The Portland Hospital for Women and Children

Quality Report

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

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding
Are services well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

The Portland Hospital for Women and Children is the largest private children's hospital in the UK and is owned and run by HCA International Ltd.

The hospital/service opened in 1983, and has been part of HCA healthcare for the past 10 years. The hospital has 76 in-patient beds, 20 day-case beds and four theatres. It is situated in central London, on Great Portland Street, in the West End, with easy access to public transport and main driving routes. Services are provided from four buildings: 205-209 Great Portland Street, 212 Great Portland Street, 234 Great Portland Street and 215 Great Portland Street. There is also a small paediatric outpatient service located within The Shard.

The Portland Hospital for Women and Children provides surgery, maternity care, services for children and young people, termination of pregnancy services and outpatients and diagnostic imaging. All services at this hospital were inspected during our visit.

We inspected this service using our comprehensive inspection methodology. We carried out the announced part of the inspection on 1 – 3 November 2016, along with an unannounced visit to the hospital on 10 November 2016.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Services we rate

We rated this hospital as good overall because:

- The hospital was managed by a team who had the confidence of patients and their teams. Both senior and junior nurses as well as doctors working in the service embedded the vision and strategy for the service into practice. Staff were encouraged to voice concerns or new ideas to improve patient experience. New staff spoke excitedly at the prospect of being a part of a team where the Chief Executive Officer (CEO) and Chief Nursing Officer (CNO) really cared and their opinions mattered.
- Care was planned and delivered in line with current evidence-based guidance, standards and best practice. Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care.
- Patients were treated with compassion and their privacy and dignity were maintained. Patient feedback surveys were positive about the care they received whilst in hospital.
- All patients were provided with individualised care. Translation services were readily available for those whose first language was not English. Meal plans and medications were tailored to the individual, to ensure that cultural and religious needs were met and maintained.
- Patients could access care when they needed it, often on the same day. There was choice and flexibility around appointments and elective procedures.
- All complaints were dealt with in an efficient manner within time scales set by the hospital.

Summary of findings

- The midwife led services held meet and greet clinics for patients interested in the hospital maternity services. The sessions were free of charge and allowed the patients to have a tour of the facilities and ask any questions they may have. Patients found this service reassuring and positive. In addition, dedicated Spinal Dorsal Rhizotomy (SDR) open days were held where patients were asked to provide feedback on how services could be improved.
- There was a midwifery lactation team responsible for the oversight of infant feeding. The midwifery lactation team were supernumerary to ward staffing numbers to ensure that women could go home with knowledge and ability to feed their babies confidently and successfully. We saw that the initiation of breast feeding rate was 80%, which was better than the national average of 75%.
- There was a dedicated family room on both paediatric inpatient ward floors. The children's outpatients department had tailored their environment for children and scheduled clinics outside of normal hours to accommodate patients and their families.
- There were systems to keep people safe and to learn from critical incidents. In maternity services, a computerised monitoring tool was used that allowed an overview of emerging themes and lessons learned to be shared widely with staff.
- The hospital environment was visibly clean and well maintained and there were adequate measures to prevent the spread of infection.
- There were systems to ensure the safe storage, use and administration of medicines, including controlled drugs. Regular audits took place to ensure that standards and best practice were maintained.

We found areas of outstanding practice in both the children and young people's services and the outpatients department:

- There were strong displays of innovative techniques from the hospital's paediatric therapies team. Staff were encouraged to input to innovative change within the service and this was evident in the celebration of new ideas from staff at all levels.
- Multidisciplinary input in paediatrics was well structured, well coordinated and attended by a wide variety of clinical specialities and therapies. The meetings were structured around the holistic needs of the patients.
- Services were tailored and planned to fit the needs of the patients using the services. There was an impressive degree of clinical input and care for complex patients.
- The hospital had implemented a specialist, sensitive birthmark screening and treatment program for paediatric outpatients.
- The security and safety of patients was important to the service. The service had put in additional measures to ensure that children in their service were protected from harm. The Hugs and Kisses security system tracked and monitored patients throughout their pathway.
- A new training and practice device was developed in the colposcopy service. This device was sponsored and developed in partnership with a medical equipment manufacturer. The device was designed to be a colposcopy simulator, which had since aided in the training and development of skills for doctors and nurses in both the NHS and independent sectors.
- The radiology department used a lot of innovative techniques to ensure a smooth process of paediatric diagnostic procedures. This included the implementation of play therapist support and 'feed and wrap' scans to negate the need of anaesthesia for children.

Summary of findings

- Consultants representing the hospital regularly provided continued professional development through master classes for GPs . They delivered training conferences four times a year for up to 200 doctors in order to educate and train GPs in issues relating to paediatric and women's health.
- The hospital facilitated the training placements for student midwives and student nurses from a London based university. This collaboration resulted in staff developing their teaching skills and students successfully completing their second year with experience in the independent sector.
- The governance team conducted a comprehensive qualitative research study into the 'Use of Team Debriefing Following a Serious Incident'. This project resulted in the development and implementation of the HCA Corporate Debriefing policy and staff information leaflet, which resulted in change of practice across all HCA sites.
- We were provided with a number of positive examples of staff development, which all included staff members from support services (identified by the CEO and other managers) as wanting to join clinical services. The staff members were supported and provided with funding to complete qualifications, allowing them to join as clinical staff.
- We were shown evidence of activities and excursions organised by the therapies department to support parents and children's psychosocial wellbeing that were planned based on individual patient needs. Trips to venues such as Regents Park and London Zoo were arranged to meet specific clinical patient goals.

However, we also found the following issues that the service provider needs to improve:

- There was lack of space in some clinical areas in the main hospital building. Some staff were concerned that this may impede the care being provided to the patients. In theatres, items were stored in corridors as there was not sufficient storage space.
- There was no integrated record keeping system, which meant that not all staff had access to up-to-date risk assessments and notes. This included agency staff and resident medical officers (RMOs), who may be attending for an emergency. Post-inspection, we were informed that the hospital was investing in a new record keeping system to ensure that patient records were consolidated in future.
- There was a high use of bank staff across the children and young people's (CYP) service. Frequently, bank staff were not available, which in turn led to a high usage of agency staff. However, bank and agency staff had an induction and shadowed a permanent member of staff on their first shift. They received the same training as permanent staff.
- We identified risks in the resuscitation trolleys throughout the paediatric service as they contained equipment and medicines for both adults and children. We observed a copy of the risk assessment and found they were in accordance with the UK Resuscitation Council guidelines to ensure appropriate use for both patient types.
- There was poor documentation from consultants in the maternity service in six of the 12 sets of notes we looked at.
- On the labour ward, medical gases were stored in an area which did not have appropriate signage on the door.
- Compliance rates of pre-assessment before surgery were low, ranging between 50% and 78% in the two months prior to our inspection. To improve this, the hospital recruited a dedicated pre-assessment nurse, scheduled to start in January 2017.
- The last staff survey showed a decline in staff satisfaction and staff commitment. The rate of ward and theatre staff turnover was above the average of other similar hospitals (July 2015 to June 2016).
- There was a resident on-call theatre team available out-of-hours for primarily obstetric patients. The same team also covered gynaecology emergencies. The absence of a second theatre team on-call was on the hospital's risk register and most surgical patients were day cases with low pre-operative risk profiles.

Summary of findings

- In the outpatients department, we found that changes in working practices arising from incident learning were not embedded into written policies or procedures in a timely manner.
- Mandatory training rates for staff in the outpatient department did not meet the hospital target of 90% compliance. Not all maternity staff were trained in the appropriate level of safeguarding.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy, or the regulated activities they provide but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

We found the following areas of good practice:

- Infection prevention and control (IPC) measures ensured that both the wards and theatres were clean and suitable for purpose.
- Medicines were managed and stored appropriately. Pain relief and antibiotic medications were given to women post-procedure to manage their symptoms.
- Documentation was concise and clear. We saw evidence that legislation relating to the termination of pregnancy (TOP) was followed in all the cases we examined.
- Staff we spoke with were knowledgeable about safeguarding and knew how to recognise if a woman was at risk or had been exposed to abuse, and how to escalate concerns. They were up-to-date with appropriate levels of training.
- There were enough nurses in the wards and theatres for staff to perform their roles safely. There was 24 hour, seven-days a week, resident medical officer (RMO) cover for the wards.
- Hospital policies were current and appropriately referenced relevant national guidance. The TOPS policy had recently been reviewed and updated.
- Consultants gave women verbal and written information on what to expect during and following a TOP procedure. Nurses on the ward also provided information about what women may experience. Women were able to contact the ward 24/7 after discharge for support or advice. Counselling was available to all women before, during and after they had received treatment, as required. This was from an external provider.
- Nurses shared responsibility for completing audits to monitor compliance and improvement. Records of all TOP procedures were maintained on a spreadsheet to monitor that all Department of Health (DH) Required Standard Operating Procedures (RSOPs) were met.
- Consent and capacity were considered by nurses when a women was admitted for a TOP procedure. All staff demonstrated a working knowledge of the Mental Capacity Act (MCA) and its implications.
- Patient's privacy was maintained throughout their stay, as they were admitted to single occupancy rooms. Feedback from women about the gynaecology wards was consistently positive, although it was not possible to identify women undergoing TOP from returns.
- All women referred to the service received timely treatment, often beginning the same day they had their initial appointment.
- Women were given enough information to make an informed choice about the sensitive disposal of pregnancy remains and time to consider this. Appropriate storage arrangements were in place.

However, we also found the following issues that the service provider needs to improve:

Summary of findings

- Not all women having surgical terminations had a pre-operative assessment. The hospital had recruited a nurse into a post to perform these, but this was not yet in place.
- The hospital could not be assured that consultants were all returning the HSA4 forms to the Department of Health within 14 days because consultants did not always copy the form to the ward.

Following this inspection, we told the provider that they should make some improvements, even though a regulation had not been breached, to help the service improve. Details are at the end of the report.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Good	We rated this service as good because: • Staff we spoke with felt confident and encouraged to report incidents and we saw evidence of learning from incidents. There was a clear complaints procedure in place and we saw evidence of learning from complaints and incidents. Effective governance structures supported quality improvement through this learning. • Staff followed infection prevention control(IPC) guidance. We observed staff wash their hands between seeing patients and use personal protective equipment (PPE) effectively. The environment and equipment were clean and ready for use. • The rate of surgical site infection was below that of other similar hospitals that we hold this type of data for. Compliance with the Safer Steps to Surgery, including the World Health Organisation (WHO) checklist, was closely monitored. Monthly audits showed 100% compliance since April 2016. Unplanned readmission and transfer rates were also lower than other comparable services. • Patient care was delivered in line with current standards of best practice and guidelines. Regular audits took place that monitored the quality of care and drove improvement across the service. • There was appropriate medical cover for the surgical wards, 24 hours a day, seven days a week. There was access to relevant consultants where required. Appropriate escalation occurred in the case of deteriorating patients. • We observed staff treating patients with dignity, kindness and respect. Patient feedback surveys were positive about the care that they received. Post-operative pain was effectively managed, with high patient satisfaction in this area. We saw staff responding promptly to call bells. • Flexible services were provided to accommodate patients' individual needs and patients were able to access services in a way and time that suited

Summary of findings

them. The hospital had a dedicated international patient centre staffed by liaison officers, who assisted and met the needs of the large demographic of international patients.
- The senior leadership team was visible and approachable. Staff felt supported, listened to and valued. They were encouraged to voice concerns or new ideas and to attend additional training suitable to their post.

