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to deal with performance and for the service to learn. The hospital had a comprehensive learning lessons framework aimed at developing and maintaining a positive culture in learning from incidents.

We saw that patient feedback was consistently used to improve the quality of care provided. For example, we saw in the 'you said' we did' poster on South One ward that patient feedback led to changes around timeliness of delivering meals, increase access to theatre live timings systems and to improve communications on how often nurses would be rounding and how long it may take to answer a buzzer.

Innovation methods and skills were available and used across the organisation and staff were empowered to lead and deliver change. This was embedded in the organisation strategy. The organisation had invested £500m into their facilities to ensure their hospitals were among the best equipped in the world. Staff told us about examples of innovative practice this included different types of robotic arms to perform spinal, orthopaedic, general hips and knees surgeries, with different techniques not available on the NHS.



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The Wellington Hospital was the first independent hospital in the UK to have an Intraoperative Magnetic Resonance Imaging (iMRI) scanner. This technology allowed neurosurgeons to carry out an intraoperative Magnetic Resonance Imaging (MRI) scan of the patient's brain during surgery. This allowed surgeons to check that they had successfully removed all the tissue that they had planned to remove, and patients were less likely to return for further surgery. This also prevented the need for post operative 48-hour radiological checks. Patients also had access to specialist neurological services including non-invasive brain Gamma Knife surgery.

The hospital was the only private dedicated spinal unit in the UK offering multidisciplinary care, treating a range of spinal conditions, using minimally invasive techniques, and providing support and ongoing care through spinal clinical nurse specialists.

Safe innovation was celebrated. There was a strong record of sharing work locally, nationally, and internationally. Staff gave us examples of closely working with their sister hospital located nearby. Incidents along with learning and improvements were shared to encourage safer care for patients.

Staff had access to the HCA UK learning academy which comprised of hundreds of internal e-learning and classroom courses and specialist training programmes, professional qualifications, Harvard management platform, and the Institute of Leadership and Management (ILM) programmes.

Methods of training extended beyond sit-down online courses. The service used specialist trainers to oversee technical equipment training. The practice facilitator was trained to deliver training specific for job roles and tailored it to patients' needs. The service also created their own training tools and used whiteboards and videoconferences to deliver this training.

The hospital had buddied up with the Talent Beyond Boundaries Charity which supported displaced people to have a chance to rebuild their careers and lives. The charity matched skilled refugees with companies in need of their skills. We were given examples of two staff members that had been recruited through this charity, staff working at the hospital had personally collected people from the airport and showed us pictures of the first time they met at the airport. The hospital provided accommodation, pastoral support and welcomed staff with a tour around London.