However:

- Electronic patient records were often incomplete. The lack of an integrated records system meant that regularly used agency staff did not have access to electronic patient records.
- Lack of storage space in theatres was identified as an issue. This meant that equipment was not ideally stored, in corridors and in large cupboards in corridors.
- Compliance rates of pre-assessment before surgery were low, ranging between 50% and 78% in the two months prior to out inspection. To improve this, the hospital recruited a dedicated pre-assessment nurse, scheduled to start in January 2017.
- The last staff survey showed a decline in staff satisfaction and staff commitment. The rate of ward and theatre staff turnover was above the average of other similar hospitals (July 2015 to June 2016).
- There was a resident on-call theatre team available out-of-hours for primarily obstetric patients. The same team covered gynaecology emergencies. The absence of a second theatre team on-call was on the hospital's risk register and most surgical patients were day cases with low pre-operative risk profiles.

Maternity

Good

We rated this service as good because:

- The elective caesarean section rate at the hospital was 34%, which was higher than the national average of 10.7%. This meant that the overall caesarean section rate was 52%, which was also higher than the national average of 25%. This was

Summary of findings

because more women chose to have an elective caesarean section at the hospital. Women were offered an informed choice on all types of birth, from normal deliveries to caesarean sections.

- We saw examples of safety incident reporting systems, audits concerning safe practice, and compliance with best practice in relation to care and treatment. Staff planned and delivered care to patients in line with current evidence-based guidance and standards. Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care.
- Patient care was consultant led. Medical staffing across the department was sufficient to provide women with good quality care. Access to consultant medical support was available seven days per week. The hospital provided evidence of one-to-one care during labour, which is recommended by the Department of Health.
- Women told us they felt well- informed and were able to ask staff if they were not sure about something. Feedback from patients and those close to them was positive. Staff helped patients and those close to them to cope emotionally with their care and treatment. Women we spoke with felt that their pain and analgesia administration had been well-managed.
- Staff were competent in their roles and undertook regular appraisals and supervision. Midwives rotated throughout the service, which meant that they were competent to work in all areas in times of escalation. Staff worked collaboratively to serve the interests of women across the service. There was evidence of effective handovers of care to community agencies when women were discharged.
- Patients' individual needs and preferences were considered when planning and delivering services. The maternity service was flexible and provided choice and continuity of care. The individual care needs of women at each stage of their pregnancy were acknowledged and acted on, as far as possible. There were arrangements in place to support people with particular complex needs.

Summary of findings

However:

- There was poor documentation from consultants regarding a common surgical procedure in six of the 12 sets of notes we looked at.
- Medical gases were stored in an area which did not have appropriate signage on the door.

Services for children and young people

Good

We rated this service as good because:

- Services were planned to fit the needs of patients. There was a dedicated family room on both inpatient ward floors. The children's outpatients department had tailored their environment for children and scheduled clinics outside of normal hours to accommodate patients and their families.
- International patients were provided with tailored care and were supervised throughout their care pathway. Multidisciplinary teams (MDTs) worked together to ensure the smooth and efficient discharge of international patients to their home countries. Translators were available 24 hours a day. Meal plans and medications were tailored to the individual, to ensure that cultural and religious needs were met and maintained.
- All staff spoke highly of their Chief Executive Officer (CEO) and Chief Nursing Officer (CNO). Both senior and junior nurses, as well as doctors, working in the service embedded the vision and strategy for the service into practice. Ward managers and senior staff had a shared purpose and strived to deliver the highest quality of care. They motivated junior staff to succeed and encouraged them to attend training to develop their careers. There was a high degree of staff participation in additional training.
- We saw examples of innovation. Staff across the service were encouraged to put forward ideas to improve patient experience and this was evident in the celebration of new ideas from staff at all levels.
- All staff were proud to work within the service and members of staff spoke very highly of one another.

Summary of findings

- The security and safety of patients was important and the service had put in additional measures to ensure that children in their service were protected from harm.
- The multidisciplinary input was highly effective, well-coordinated and considered the patients holistic needs as well as clinical care. MDT meetings were well attended by a wide variety of specialities. Parents were also invited along to these meetings and had a high degree of involvement in the care planning of their child.

However:

- There was lack of space in some clinical areas and staff were concerned that this may impede the care being provided to the patients.
- There was no integrated record keeping system, which meant that resident medical officers (RMOs) attending for an emergency wouldn't always have access to up-to-date medical records.
- We identified risks in the resuscitation trolleys as they contained equipment and medicines for both adults and children. We observed a copy of the risk assessment and found they were in accordance with the UK Resuscitation Council guidelines to ensure appropriate use for both patient types.

Outpatients and diagnostic imaging

Outstanding ☆

We rated this service as outstanding because:

- Staff were encouraged to develop within their roles and seek out opportunities for progression. We were provided of numerous examples of support staff being provided support, training and funding to progress to a clinical role.
- There was an active culture of innovation and improvement. We were provided examples of staff members and also whole department efforts that changed working practice across the hospital and other organisations.
- There was cohesive multidisciplinary team (MDT) working. There was evidence of collaborative working and positive relationships with other departments within the hospital.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. We observed staff interaction with patients and

found them to be polite, friendly and helpful. Patient satisfaction results were consistently positive in all areas of the outpatients and imaging departments, with 99% of patients in the most recent survey saying they would recommend the hospital to friends and family based on the care and support they received.
- On inspection we observed numerous examples of the service proactively responding to patient needs and wishes.
- Complaints were handled in a professional and timely manner within the hospital timeframe.
- We observed that there were minimal waiting times for outpatient clinics and diagnostic imaging. Patients we spoke with confirmed this.
- All departments we visited had clear vision and strategy for future goals and expansion projects. Staff we spoke with were aware of this.
- We saw evidence of positive public and staff engagement. Staff felt highly supported by their managers. All departments we visited demonstrated patient experience was key factor for their service.

However:

- We found that changes in working practices arising from incident learning were not embedded into written policies or procedures in a timely manner.
- Mandatory training rates for staff in the outpatient department did not meet the hospital target of 90% compliance.

Termination of pregnancy

We do not currently have a legal duty to rate this service but we highlight good practice and issues that service providers need to improve and take regulatory action as necessary. We found that the TOP service was providing safe, effective, caring, responsive and well-led care to women. This was because:

- Medicines were managed and stored appropriately. Pain relief and antibiotic medications were given to women post-procedure to manage their symptoms.

Summary of findings

- Documentation was concise and clear. We saw evidence that legislation relating to the termination of pregnancy (TOP) was followed in all the cases we examined.
- Staff we spoke with were knowledgeable about safeguarding and knew how to recognise if a woman was at risk or had been exposed to abuse, and how to escalate concerns. They were up-to-date with appropriate levels of training.
- Hospital policies were current and appropriately referenced relevant national guidance. The TOPS policy had recently been reviewed and updated.
- Consultants gave women verbal and written information on what to expect during and following a TOP procedure. Nurses on the ward also provided information about what women may experience. Women were able to contact the ward 24/7 after discharge for support or advice. Counselling was available to all women before, during and after they had received treatment, as required. This was from an external provider.
- Nurses shared responsibility for completing audits to monitor compliance and improvement. Records of all TOP procedures were maintained on a spreadsheet to monitor that all Department of Health (DH) Required Standard Operating Procedures (RSOPs) were met.
- Consent and capacity were considered by nurses when a women was admitted for a TOP procedure. All staff demonstrated a working knowledge of the Mental Capacity Act (MCA) and its implications.
- All women referred to the service received timely treatment, often beginning the same day they had their initial appointment.
- Women were given enough information to make an informed choice about the sensitive disposal of pregnancy remains and time to consider this. Appropriate storage arrangements were in place.

However:

- Not all women having surgical terminations had a pre-operative assessment. The hospital had recruited a nurse into a post to perform these, but this was not yet in place.

Summary of findings

- The hospital could not be assured that consultants were all returning the HSA4 forms to the Department of Health within 14 days because consultants did not always copy the form to the ward.

Summary of findings

Contents

Good

The Portland Hospital

Services we looked at

Surgery; Maternity; Services for children and young people; Outpatients and diagnostic imaging; Termination of pregnancy.

Summary of this inspection

Background to The Portland Hospital for Women and Children

The Portland Hospital for Women and Children is operated by HCA International Ltd. The hospital/service opened in 1983, and has been part of HCA healthcare for the past 10 years. The hospital has 96 in-patient and 11 day-case beds and four theatres. It is situated in central London, on Great Portland Street, in the West End, with easy access to public transport and main driving routes. Services are provided from four buildings: 205-209 Great Portland Street, 212 Great Portland Street, 234 Great Portland Street and 215 Great Portland Street. There is also a small paediatric outpatient service located within The Shard.

The hospital provides service to both UK and international patients with medical insurance, those who are sponsored by their respective embassies, those who self-fund and a very limited number of patients referred through NHS contracts.

The registered manager designate was Janene Madden, who has been in post since 2010. The provider's nominated individual for this service was Michael Neeb. The controlled Drug Accountable Officer was Elaine Stewart.

Our inspection team

Our inspection team was led by Michelle McCarthy, Inspection Manager, Care Quality Commission. The team included CQC inspectors, and a variety of specialist advisors:

- A board level director
- A consultant obstetrician
- A paediatric doctor
- A matron for antenatal clinics and specialist midwives
- Three midwives, including a supervisor of midwives
- Four nurses, including three paediatric specialists and a surgical nurse

The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

Information about The Portland Hospital for Women and Children

The hospital is registered to provide the following regulated activities:

· Diagnostic and screening procedures

· Family planning

· Maternity and midwifery services

· Termination of pregnancies

· Surgical procedures

· Treatment of disease, disorder, or injury

We inspected five core services at the hospital, which covered all the activity undertaken. These were children and young people's services, maternity, surgery, termination of pregnancy services and outpatients and diagnostic imaging.

We reviewed a wide range of documents and data we requested from the provider. This included policies, minutes of meetings, staff records and results of surveys and audits. We placed comment boxes at the hospital before our inspection, which enabled staff and patients to provide us with their views. We received 25 comments in total.

We carried out an announced inspection between 1 and 3 November 2016 and an unannounced visit on 10 November 2016.

We held six focus group meetings where staff could talk to inspectors and share their experiences of working at the hospital. We interviewed the management team and chair of the Medical Advisory Committee. In addition to these meetings, we spoke with 103 staff including:

Summary of this inspection

registered nurses, midwives, health care assistants, nursery nurses, reception staff, medical staff, operating department practitioners, and senior managers. We spoke with 26 patients and nine relatives. During our inspection, we also reviewed 66 sets of patient records.

During the inspection, we visited the five delivery suites, the 18-bedded maternity ward, the 12-bedded overflow ward, the 14-bedded children's inpatient ward, the 11-bedded paediatric day case unit, the 10-bedded paediatric intensive care unit (PICU), the six-bedded neonatal unit (NNU), the 12-bedded gynaecological and general surgery ward, all four operating theatres, recovery areas, the nine-bedded surgical ward and the minor procedures room. We also visited midwife-led outpatients, gynaecology outpatients, women's services outpatients, the colposcopy department, the audiology department, therapies, radiology and many of the children's outpatient departments.

There were no special reviews or investigations of the hospital ongoing by the CQC at any time during the 12 months before this inspection. The hospital has been inspected four times, and the most recent inspection took place in December 2013, which found that the hospital/service was meeting all standards of quality and safety it was inspected against.

In the reporting period July 2015 to June 2016, there hospital treated 1,433 patients under 18 and 1,949 adults requiring overnight stays. In the same period, there were 2,827 paediatric day case patients and 1,274 adult day case patients. Of these, 5.6% were NHS-funded and 94.4% other funded. In addition, the hospital saw 57,185 paediatric outpatient and 47,221 adult outpatient attendances, of which only 0.5% were NHS funded.

Between July 2015 and June 2016, the most common surgical procedures performed were classified under ear, nose & throat (1782), gynaecological surgery (1456), obstetric surgery (862) and plastics (777). In the same period, the most common medical procedures performed were cervical smear (4360), colposcopy (1354), deliveries (714) and the removal of sutures in outpatients (564).

There were 598 doctors with practising privileges at the hospital, and 22% of these carried out over 100 procedures between July 2015 and June 2016. Of this total number, 163 doctors did not have any recorded episodes of care, as they were part of the care team, and not independent practitioners (for example, a radiologist). There were 231 registered staff employed, including nurses, 51 care assistants and 269 others, including administrative staff. Staff turnover for nursing staff varied between 17.1% and 27.5%, depending on department. For care assistants, this figure stood between 0% in outpatients and 33.3% in theatres. The figure was 19.7% for other staff roles.

Sickness rates were low for all groups of staff, ranging from 0% to 9.7%. Bank and agency use was highest in inpatient nursing, with between 30.4% and 43.9% of shifts being filled by temporary staff between July 2015 and June 2016. This figure was lowest in theatres, with between 8.5% and 14.6% of nursing shifts being filled by bank or agency nurses.

Between July 2015 and June 2016, the CQC received two direct complaints about the hospital. The hospital received 119 complaints, a slight increase on the previous two years.

In the same reporting period, there were four serious incidents and one never event at the hospital. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

There were 854 other clinical incidents during this time. Between July 2015 and June 2016, the overall assessed rate of clinical incidents in surgery, inpatients or other services (per 100 bed days) was mainly higher than the rate of other independent acute hospitals we hold this type of data for, except for during July 2015 to September 2015 when it was lower (per 100 inpatient discharges). The hospital reported 0.5% of all incidents as resulting in severe harm or death. There were no unexpected deaths reported between July 2015 and June 2016. Between the reporting period and the date of inspection, one incident at the hospital resulted in the unexpected death of a patient. This patient death was not recorded in the hospital incident data, as it occurred in a hospice after the patient was transferred.

There were two safeguarding concerns reported to CQC in the reporting period (July 2015 to June 2016).

Summary of this inspection

Between July 2015 and June 2016, there was one incident of hospital acquired MRSA or MSSA, two incidents of hospital acquired E-Coli and four incidents of hospital acquired Clostridium difficile (C.diff).

Termination of Pregnancy

Termination of pregnancy (TOP) refers to the treatment to end a pregnancy, by surgical or medical methods. The hospital holds a licence from the Department of Health (DH) to undertake termination of pregnancy services (TOPS) in accordance with the Abortion Act 1967. It is licensed to provide terminations up to 23 weeks plus six days gestation. The hospital policy was not to carry out terminations later than 12 weeks six days except for women with a confirmed fetal abnormality.

The hospital offers medical abortion using prescribed medicine, as well as surgical abortion, under general anaesthesia, to women over the age of 16 years. One consultant uses conscious sedation.

Between July 2015 and June 2016, 165 abortions were carried out, of which 107 (64%) were surgical abortion under general anaesthesia. Five surgical abortions had taken place after 20 weeks gestation between July 2015 and June 2016.

Women are referred by a consultant with practising privileges at the hospital and pay for the procedure. Some women are referred to consultants by their GPs, some women refer themselves and some are referred through the corporate helpline, HCA connect. Women have their initial appointment with the consultant gynaecologist at their consulting rooms, not all of whom used Portland consulting rooms. Such consulting rooms are registered separately with CQC so were not inspected as part of this inspection. Women coming to the hospital for a termination have already had a consultation with a gynaecologist.

Women having a medical termination have their first dose of medicine in the gynaecology outpatients department. The second stage of medical termination is undertaken on a ward. All women are admitted directly to single occupancy rooms in the gynaecology and general surgery ward (4th floor). For a late termination (after 18 weeks) women are admitted to the delivery suite.

Surgical terminations take place in one of the three multi-purpose operating theatres in the basement. A recovery room is adjacent to the theatres. Most women attended as day cases but if a woman was not fit for discharge on the same day, they could stay overnight.

Services accredited by a national body:

The hospital is currently working towards Joint Advisory Group (JAG) accreditation for paediatric endoscopy services.

Services provided at the hospital under service level agreement:

- Generators
- Lifts
- Water treatment
- Firefighting equipment
- Gas/diesel boilers
- Portable appliance testing
- Electrical fixed wiring
- Medical gases
- UPS/IPS systems
- Insurance Plant, Equipment, Lifts
- Emergency Lighting
- Air Handling Units
- Chiller
- Nurse call
- Water feature
- Grease traps/ Sewage Pits
- Kitchen equipment
- Air conditioning
- Water treatment
- Lifting equipment
- Dose monitoring
- Laser protection
- MRI physics advice
- Ambulance services
- Archive services
- Biomedical devices management
- Clinical waste removal
- Confidential waste removal
- Courier services
- Deep cleaning services
- Funeral services
- Health and safety
- Housekeeping services
- Laundry
- Maintenance of imaging equipment

Summary of this inspection

- Microbiology
- Pathology services
- Pest control
- Radiation protection
- Sanitary waste disposal
- Sterilization of surgical equipment
- Window cleaning
- Hugs and kisses patient security tag

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- There were systems for the reporting and investigation of safety incidents that were well understood by staff. Openness and transparency were encouraged. Both junior and senior nurses were well aware of the duty of candour.
- Staff followed infection prevention control (IPC) guidance. The environment and equipment were clean and ready for use.
- Medicines, including arrangements for storage and administration, were effectively managed across the hospital. Regular audits were undertaken to ensure standards were met.
- We found suitable medical cover at all times from a resident medical officer (RMO) and on-call consultants and noted arrangements for consultants to provide cover for absent colleagues. Appropriate escalation occurred in the case of deteriorating patients.
- There were sufficient numbers of nursing and support staff to meet patients' needs, even where this had to be supplemented by non-permanent staff.
- We saw there were efficient and effective methods for the handover of care between clinical staff.
- There was a designated lead for safeguarding and staff were trained appropriately to recognise and report suspected abuse in vulnerable adults.
- The security and safety of patients was of high importance and the children and young people's (CYP) service put in additional measures to ensure that children in their service were protected from harm.

However:

- There was no integrated record keeping system, which meant that resident medical officers (RMOs) and agency staff did not have access to patient notes. There was poor documentation from consultants regarding a common surgical procedure in six of the 12 sets of maternity notes we looked at.
- Compliance rates of pre-assessment before surgery were low, ranging between 50% and 78% in the two months prior to out inspection. To improve this, the hospital recruited a dedicated pre-assessment nurse, but they were not yet in post.

Summary of this inspection

- The rate of ward and theatre staff turnover was above the average of other similar hospitals (July 2015 to June 2016). The surgical ward had two vacant posts since early 2016. Staff recruitment for these posts had started recently.
- There was no second on-call theatre team out-of-hours. This meant there was no theatre team available for gynaecology emergencies. This was on the hospital's risk register and most surgical patients were day cases with low pre-operative risk profiles.
- We found that changes in working practices arising from incident learning in the outpatient department were not embedded into written policies or procedures in a timely manner.
- Mandatory training rates for some hospital staff did not meet the hospital target of 90% compliance. Not all maternity staff were trained in the appropriate level of safeguarding.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy services.

We found the following areas of good practice:

- There were effective hospital-wide systems to ensure incidents were reported and lessons from these were shared across the hospital. No adverse incidents had been reported in relation to TOPS.
- Infection prevention and control (IPC) measures ensured that both the wards and theatres were clean and suitable for purpose.
- Staff we spoke with were knowledgeable about safeguarding and knew how to recognise if a woman was at risk or had been exposed to abuse, and how to escalate concerns.
- There were enough nurses in the wards and theatres for staff to perform their roles safely. There was 24 hour, seven-days a week, RMO cover for the wards.

However, we also found the following issues that the service provider needs to improve:

- Not all women having surgical terminations had a pre-operative assessment. The hospital had recruited a nurse into a post to perform these, but this was not yet in place at the time of inspection.

Are services effective?

Good

Are services effective?

We rated effective as good because:

Summary of this inspection

- We found there were arrangements to review guidance from national bodies such as the National Institute for Health and Care Excellence (NICE) and that care was delivered in line with best practice. Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care.
- There was a system for reviewing policies and these were discussed at the medical advisory committee (MAC) and other governance forums at the hospital.
- Patient outcomes were good when benchmarked against national standards. There were no concerns regarding rates of unplanned admissions, return to theatres or transfers to another hospital.
- Pain was effectively managed, with high patient satisfaction in this area.
- The multidisciplinary input was highly effective, well-coordinated and considered the patients holistic needs as well as clinical care. There was evidence of collaborative working and positive relationships across all departments within the hospital.
- Staff were competent in their roles and undertook regular appraisals and supervision. There was a high degree of staff participation in additional training.
- We found arrangements that ensured that doctors and nurses were compliant with the revalidation requirements of their professional bodies. All consultants had clear practising privileges agreements which set out the hospitals expectations of them, and ensured they were competent to carry out the treatments they provided.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy services.

We found the following areas of good practice:

- Hospital policies were current and appropriately referenced relevant national guidance. The TOPS policy had recently been reviewed and updated.
- Records of all TOP procedures were maintained on a spreadsheet to monitor that all Department of Health (DH) Required Standard Operating Procedures (RSOPs) were met.
- Pain relief and antibiotic medications were given to women post-procedure to manage their symptoms.

Summary of this inspection

- Consent and capacity were considered by nurses when a women was admitted for a TOP procedure. All staff demonstrated a working knowledge of the Mental Capacity Act (MCA) and its implications.

Are services caring?

Good

We rated caring as good because:

- Patients were treated with dignity and respect and their privacy was maintained.
- We saw that staff offered appropriate emotional support. Additional psychological support was available where needed. Ongoing support was offered to women and children post-discharge to ensure their emotional needs were met.
- Patients who shared their views said they felt well-informed and involved in their care. They reported staff were kind and compassionate at all times.
- We saw that results of the friends and family test (FFT) and other patients satisfaction surveys demonstrated that patients would recommend the hospital to others.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy services.

We found the following areas of good practice:

- Patient's privacy was maintained throughout their stay, as they were admitted to single occupancy rooms.
- Feedback from women about the gynaecology wards was consistently positive, although it was not possible to identify women undergoing TOP from returns.
- Consultants gave women verbal and written information on what to expect during and following a procedure. Women were able to contact the ward 24/7 after discharge for support or advice.
- Counselling was available to all women before, during and after they had received treatment, as required. This was from an external provider.

Are services responsive?

Outstanding

We rated responsive as outstanding because:

- Services were planned to fit the needs of patients. The environment was tailored for the needs of different patients and clinics were scheduled outside of normal hours.

Summary of this inspection

- International patients were provided with tailored care and were supervised throughout their care pathway. Translators were available 24 hours a day. The international team had good links to each embassy, in the event that the translators were not able to assist.
- There were arrangements in place to support people with particular complex needs. We saw many examples of tailored packages of care to suit the needs of women and children with different backgrounds and circumstances.
- The hospital had implemented a specialist, sensitive birthmark screening and treatment program for paediatric outpatients.
- Patients were assessed prior to admission to ensure that hospital could safely meet their needs.
- Patients were often seen on the same day if presenting as an outpatient. Elective procedures were scheduled to meet the needs of patients.
- There was evidence of effective handovers of care to community agencies when patients were discharged.
- There was a clear complaints procedure in place and we saw evidence of learning from complaints and incidents. Staff were able to give examples about things that had changed as a result.

However:

- There was lack of space in some clinical areas in the main hospital building. Some staff were concerned that this may impede the care being provided to the patients. Equipment in theatres was not ideally stored.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy services.

We found the following areas of good practice:

- All women referred to the service received timely treatment, often beginning the same day they had their initial appointment.
- Women were given enough information to make an informed choice about the sensitive disposal of pregnancy remains and time to consider this. Appropriate storage arrangements were in place.
- Hospital-wide processes ensured that any complaints would be reviewed and were responded to appropriately.

Are services well-led?

Good

We rated well-led as good because:

- Both senior and junior nurses, as well as doctors working in the service, embedded the vision and strategy for the service into their clinical practice.
- There were clearly defined and visible local leadership roles. Managers provided visible leadership and motivation to their teams. It was clear that the vast majority of staff felt supported by management.
- There was an appropriate system of governance and managers knew the key risks and challenges to the hospital. They were taking steps to mitigate the impact of these.
- Practising privileges were received, authorised and granted in conjunction with the medical advisory committee (MAC) and kept under review.
- Staff across the hospital were encouraged to put forward ideas to improve patient experience and this was evident in the celebration of new ideas from staff at all levels.
- We were provided with a number of positive examples of staff development, which all included staff members from support services identified by the CEO and mother managers as wanting to join clinical services. The staff members was supported and provided with funding to complete qualifications, allowing them to join as clinical staff.
- We saw examples of initiatives that were introduced to improve patient experience and to ensure the safety and quality of care kept pace with new developments and growing expectations. However:
- While the hospital collected some data around equality and diversity, it did not include the four specific workforce metrics identified in the NHS Workforce Race Equality Standards (WRES) to demonstrate progress against a number of indicators of workforce equality.

Services we do not rate

We do not currently have a legal duty to rate termination of pregnancy services.

We found the following areas of good practice:

- We saw evidence that legislation relating to the termination of pregnancy (TOP) was followed in all the cases we examined.

However, we also found the following issues that the service provider needs to improve:

- The hospital could not be assured that consultants were all returning the HSA4 forms were to the Department of Health within 14 days, because consultants did not always copy the form to the ward.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Good	Good	Good	Good	Good	Good
Maternity	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	☆ Outstanding	Good	Good
Outpatients and diagnostic imaging	Good	N/A	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Termination of pregnancy	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Good	Good	Good	☆ Outstanding	Good	Good

Good

Surgery

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

Are surgery services safe?

Good

Incidents

- Staff we spoke with felt confident and encouraged to report incidents on the electronic incident reporting system.
- The hospital reported 32 incidents that occurred in surgical services between April and October 2016, all of which resulted in low or no harm.
- There were no never events reported in surgical services in the last 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- A weekly incident review meeting group for all staff discussed recent incidents and learnings. Lessons learned were published in a summary and distributed to all staff via weekly newsletters, team meetings and incident debriefings. We were shown examples of lessons learned from incidents. One of the effects after incidents associated with peri/postoperative bleeding was that nursing staff were reminded to remain vigilant during patient observations and to escalate early signs of postoperative complications.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that the hospital had a duty of candour policy and that staff were aware of the terminology. The process they described in communicating with patients and their relatives reflected openness and transparency. Staff gave of examples of when duty of candour had been applied.
- We saw evidence of Mortality and Morbidity meetings including case study, analysis and assessments, literature review and recommendations.

Clinical Quality Dashboard or equivalent

- The hospital had developed a dashboard that monitored pressure ulcers, falls, catheter associated urinary tract infection (CAUTI) and venous thrombembolism (VTE). There had been no pressure ulcers, falls, CAUTI or VTE in the three months prior to inspection.
- The hospital reported screening rates of 100% for VTE from January 2016 to June 2016.
- Staff were able to access an up-to-date dashboard for their ward on computer workstations. These were not publicly displayed.

Cleanliness, infection control and hygiene

- All areas we visited were well lit and looked clean.
- Equipment was marked with a green 'I am clean' sticker when it had been cleaned and was ready for use.
- Personal protective equipment (PPE) such as disposable gloves and aprons were readily available in all areas.

- There were hand wash basins in all patient rooms and hand disinfection foam dispensers were available throughout the ward and theatre department. We observed staff making use of them regularly.
- The hand hygiene observational audit reported compliance rates of between 80% to 100% for the ward, and 100% for theatres, from April 2015 to June 2016. The hospital target was 95%.
- During our inspection we observed staff adhering to the 'bare below the elbows' (BBE) policy. The BBE audit April 2015 to June 2016 for the ward showed a 85% to 100% compliance and 90% to 100% for theatres.
- The hospital reported no cases of Meticillin resistant or sensitive Staphylococcus aureus (MSSA), Escherichia coli (E. coli) or Clostridium difficile for surgical services in the reporting period July 2015 to June 2016.
- The monthly MRSA screening audit demonstrated varied compliance rates from 88% to 93% for the hospital from October 2015 to September 2016. This was below the target of 100%. As consequence, the hospital reviewed ways to increase screening compliance and planned to expand pre-admission service.
- The pharmacist we spoke with told us about national antimicrobial guidelines that could be accessed from a mobile phone or desktop. This provided quick and up-to-date information about antibiotic prescription.
- The hospital employed staff that undertook the cleaning of the hospital. We saw cleaning schedules in areas we visited. Cleaning equipment was not stored on the ward. Cleaning personnel would arrive and leave with the cleaning trolley.
- We observed that sharps and clinical waste management complied with Health and Safety Regulations 2013. The sharp bins were clearly labelled and tagged to ensure appropriate disposal.
- The hospital reported one gynaecology surgical site infection between July 2015 and June 2016. This was below the rate of other independent acute hospitals we hold this type of data for.

Environment and equipment

- Resuscitation trolleys were readily available in all areas of the department. We saw the contents of the trolleys were checked daily by nursing staff and were tagged and sealed.
- A difficult intubation trolley was readily available for theatres and recovery.
- We observed safety testing stickers on equipment to show when safety checks were due.
- Anaesthetic equipment was stored in drawers and cupboards in the anaesthetic rooms adjacent to each theatre. Equipment was well stocked and organised and checked daily. Staff told us that they had sufficient equipment.
- Lack of storage space in theatres was an issue identified by the theatre manager. Equipment was stored in corridors and in large cupboards in corridors. The theatre manager told us about hospital plans to increase space.

Medicines

- Medicines were stored safely in locked cupboards and refrigerators within locked rooms. The ward had a range of frequently used medicines in stock to be readily available when required. Patients' own medicines were stored separately.
- Controlled drugs (CDs) were stored appropriately in a separate locked cupboard together with the CD register. Access was restricted to the nurse in charge who held the keys.
- Intravenous fluids were stored safely in locked cupboards on the ward. Theatres used a fluid warmer to store labelled intravenous fluids. The temperature was monitored and recorded daily.
- Room and fridge temperatures were within acceptable limits during inspection. Temperatures were monitored by a continuous electronic temperature recording system, which would alert the duty manager in case of temperatures being out of range.
- The quarterly audit for medicine storage and treatment rooms showed 100% compliance in 2016 for the ward, theatres and recovery.

- The ward used a paper-based prescription and medication administered chart. We looked at four different drug charts and saw appropriate recordings of medicine administration.
- A pharmacist reviewed prescription charts daily and was available from 8.30am to 7pm, Saturdays until 1pm and on-call out of hours.

Records

- A combination of paper and electronic patient records were in use. Paper records were kept in lockable cupboards. Electronic records and patient information were password protected. Staff locked the screen when leaving the computer workstation.
- Most agency staff did not have access to the electronic patient record system and used paper documentation instead. At the beginning of the shift, the nurse in charge printed paper copies of all relevant nursing documentation for the agency nurse's allocated patients and made a note in the electronic patient record. The paper documentation was scanned and added to the electronic file on patients' discharge. This meant electronic patient records were incomplete before patients' discharge. This had been recognised by the hospital and was on the risk register with controls in place and additional mitigating measures. For example, there was an on-going recruitment programme and plans to provide agency nurses with logins.
- We looked at four sets of medical records and found them to be complete, clear and legible.
- Nurses entered risk assessments on the electronic patient record. We observed a nurse assessing a patient's risk for developing pressure ulcer, acute kidney injury, for falls and nutritional risks during a pre-assessment visit.
- We saw a nursing documentation audit report for the period January 2016 to June 2016. The monthly audit tested that records met the professional standards required. Results demonstrated 93% to 100% compliance for the surgical ward. The hospital target was 100%.

Safeguarding

- Safeguarding policies and procedures were in place. These were available electronically for staff to refer to. Staff understood their roles and responsibilities to safeguard people. The chief nursing officer (CNO) was the safeguarding lead for the hospital.
- Safeguarding adults and children level one and two were part of mandatory training for all staff with compliance rates between 91% and 100% for ward and theatre staff. Safeguarding children level three was mandatory for theatre staff and 70% had completed this training; this was below the hospital target of 90%.
- PREVENT training was part of statutory training for nursing staff. The Prevent duty is the duty in the Counter-Terrorism and Security Act 2015 on specified authorities, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism.
- There were no recent safeguarding referrals in surgery.

Mandatory training

- Mandatory training was monitored and all staff were expected to attend on regular basis. The mandatory training programme included topics such as: health and safety, infection control, information governance, manual handling, equality and diversity, fire safety, ethics and code of conduct, safeguarding children and vulnerable adults, basic life support and disability awareness. Compliance rates varied between 85% and 100% for theatre staff, and 92% to 100% for ward staff. The hospital target was 90%.
- Nursing and theatre staff had to complete additional training. For example, staff received training in anaphylaxis, blood transfusion, medical gases and medication safety.
- Mandatory training was a mixture of e-learning and face-to-face training. Staff told us it was completed during work time.
- Mandatory training was monitored and compliance discussed during the appraisal process. We reviewed learning logs which included details of completed mandatory training.
- The induction programme for all staff included all mandatory training for their individual roles. All staff we spoke with found it comprehensive and useful.

Good

Surgery

Assessing and responding to patient risk

- The pre-operative assessment was defined in corporate and local guidelines. The purpose of the pre-operative assessment was to ensure that patients were fully informed about the procedure and the post operative recovery, were in optimum health and had made arrangements for admission, discharge and post operative care at home. During inspection, pre-operative assessment took place twice a week and was performed by the ward sister as a phone call or face-to-face. We observed a pre-assessment process prior to major abdominal surgery and found it provided comprehensive information, safe preparation and assessment. The nurse completed risk assessments including falls, nutrition, VTE, acute kidney injury and skin integrity. Compliance rates for this pre-operative assessment ranged between 50% and 78% in the two months prior to inspection. This was below the target of 100%. To improve this, the hospital recruited a dedicated pre-assessment nurse to start in January 2017.
- The ASA (American Society of Anaesthesiologists) score is a physical classification system to assess the fitness of patients before surgery. A normal and healthy patient has an ASA score I. This was the case for 88% of admitted patients to the surgical ward in May to October 2016. An additional 11% had an ASA score II (mild systemic disease) and 1% had ASA score III (severe systemic disease). This meant the vast majority of patients presented with a low pre-operative risk profile.
- Nursing staff recorded and monitored patients' clinical observations in line with NICE guidance 'acutely ill patients in hospital'. Staff used a national early warning scoring (NEWS) system to measure vital signs and identify patients at risk of deterioration. Observations were entered into an electronic recording system on portable devices, which automatically calculated the level of risk. When a certain level was reached, the on-call resident medical officer (RMO) was automatically informed and would review the patient. We saw evidence of this being used.
- Nursing staff told us medical support was readily available when required. A resident medical officer (RMO) was on call and available 24 hours a day, seven days a week. Staff explained they would call the RMO in case of patient deterioration, high NEWS score or other concerns. The RMO would assess the patient and inform the patient's consultant as well. The hospital did not audit RMO response time. However, staff told us that RMOs attended to patients in a timely manner.
- There was a resident on-call theatre team available for primarily obstetric patients. There was no provision of a second on-call theatre team out of hours. This meant there was no theatre team available for gynaecology emergencies out of hours. This was on the hospital's risk register. However, most surgical patients were day cases with low pre-operative risk profiles.
- The WHO (World Health Organisation) safer surgery checklist is a system to safely record and manage each stage of a patient's journey from the ward through to the anaesthetic and operating room to recovery and discharge from the theatre.
- We found evidence of staff completing the WHO safer surgery checklist documentation when we reviewed patients' notes postoperatively. We observed one example of the WHO checklist in use in theatres. The team followed a standardised, accurate approach, were well led and had good staff engagement. Staff told us compliance with the checklist was closely monitored and monthly audits of compliance took place on a regular basis. The August 2016 surgical safety checklist audit demonstrated a compliance of 100% since April 2016. The audit showed an improvement since 2015, contained recommendations, and an action plan.
- Staff in the minor procedure room used an abbreviated version of the WHO safety checklist for their patients. However, they did not audit this.
- The hospital used a local escalation policy for patient with sepsis, based on the 'sepsis six', which is a national screening tool for sepsis. The hospital had a formal transfer agreement with another independent hospital to provide adult level three care on their intensive care unit if required. In such case, a consultant anaesthetist would look after the critically unwell patient until the transfer was completed.
- The blood fridge was located within main theatres and stored four units of emergency blood. Further cross-matched units were available from HCA labs.

Nursing and support staffing

Good

Surgery

- Staffing levels in theatres were compliant with recommendations from the Association for perioperative practice (AFPP). There were three scrub nurses per theatre; the AFPP guidelines recommend two qualified nurses per theatre.
- For July 2016, the hospital reported 37.5 full time equivalent (FTE) staff for theatres. The vacancy rate was 21% for theatre nurses, which was higher than the rate for this staff group of other independent hospitals we hold this type of data for. At the time, there were no vacancies for ODPs and health care assistants.
- The use of bank and agency nurses in theatre departments from July 2015 to June 16 was 11%. This was lower than the average of other independent acute hospitals we hold this type of data for.
- The rate of ward and theatre staff turnover was 28% and 17%. This was above the average of other similar hospitals from July 2015 to June 2016.
- Staffing levels on the surgical ward were in line with Royal College of Nursing and NICE recommendations. We reviewed ward nurse rotas and bed occupancy for August to November 2016. Nurse to patient ratio varied from 1:2 to 1:4. The ward had an establishment of 16.58 full time equivalent (FTE) nursing posts, including the matron. Bank and agency nurses covered remaining shifts. As most patients were day cases and discharged the same day, staffing requirements were lower at nights and on weekends.
- The ward displayed the name of the nurse in charge of the day who would usually also look after patients. There were no healthcare assistants on the ward and patient numbers often meant that there were two qualified nurses on shift, one of them often agency or bank staff. Agency nurses did not always have access to electronic patient records and needed guidance from the permanent member of staff. Staff told us that one nurse would often look after patients on her own while her colleague transferred patients to and from theatres. In such cases, additional help would not be readily available and break times could not be easily organised.
- For July 2016, the hospital reported a vacancy rate of 33% for inpatient nurses, which was higher than the rate for this staff group of other independent hospitals we hold this type of data for. The ward had two vacant posts since early 2016 and according to nursing staff recruitment started recently.
- The hospital did not use an acuity tool, but instead assessed staffing requirements daily.
- The hospital recruited for a new post for pre-operative assessment service, which was provided by the ward sister at the time of inspection.
- The sickness rates for nurses working in the surgical department ranged from 0% to 9.5% and therefore varied when compared to the average of other similar hospitals.
- Hospital data showed there were no unfilled shifts in the surgical department from April 2016 to June 2016.
- Two nursing staff looked after patients undergoing surgery in the minor procedure room. There were two permanent members of nursing staff and two regular bank nurses.

Medical staffing

- One resident medical officer (RMO) provided cover 24 hours a day, seven days a week, for the adult wards. All RMOs had experience in gynaecology and were trained at ST3 level or above. They all had completed advanced life support training.
- The hospital employed six RMOs to cover the gynaecology and obstetrics wards working 24 hour shifts. The hospital also had a bank of RMO to cover remaining shifts. There was one vacancy and the hospital informed us that the post had been offered to a candidate.
- The service was fully consultant led. Gynaecology consultants reviewed patients daily and were available on the phone out of hours. A consultant anaesthetist provided cover 24 hours a day, seven days week, mainly for maternity services, but would be available for gynaecology patients as well. If acuity demanded, a second consultant anaesthetist would be available on call for the hospital.

Good

Surgery

- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.

Emergency awareness and training

- The hospital had major incident and business continuity plan in place. Staff we spoke with were aware of guidance and how to access it. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The duty manager had overall responsibility to maintain an overview of all the incidents which could have the potential to affect the hospital. In the event of an emergency the duty manager would manage the emergency control room and be in charge of the response. Both junior and senior nurses were aware that if there was an emergency the duty manager would be informed in the first instance.
- Fire safety was part of mandatory training for all staff.

Are surgery services effective?

Good

Evidence-based care and treatment

- We viewed a selection of clinical policies with reference to NICE, Nursing and Midwifery Council (NMC), Royal College or other national guidelines. For example, the CPR policy was based on the UK Resuscitation Council guidelines.
- The hospital's audit and guideline group committees monitored adherence to best practice, NICE and Royal College guidelines.
- The hospital's audit calendar included 26 audits for gynaecology and theatres. For example, there were audits for pain, record keeping, VTE, MUST scores, Waterlow scores, blood transfusion, temperature, fluid monitoring, completion of the WHO checklist and consent.
- We observed patients receiving regular observations, for example, blood pressure and oxygen saturation, to monitor their health post-surgery. This was in line with NICE guideline CG50: Acutely ill patients in hospital - recognising and responding to deterioration.
- In theatres, and in the patient notes, we saw evidence of the hospital providing surgery in line with local policies and national guidelines such as NICE guideline CG74: Surgical site infections: prevention and treatment. For example, in theatre we saw that the patient's skin was prepared at the surgical site immediately before incision using an antiseptic (aqueous or alcohol-based) preparation: povidone-iodine or chlorhexidine.
- Anaesthetist consultants told us they followed the 'Audit Recipe Book' of the Royal College of Anaesthetists to benchmark themselves against national standards. The book contains best practice guidance, proposed standards or targets for best practice, suggested data to be collected and common reasons for failure to meet standards.
- The hospital did not participate in national surgical or anaesthetic audits for the gynaecology department. Managers told us that procedure numbers were too small to participate.

Pain relief

- Pain documentation showed level of pain was assessed regularly as part of observation records. Nursing staff used a verbal pain score of between zero and three to record patients' pain.
- Procedures in the minor procedure room were performed under local anaesthesia by injection or cream, where appropriate, as per patient preference.
- There was no dedicated pain team. Pain management was consultant led with input from anaesthetist consultants on call if required.
- Patients were asked about the quality of pain management as part of patient feedback. Between 80% to 90% of patients rated it as 'excellent'. This demonstrated that pain was effectively managed for most patients.
- A monthly pain audit determined compliance with effective pain assessment and management. From

January 2016 to May 2016, data showed 88% to 100% compliance for audit aims. In 100% of cases of moderate or higher pain score for four or more hours, the patient was reviewed by RMO.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The malnutrition universal screening tool (MUST) was used to identify the risk level of each patient and this was documented in each set of notes we saw. Training in the use of MUST was mandatory for all nursing staff.
- The MUST audit of the gynaecology ward showed 100% compliance with all audit standards in the first two quarters of 2016.
- The service complied with the Royal College of Anaesthetists recommended fasting time for six hours for food and two hours for clear fluids for surgical patients.
- We saw evidence of staff documenting food and fluid intake in patients' records.
- Dietitians reviewed patients on the ward if required.
- Patients we spoke with were generally happy with the availability of food provided to them.

Patient outcomes

- Data provided showed there had been 7481 inpatient and day case attendances from July 2015 to June 2016. There were five unplanned readmissions within 28 days of discharge within the gynaecology surgical service. This number was not high when compared to a group of independent acute hospitals, which submitted performance data to CQC.
- There was one unplanned transfer of a patient to another hospital in the same period. This was not high when compared to a group of independent acute hospitals, which submitted performance data to CQC.
- There were no cases of unplanned returns to theatre within the gynaecology surgical service from July 2015 to June 2016.
- The hospital participated in data collection for the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

Competent staff

- The medical advisory committee (MAC) reviewed consultants requesting practising privileges and advised the CEO.
- Medical staff were appraised and revalidated in their NHS role, or if required, by the responsible officer from the provider.
- All RMOs covering the ward had experience in gynaecology at ST3 level or above and were trained in ALS (advanced life support).
- There were processes in place to ensure staff had access to regular appraisals. Staff told us about annual salary increments that were linked to training and appraisal. This ensured staff were motivated to complete this. The appraisal rate for staff across the department was 100%.
- Nursing staff received additional statutory training relevant for their role, for example ILS (intermediate life support), medication safety, anaphylaxis, blood transfusion, safer anticoagulation. Staff showed us examples of electronic training documentation.
- Nursing staff used corporate competency booklets for core competencies or equipment training. We saw examples of booklets with completed assessments and competency checks.
- All new staff underwent a four day induction programme to ensure they became familiar with local policies and procedures, including mandatory training.
- A practice development nurse supported staff in their training and nursing practice.
- A clinical nurse specialist in plastic surgery looked after patients in the minor procedure room. Nursing staff working there were all trained in ALS.

Multidisciplinary working

- There were no regular multidisciplinary team (MDT) meetings for gynaecology. Most patients on the ward were uncomplicated day cases and young patients without comorbidities. Staff told us that MDT meetings would be organised if required.

Good

Surgery

- A microbiology round took place once weekly to review antibiotic treatment and give updated results. A microbiology consultant, employed by the provider, led the round and was joined by the local pharmacist and infection control nurse.
- Staff could refer patients to the in-house physiotherapy department if needed.

Seven-day services

- There was a 24 hour, seven days a week rota of resident RMOs to cover surgical inpatient care.
- Surgical consultants were available 24 hours a day, seven days a week if their patient required urgent review. If they were not available, they arranged alternative consultant cover.
- There was a 24 hour, seven days a week resident anaesthetist consultant cover for the hospital. If required, a second consultant anaesthetist would be on call.
- There was an on-call pharmacist service out of hours when the hospital pharmacy service was not available.
- Radiology services were available 24 hours, seven days a week.
- There was a 24 hour, seven days a week microbiology consultant cover to discuss microbiology results, antibiotic treatment or any infection control issues.

Access to information

- Staff had access to hospital policies in the policy library of the intranet and staff showed us a demonstration of this.
- Staff accessed and entered patient information on an electronic patient record system. We saw portable computers which enables staff to enter patient data during rounds. Staff told us there were sufficient computer workplaces.
- Most agency staff did not have access to the electronic patient record and used paper documentation. This meant they could not easily access information from the electronic patient record and had to ask their colleagues to login into the system. Before starting the shift, the nurse in charge printed relevant documents for the agency nurse's patients. The paper documentation was scanned and added to the electronic file after discharge. All nurses had access to the electronic patient observation chart.
- The ward clerk provided patients with a discharge pack upon discharge. It included a discharge letter that could be taken to the GP and the telephone number of the ward if they experienced any problems after discharge.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Theatre staff audited daily all patients undergoing a procedure in main theatre to ensure compliance with consent policy. The consent policy was based on the current legislation and best practice and was aligned to NHS consent forms. Audit results from March to July 2016 showed improvements and compliance with most audit questions and action plans for topics requiring improvement.
- Consultants discussed procedures, risks and outcomes during clinic appointments. Patients who underwent pre-operative assessment received further information then. Consultants obtained formal consent on the day of surgery. Our review of patient records found that in all cases, consent to surgical procedure had been obtained and consent forms were completed correctly.
- Senior staff knew about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff told us they rarely had patients who lacked capacity and there had been no DoLS applications recently.
- MCA and DoLS was part of mandatory training programme for nursing staff. Staff we spoke with had a good understanding of their role and responsibility in ensuring patients had sufficient capacity to consent.

Are surgery services caring?

Good

Compassionate care

- We spoke with two patients on the ward who provided positive feedback about the care and treatment they received.

Good

Surgery

- Patient consultations, treatment and personal care on the ward took place in private rooms that ensured privacy and dignity. Patients we spoke with felt safe in their environment.
- We observed staff being kind, respectful and professional when speaking to patients and delivering care.
- The ward results from the patient experience feedback showed that 80% to 95% patient rated overall quality of care as 'excellent' between April and September 2016. However, a response rate was not provided.
- Friends and Family test (FFT) data was collected as part of the survey. According to the data, almost all patients would recommend the surgical service to friends or family. The hospital wide response rate for the FFT ranged from 23% to 41% (January to June 2016).

Understanding and involvement of patients and those close to them

- We observed nursing staff explaining to patients and their relatives the care and treatment that was being provided. Patients told us they were given sufficient information before the surgery and that they felt well prepared.
- We saw documentation about consultants' discussion with patients about procedure and treatment options in medical records.
- Patient feedback forms were available in all patient rooms and patients were encouraged to fill them in.

Emotional support

- Patients we spoke with felt supported by staff throughout their surgical journey.
- An endometriosis nurse specialist offered additional support to patients undergoing surgery for endometriosis.
- Patients had access to psychological support through an in house psychology and counselling team.
- Patients had access to a multi-faith spiritual support team who were available 24 hours, seven days a week.

Are surgery services responsive?

Good

Service planning and delivery to meet the needs of local people

- The hospital mainly provided private care and most admissions were for elective procedures. This meant admissions to the surgical ward were planned in advance with the patient. Staff told us that about 90% of admissions were day cases. Emergency admissions were also accepted from the outpatients department.
- The hospital had a dedicated international patient centre staffed by liaison officers. This service was designed to meet the needs of the large demographic of international patients the hospital received. The centre arranged assisted and escorted patients through their hospital journey, liaising with insurance companies and embassies if required. The centre also provided translation, accommodation booking and travel booking.

Access and flow

- Patients could access the service via referral by their consultant, GP or embassy. According to the hospital, patients were admitted and treated as required; therefore, there was no audit of waiting times.
- Hospital data showed a bed occupancy rate of 39% for the ward in May to October 2016.
- A gynaecology consultant would review the patient in outpatients departments and book surgery. Booking forms were sent to the reservations team and pre-operative assessment nurse.
- Information provided showed 30 procedures had been cancelled for non-clinical reasons between July 2015 and June 2016. Funding issues were the reason for most cancellations.
- The majority of admissions were for elective surgical procedures and planned by the admitting consultant. There were five unplanned emergency admissions between October 2015 and September 2016.
- According to data theatre use varied from 57% to 68% from April 2016 to September 2016. This was low compared to other similar hospitals.

Good

Surgery

- Patients undergoing procedures in the minor procedure room received a letter by email containing medical information. Nurses called each patient the day after discharge routinely, to follow-up any concerns or questions.

Meeting people's individual needs

- The majority of admissions for surgical procedures were elective and planned in advance. Admission was facilitated in a timely manner and could be arranged at short notice to meet patient's individual needs and ensure they received treatment as soon as possible.
- Dementia training was part of the mandatory training programme. However, staff told us that patients with dementia or learning disability (LD) were rarely admitted to the ward. Therefore, they were not aware of any specific tools available for patients living with dementia or LD.
- Every patient room had a call bell. We observed staff responding promptly to call bells.
- Every patient room was fitted with a foldable extra bed. This enabled family members or carers to stay with the patient.
- There was step-free access in both the theatres and wards and all inpatient rooms had step-free access to bathrooms.
- Information leaflets about various treatments and procedures were available for patients in different languages.
- Interpreters were employed by the hospital and readily available. In the rare case that an interpreter could not be booked in advance or was unavailable, staff would access a telephone translation service.
- The hospital provided 24 hours, seven days a week multi-faith chaplaincy service through a service level agreement with a local NHS trust. Staff knew how to access the service, which was available for patients, visitors and staff.

Learning from complaints and concerns

- Patients were made aware of how to raise complaints and were provided with information leaflets.
- Staff told us they would attempt to resolve verbal complaints informally. This was in line with the hospital expectation that any issues should be addressed immediately.
- The hospital's complaint procedure was to acknowledge formal complaints within two working days and to send a written response within 20 working days. If these time scales could not be achieved the complainant would be informed of the delay and anticipated time for response. According to data, 99% of complaints were responded to in time.
- There were no formal complaints related to gynaecology surgery inpatient services between July 2015 and June 2016.
- Staff told us about examples of learning from complaints; a patient complained about loud ticking noise of the wall clock in the room. As consequence, the hospital exchanged all wall clocks with silent clocks.

Are surgery services well-led?

Good

Leadership / culture of service related to this core service

- The heads of departments were the women's services and neonatal manager and the theatre manager who reported to the chief nurse. They supervised the matrons for the ward and for theatre.
- The ward sister, matrons and managers were knowledgeable about their areas and were visible, with the ward sister being hands-on. Theatre staff felt well supported by their manager and described her as "helpful and approachable", and as "promoting education and training".
- All staff we spoke with enjoyed working in the department with their colleagues and praised teamwork. Especially ward staff spoke highly of their "fantastic team" and the engaging ward sister. Nursing staff felt supported by doctors and told us about a good relationship.

- All staff we spoke with praised the hospital's leadership team and especially the chief executive officer (CEO). They told us that managers were accessible and easy to approach.
- Medical staff felt supported by management and told us about good working relationships with each other and nursing staff.
- Nursing staff felt that there were limited opportunities for career progression.
- While the hospital collected some data on equality and diversity, it did not include the four specific workforce metrics identified in the NHS Workforce Race Equality Standards (WRES) in order to demonstrate progress against a number of indicators of workforce equality.

Vision and strategy for this core service

- Staff were aware of the Portland Hospital's vision to deliver exceptional care by exceptional people. Staff knew how their work contributed to this and were aware of the corporate values.
- There was no separate vision or strategy for the surgical services at the hospital. However, we saw business objectives and the service plan for theatres.
- The hospital recently recruited an endometriosis clinical specialist nurse to help developing an endometriosis centre.

Governance, risk management and quality measurement

- There were clear governance arrangements in place to ensure high standards of care were maintained. We saw the hospital's audit calendar, risk register, complaints log and incident log.
- A governance structure was in place for the hospital. The three main committees were the medical advisory committee, integrated governance committee and incident review meeting. Cascading down were Obstetrics and Gynaecology subcommittee, theatre user groups and audit and guideline groups. We reviewed meeting minutes of ward meetings, theatre group meetings and audit and guideline meetings. Quality and governance issues were discussed in those meetings.
- The medical advisory committee (MAC) reviewed each application for practicing privileges and advised the hospital chief executive officer (CEO). The advisory function covered granting, renewal, restriction, suspension and withdrawal of practicing privileges. Consultant credentials were reviewed via a report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office. If there were delays in receiving evidence of up to date documentation, the CEO suspended the privileges accordingly until credentials were provided. There was an annual review of practicing privileges, including scope of practice and activity. Any concerns, including competencies, raised about consultants were dealt with through the 'Responding to Concerns' policy via Decision Making Group (DMG)and then the Corporate DMG if required.
- There were a number of other committees, including medicine management, safeguarding, infection control, health and safety, resuscitation, blood committee or patient experience group. They reported to the integrated governance committee.
- The hospital wide risk register included risks relevant to the surgical department. Senior staff could name main risks for their department.

Public and staff engagement

- A weekly governance newsletter provided feedback to staff informing about incidents by department and wards, including most recent incidents and learning.
- The staff satisfaction survey of 2016 showed that 95% of staff felt committed to doing their very best for HCA. Overall, 67% of respondents felt satisfied overall working for HCA, and 53% were not planning to leave HCA in the next 12 months. The survey demonstrated a slight decline in all points compared with results two years ago.
- We observed feedback forms in all patient rooms and patients were encouraged to leave feedback. Results were analysed by an independent company and discussed at the patient experience group, heads of department and senior nurses meetings. We saw examples of initiatives that had been implemented following patient feedback.

Good

Surgery

- The hospital had an 'employee of the quarter' award for any member of staff. Everyone could nominate a colleague to receive a prize. The hospital also recognised staff employment for every five years and would sponsor a dinner and a gift for the employee.
- The hospital hosted an annual staff party. Staff could obtain tickets free of charge.
- The hospital had a blog on their public web site and was present in social media where people were able to leave comments.

Innovation, improvement and sustainability

- The hospital used a tracking system to alert nurses on the ward ahead of the theatre being ready for the next case to give plenty of time to prepare and transfer the patient to surgery. This helped to achieve an efficient workflow.
- The Portland Hospital had a Comprehensive Unit-based Safety Program (CUSP) in place. CUSP is an American model to improve patient safety based on the understanding that work for improvements must be made at a local level. The hospital partnered a senior executive with a specific clinical area; the clinical team benefitted from the executive's ability to make decisions at a high level, rapidly progressing safety improvements, and the executive benefitted from the immediate knowledge and direct care experience of the clinical staff.
- The hospital showed us plans to roll out a fasting improvement tool to help reduce fasting errors. The idea was developed after incidents and patient feedback. We were shown the prototype of a visual aid helping patients and relatives remember the fasting time frame and fasting instructions before surgery.

Good

Maternity

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

Are maternity services safe?

Good

Incidents

- There were no never events reported within the maternity service in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- We were assured from interviews with senior management, the risk matron and midwifery staff that the hospital's approach to incident management was timely and enabled quick mitigation of the risks relating to the health, safety and welfare of service users. For example, we saw that incident forms were reviewed within 24 hours, and categorised according to level of risk. Incidents graded as moderate harm and above were presented at a weekly incident review meeting. We attended a weekly meeting and saw triangulation of this process as the agenda included interrogation and discussion on the number of incidents, any trends identified from incidents, complaints and duty of candour, and risk assessments requiring approval.
- The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool (list of incidents to report) was used for incident reporting. All incidents were reported according to the Serious Incident Framework (NHS, March 2015).
- Midwifery staff told us that they were able to raise concerns and were confident that their concerns were listened to. All staff we spoke with understood their responsibilities to raise concerns and near misses on the hospital electronic reporting system. We saw that 166 maternity incidents were reported between October 2015 and October 2016. Of these 107 (64.6%) were classified as no harm, 55 (33%) classified as low harm, three (1.8%) were classified as moderate harm and one (0.6%) was classified as severe harm.
- Incidents were reviewed on a daily basis by the risk manager, who liaised with the maternity Risk Matron and departmental managers. The maternity risk matron was responsible for preparing a time line for incidents which were classified as moderate to high risk. The purpose of the timeline is to examine service or care provision problems in detail. This was then presented at a weekly incident review meeting (IRM).
- Learning from incidents was shared with staff via a newsletter. For example, staff were reminded to ensure they maintained safe practice when cleaning up bodily fluids, including a prompt for staff to ensure they were up to date with mandatory training for infection control.
- If investigations identified practice issues, supervisors of midwives (SoMs) performed independent investigations and devised action plans to tackle any issues identified. Staff were able to give examples of changes that had been implemented as the result of incidents, such as the introduction of a separate neonatal emergency trolley in the delivery suite. This was to facilitate an increased work surface for staff involved in neonatal resuscitation following an incident.

- We were given a demonstration of computerised monitoring tool which allowed staff to access a breakdown of incidents which occurred in their respective clinical area each month. A synopsis of each incident was provided, as well as an overview of emerging themes. A summary of lessons learned from each of the hospitals within the HCA group was also accessible. However, not all staff were aware of the tool.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Women and those close to them were involved in reviews where necessary. Staff ensured that requirements under the duty of candour requirement were met. We saw from a completed root cause analysis (RCA) that parents involved had been given a verbal apology and that a duty of candour letter had been sent. This offered them the opportunity to participate in the investigation of the incident should they wish.
- We saw an example of a completed investigation, which demonstrated that lessons learned had been identified. Duty of candour had also been observed. We also saw documentary evidence of action plans that the service had devised in relation to lessons learned. Any action plans were regularly review at the monthly integrated governance committee (IGC).

Clinical Quality Dashboard

- The Maternity Safety Thermometer is a national improvement tool used in the NHS for measuring, monitoring and analysing harm to people and 'harm free' care. It measures harm from trauma during birth, infection, length separation between mother and baby and psychological safety amongst other metrics. Although the service did not have to display this data as it is an independent hospital, we did see copies of an information leaflet entitled 'Maternity Outcomes', published in March 2016. This included details of a recent benchmarking exercise that the hospital had undertaken against the Royal College of Obstetricians and Gynaecologists (RCOG) 'Patterns of maternity care in English NHS hospitals 2013-2014.' This demonstrated that the service had a lower rate of third and fourth degree perineal tears (1.9%) than the national average (5.1%).
- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism (VTE). The hospital had developed their own dashboard, which staff were able to access from their computer workstations. However, this information was not displayed for patients. When asked, the hospital informed us that they had held several focused patient listening sessions in which their patients indicated that they did not wish to view this information, or for it to be displayed around the hospital or their website. Senior staff assured us that it was readily available for patients if they asked to review it.There had been no pressure ulcers, falls, urinary tract infections or VTE in the previous three months. The hospital reported screening rates of 100% for VTE from January 2016 to June 2016.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained. Housekeeping staff were responsible for cleaning and we saw cleaning schedules on all wards visited.
- We saw that equipment was labelled with tags to indicate when it had last been cleaned.
- Sluice areas were clean and had appropriate disposal facilities. There were reliable systems in place for the management and disposal of clinical waste and sharps in accordance with the hospital policy.
- We observed compliance with the hospital infection prevention and control policy. We saw that staff used hand gel, protective clothing and adhered to the bare below the elbow (BBE) policy.
- In accordance with Health and Safety Executive (HSE) guidance on managing legionella, all ward taps had a suitable filter and water was run for 15 minutes per day. We saw documentation to confirm that this was completed by nominated staff throughout the hospital.
- There were no reported cases of MRSA, Clostridium Difficile or E. Coli Infection between January and September 2016 within maternity services.

- The hospital reported and investigated all readmissions for surgical site infections. In maternity, two cases of surgical site infection were reported between January to June 2016.

Environment and equipment

- We found equipment was clean and fit for purpose. External company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- We found that resuscitation equipment, including resuscitaires, were checked daily to ensure equipment and supplies were complete and within use-by date. We saw evidence that defects or absences were reported and acted upon.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures for women wishing to have water births. The birthing pool was clean and fit for purpose.

Medicines

- Medicines, including controlled drugs, were safely and securely stored. We saw evidence that issues identified around medication storage had been audited and rectified. Records demonstrated that twice daily stock checks of controlled drugs were maintained and appropriate security measures were taken around administration of these substances.
- Temperatures of refrigerators used to store medicines were monitored daily by nursing staff. Any recordings outside of the normal range were recorded and appropriate actions were taken. We saw that ambient room temperatures in treatment rooms were also recorded on a daily basis.
- Appropriate arrangements were in place for recording the administration of medicines. We looked at 12 prescription charts during the course of inspection. All were clear and fully completed, with allergy status complete. The records showed that patients were getting medicines when they needed them and any reasons for not giving patients their medicines were recorded. Patient's weights were always recorded on prescription charts to ensure that weight dependent medications were prescribed correctly.
- In the delivery suite, cylinders of oxygen and nitrous oxide were stored in an area which did not have appropriate signage on the door.

Records

- Patient care records were in paper and electronic format. We saw that patient records were stored securely on the maternity ward, in line with data protection policies. Information governance updates were part of the mandatory training programme. There was 94% compliance with this training across the hospital.
- We reviewed 12 sets of maternity records. Record keeping around cardiotocograph (CTG) met minimum data set requirements. This is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy. All CTG records were all signed and dated, with a manual check of the maternal pulse recorded. However, initial risk assessments were not always recorded or revisited in the antenatal period.
- In six of the 12 sets of notes examined, we saw poor documentation from consultants performing perineal repair. No details of the type or nature of repair were recorded. This is contrary to National Institute for Health and Care Excellence (NICE) guidance, which states that documentation should include a detailed account covering the extent of trauma, the method of repair and the materials used (NICE CG190, 2007).
- Patients using the maternity service were also provided with their own set of hand held care records to bring into the hospital with them. On the maternity unit, we saw individual maternity records being reviewed as part of the women's routine care. The personal child health record (red book) was introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.
- In all of the sets of notes we reviewed, the named consultant leading the patients care was documented. All records were multidisciplinary and we saw where midwives, doctors and allied health professionals, including physiotherapists, had made entries. Risks to patients, for example falls, malnutrition and pressure damage, were assessed, monitored and managed on a day-to-day basis using nationally recognised risk assessment tools incorporated into care plans.

- Record keeping audits were conducted on a monthly basis across all hospital departments. In June 2016, the maternity service recorded a result of 98%, against a hospital target of 100%.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect. These arrangements reflected up-to-date safeguarding legislation, including national and local policy. Staff we spoke with demonstrated an understanding of the hospital's safeguarding procedures and reporting process for any concerns.
- Senior staff told us that all midwives and maternity care assistants had access to Safeguarding Children Level 3 training, in line with the intercollegiate document (2015). Updates were provided annually in the mandatory clinical skills update week. Safeguarding Children Level 3 training compliance was recorded at 73% (year-to-date) against a hospital target of 90%. Attainment and completion of mandatory training was rewarded by 1% pay increase, which encouraged people to complete this. Senior staff told us that year-end figures usually met the hospital benchmark.
- The matron of the maternity unit and other individuals across the service had been trained to Safeguarding Children Level 4. Ten members of staff in total had this training, which ensured that there was an individual on shift with a level 4 safeguarding qualification 24 hours a day, seven days a week. Junior nurses we spoke with were aware of who to contact should they have a safeguarding concern.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on hospital premises. This included measures to ensure the security of patients and the prevention of baby/child abduction, as defined under the Child Abduction Act 1984. All babies had an electronic tagged bracelet applied at birth which was removed immediately prior to discharge home.
- Training was ongoing to safeguard people at risk of and treat those affected by female genital mutilation (FGM).
- We saw evidence of systems in place to monitor the disclosure of domestic abuse by midwifery staff in line with NICE guideline [PH50]. Any disclosure was recorded appropriately.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). Senior staff told us that this was provided for all staff working in maternity services.

Mandatory training

- Hospital mandatory training covered subjects including health and safety, manual handling, ethics and code of conduct, fire safety, infection control, equality and diversity, information governance and disability awareness. We saw that 73% of midwives had completed their overall mandatory training compared to the hospital target of 90%. However, attainment and completion of mandatory training was rewarded by 1% pay increase, which encouraged people to complete this. Senior staff told us that year-end figures usually met the hospital benchmark.
- As the majority of medical staff also had NHS contracts, any mandatory training was undertaken in their parent organisation. The hospital asked for a copy of each doctor's annual appraisal and competencies.

Assessing and responding to patient risk

- An initial maternity booking and referral form was completed for each patient during the booking visit. Between January and October 2016, between 87.5% and 96% of women were seen by a midwife in the booking clinic. We saw that on-going risk assessment was documented at subsequent antenatal visits. This meant that referral to the complex care team would be made if any risk factors were detected. In addition, a complex care obstetrics care pathway had been established. This ensured that any complex cases were reviewed weekly, with any actions or plans being monitored and adjusted. This was uploaded electronically to ensure timely and appropriate access for all staff involved in the woman's care.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. During the inspection we did not see that these recommendations had been introduced. No customised fetal growth charts were in use to help identify babies who were not growing as well as expected.

Good

Maternity

- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating woman. There was an extended MEOWS chart used when women required high dependency care. During our visit, we observed that MEOWS was used to identify deteriorating women and appropriate clinical decisions were made when this occurred. We also saw evidence of a guideline for management of sepsis in the obstetric patient. This helped staff identify women at risk of sepsis and supported them to initiate the required treatment. The hospital had recently introduced an electronic system for recording vital signs of patients. Results from the annual audit demonstrated 90% compliance of full completion of MEOWS charts. The audit concluded that a single system of documenting observations, either via the electronic system or completion of MEOWS charts, needed to be identified. The hospital planned to re-audit practice in January 2017.
- Women requiring management of complications were cared for in the high dependency room on the delivery suite. Care was provided by a midwife who was not trained in high dependency care. However, we were told by the duty consultant anaesthetist that they provided close support and supervision of any woman requiring level 2 high dependency care. Any woman who required additional support and care would be transferred to the intensive therapy unit (ITU) of a sister hospital within the HCA group.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) 'five steps to safer surgery' guidelines. We saw conflicting documentary evidence that all the stages were completed correctly. For example, in the caesarean section guideline, the checklist (included as appendices) was not the maternity specific proforma. When we witnessed an elective caesarean section, the maternity specific form was not utilised. However, in six sets of records we reviewed, we saw examples of the maternity specific form in all. An audit of checklist adherence was conducted from January to June 2016, which demonstrated 100% compliance.
- The midwives on duty provided cardiotocograph (CTG) review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that it was within normal parameters. We saw evidence in the six sets of maternity notes that we checked that 'fresh eyes' reviews had been completed. This indicated that a proactive approach in the management of obstetric risks.
- Between January to September 2016, there were two cases of postpartum haemorrhage (PPH) that exceeded two litres of blood loss. This is low compared to other maternity services.
- Formal handovers were carried out twice per day on the labour ward, attended by midwifery staff. We observed the morning handover. This was structured and included discussion of all maternity inpatients and overnight deliveries. Care was assessed and planned at this handover to enable work to be allocated to the appropriate member of staff.

Midwifery staffing

- Midwives worked 12-hour shifts. Delivery suite coordinators, who were responsible for the management of the activity on the ward, were supernumerary.
- The hospital did not use an acuity tool. Acuity tools are used to measure and respond to capacity on the delivery suite and indicate to staff when escalation policies should be used to ensure the safety of women and their babies. Instead, the delivery suite co-ordinators carried bleeps in order to manage the required response to changes in acuity and activity.
- The hospital did not use the same workforce planning tool as the NHS as it did not fit the service requirements. Instead, the service maintained a ratio of one midwife to every four patients. The labour ward required four midwives and one maternity support worker (MSW) on each shift. Staffing levels were adjusted and assessed between the delivery suite and maternity ward by the co-ordinator, three times per day. They were responsive to the staffing ratio, with calls being made to both bank and agency .midwives to maintain this ratio. The monthly budgeted hours varied every month in response to activity.

Good

Maternity

- Staff turnover rate was 1% within the service, with the sickness rate at 2%. This is below the average for NHS maternity services. The service did not provide us with a vacancy rate at the time of inspection.
- The maternity unit used agency staff, and it had its own bank of temporary staff, which was made up of permanent staff who undertook extra work to cover shortfalls. Bank midwives undertook the same mandatory training as substantive staff. We saw that on average 44% of shifts were covered by bank and agency staff each month, which is higher than the average for NHS maternity services. The service utilised the services of two agencies and senior staff told us that this resulted in the majority of agency midwives being known to them. We saw documentary evidence of bank and agency midwives' comprehensive orientation to the delivery suite.

Medical staffing

- The maternity service had approved safe staffing levels for consultant obstetric anaesthetists, which were in line with Safer Childbirth (RCOG 2007) recommendations. There was a resident consultant anaesthetist provided 24 hours, seven days per week on the labour ward.
- The hospital employed Resident Medical Officers (RMOs) for obstetrics and gynaecology and paediatrics and neonatology. They worked either a 12 or 24 hour shift. All RMOs were required to have a current advanced life support certificate and were suitably experienced to work within maternity services.
- Each consultant obstetrician was on-call for their patients throughout their pregnancy and for their delivery. They provided individualised care for their women on the labour ward. Each consultant obstetrician worked within a team of consultant obstetricians, providing cross-cover arrangements. This meant there were multiple obstetricians on-call at any time.
- In the event of a known high-risk case, a second obstetrician could be requested to be available to attend and assist at the delivery. This was usually for elective high-risk caesarean section cases where additional experienced surgical support was required. This was planned and arranged through the complex care team and multidisciplinary team (MDT) meeting. Following this, a second on-call rota for anaesthetists would be put into place. This ensured that full anaesthetic support was available for the high-risk patient, in addition to continued anaesthetic support for other labouring women. This rota remained in place until the woman was deemed stable postnatally by the anaesthetist overseeing their care.

Emergency awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents. All staff reported feeling supported by site managers in the event of loss of power, water or information technology programmes.
- Fire safety training was a constituent of the hospitals mandatory training programme. We saw 95% of staff across the hospital had completed this training.

Are maternity services effective?

Good

Evidence-based care and treatment

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the hospital intranet.
- The care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist (RCOG) guidelines. These standards set out guidance in relation to areas such as: safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment required to support the service.
- We found evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190: Intrapartum care. This outlines the expected standard a woman and her family may expect to receive during the intrapartum period. For example, we observed that women were given a choice as to their preferred mode of delivery.
- The latent phase of labour is the early stage of labour before contractions become regular, longer and

stronger). Best practice (NICE, 2014) is that women who are not in established labour stay at home as this produces better outcomes. We saw that low risk women were provided care in line with this best practice.

- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to, in respect of postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the postnatal ward, staff supported women with breast feeding and caring for their baby prior to discharge.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 32. For example, women who request a caesarean section because of anxiety were given the opportunity to discuss this with a member of the psychological services team, who had expertise in perinatal mental health support.
- The fetal monitoring guideline was not compatible with NICE (2014) recommendations for categorising fetal heart rate monitoring during labour. The hospital explained that they are still using the 2007 guidance as the 2014 recommendations are currently under review.
- Some obstetricians practising at the Portland did not adhere to NICE QS60 (induction of labour) in relation to methods of induction. This was because some of the obstetricians used Misoprostol as a method of induction. Misoprostol does not have UK marketing authorisation (NICE 2008) and guidance states that it should only be offered to women for induction in cases of intrauterine fetal death. However, as mitigation, the hospital ensured the consultant must have obtained informed consent from the patient and have documented this in the notes. The consultant was also required to be present each at each administration of Misoprostol.

Pain relief

- Detailed information regarding pain relief options available was provided to women in the antenatal period so they could make an informed choice. Documentation we reviewed demonstrated a continuous assessment of women's pain relief options during labour.
- On the labour ward, we saw a variety of pain relief methods available including a ready-to-use medical gas mixture of 50% nitrous oxide and 50% oxygen that provided short-term pain relief. This was piped in all delivery rooms. Pethidine and Diamorphine injections were available if women required stronger pain relief. Epidurals were available 24 hours a day and most women who requested epidural anaesthesia received it within thirty minutes.
- A birthing pool was also available so women could use water immersion for pain relief in labour of they wished.
- Women were able to access pain relief during birth and post operatively in a timely way. Analgesia was offered regularly, and the women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines was well managed.

Nutrition and hydration

- There was a midwifery lactation team responsible for the oversight of infant feeding. The hospital promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The hospital policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- The hospital had registered interest in being part of the UNICEF Baby Friendly Initiative. This meant that the hospital was working at supporting women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Women told us that they received support to feed their babies. The midwifery lactation team were supernumerary to ward staffing numbers to ensure that women could go home with knowledge and ability to feed their babies confidently and successfully. We saw that the initiation of breast feeding rate was 80%, which was better than the national average of 75%.
- Babies with tongue tie (a condition where the string of tissue between the baby's tongue and floor of the

mouth is too short and affects the baby's ability to latch onto the breast, causing feeding problems) were referred to a neonatal clinic where the doctor could divide the tongue tie if required. This meant that women and babies received timely intervention when feeding was complicated by tongue tie.

- Patients told us that food was available outside of set meal times and could be ordered from 24-hour room service.

Patient outcomes

- The RCOG good practice standard number 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The Maternity Dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care. Information on the dashboard from January to September 2016 demonstrated that:
  - The elective caesarean section rate was 34%, which was higher than the national average of 10.7%. The overall caesarean section rate was 52%, which was also higher than the national average of 25%. This was because more women chose to have an elective caesarean section.
  - The emergency caesarean rate was 18%, compared to the national average of 14.7%.
  - The instrumental delivery rate was 12.4%. The differentiation between Ventouse (assisted instrumental delivery) and forceps delivery was not recorded. The national average for Ventouse delivery was 7% and the national average for forceps delivery was 5.8 %.
  - The third or fourth degree tear rate was 1.9% for first time births, compared to a national average of 5.1%
  - The provider recorded postpartum haemorrhage of 2 litres and above on the dashboard. There were two such haemorrhages in the reporting period, which equated to 0.2% of patients.
  - The normal birth rate was not recorded on the dashboard
  - We saw documentary evidence that 33 (2.8%) of babies were admitted to the neonatal unit in this period. Of these, there was one case of hypoxic encephalopathy (a type of brain damage) which is lower than the national average of between two to nine cases for every thousand births.
  - A total of 23 babies were readmitted in the reporting period. There were nine cases of puerperal sepsis or other puerperal infections.
- The hospital provided us with the clinical audit plan for 2016. This was based upon national and local maternity service drivers, and was also informed by national and local service development including incidents and complaint action plans. Audits were presented and discussed at the Integrated Governance meeting, although these meetings were not open to all staff. We saw that data was analysed and that recommendations and action plans were made as a result of audits.
- The hospital participated in national audits including the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). Results from the 2014 report demonstrated that both the stillbirth and neonatal rates were up to 10% lower for the hospital than those seen across similar hospitals and health boards.
- We saw results of the Fetal Heart monitoring in labour audit for June to September 2016. Although the audit looked at only ten sets of records, results were positive. The audit concluded that 90% of cardiotocographs (CTGs) had a sticker with the woman's demographics applied at the start of the recording. A further 70% of the records had a 'fresh eyes' sticker in the corresponding patient record and 100% of the records had documentation of escalation in situations where the fetal heart had been classified as suspicious or pathological.
- Examples of other obstetric audits included major obstetric haemorrhage, shoulder dystocia and category one (emergency) caesarean sections.

Competent staff

- An induction period of four weeks orientation was offered to newly appointed staff. The hospital had a policy of only offering employment to midwives who had at least two years of post-registration experience.

- Appraisal rates for staff demonstrated that 100% of midwives had been through this process in the last 12 months. Consultant appraisals were undertaken in their respective NHS organisations and shared with the hospital by agreement.
- Specific maternity mandatory training took place over four days and covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, risk management, mentorship, domestic violence in pregnancy, supervision and care planning, care of the deteriorating woman and infant feeding. Multidisciplinary simulated 'core skills' training also took place for maternity staff to maintain their skills in obstetric emergencies, including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse. This training took place off-site in the education centre's simulated training suite. Compliance with this training for midwives employed at the hospital was 92%.
- The responsibilities of the practice development midwife focus on the planning and facilitation of all mandatory training, in line with hospital and national policy. At the time of the inspection, there was no practice development midwife in post. Senior management informed us that the vacancy was short-term and the new post holder was expected to start shortly.
- Staff told us that they were "impressed" with the professional development opportunities available to them. They were encouraged to apply and attend study course outside of mandatory training, such as degree programmes.
- The Royal College of Anaesthetists (2011) recommended that practitioners, who undertake recovery duties post-surgery, must meet specific criteria in achieving their competencies. The Portland hospital met this standard as all midwives underwent 1:1 theatre induction, which included recovery training.
- Midwives rotated throughout the service, which meant that they were competent to work in all areas in times of escalation.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) are a source of professional advice on all midwifery matters within the hospital. They are accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities. At the time of inspection, the NMC Midwives Rules and Standards (2012) required a ratio of one SoM for every 15 midwives. We saw that the SoM ratio was 1:20 at the hospital, which highlighted that there may not have been enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice. However, this is no longer a statutory requirement as of March 2017. Midwives that we spoke with reported having access to and support from a SoM 24- hours a day, seven days a week. They knew how to contact the on-call SoM. The NMC has also removed this as a statutory responsibility from 2017.
- The Portland Hospital had 70 Obstetric Consultants with practising privileges at the time of our inspection. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) reviewed each application for practising privileges and advised the hospital chief executive officer (CEO). Consultant anaesthetists were linked specifically to each surgeon and also operated under a practising privileges agreement.

Multidisciplinary working

- A handover took place twice a day on the labour ward. The handover used an SBAR (Situation-Background-Assessment-Recommendation) handover sheet and included an overview of all maternity patients.
- The hospital offered midwife-led care packages, although most births at the hospital were consultant-led. Included within the package were two consultations with a consultant obstetrician. In the event of a pregnancy or labour becoming abnormal, the same consultant obstetrician assumed the responsibility for the care of the woman and delivery of her baby.
- The hospital did not provide any community maternity services. Following discharge, postnatal care was

provided by the respective local NHS team for each patient. We saw evidence of an intervention made by a midwife at the hospital when a woman reported that the community midwife had not visited.

- Senior staff were able to give examples of multidisciplinary links with external organisations. For example, the women's services and neonatal manager was a member of the London Maternal Death Review Group, which enabled the hospital to develop shared policies to ensure consistency of quality across the region.

Seven-day services

- Consultant obstetricians and anaesthetists were available on call 24-hours a day, seven days a week. There was a resident consultant anaesthetist who provided cover 24 hours a day, seven days per week on the labour ward. Each consultant obstetrician was on-call for their patients throughout pregnancy and for delivery. They provided individualised care for their women on the labour ward. Each consultant obstetrician worked with a team of consultant obstetricians providing cross-cover arrangements. Therefore, at any given time there were multiple obstetricians on-call.
- The hospital employed Resident Medical Officers (RMOs) for obstetrics and gynaecology and paediatrics and neonatology, who worked either a 12 or 24 hour shift.
- There was a resident on-call theatre team available for that provided cover 24 hours a day, seven days per week.
- The pharmacy department were available from 8.30 to 7pm, Monday to Friday. On Saturdays they were available from 9am to 1pm. On bank holidays they were available from 9am to 12pm. Out-of-hours, the RMO and duty manager could access pharmacy to obtain urgent medication. There was also an on-call pharmacist service.
- Newborn hearing screeners were available Monday to Friday. Parents of babies requiring newborn hearing screening outside these hours were given the option of either attending a NHS service or returning to the audiology department as an outpatient.

Access to Information

- Staff told us there were sufficient computer workplaces to access policies and procedures on the intranet.
- We saw evidence of electronic communication between the hospital and a neighbouring NHS community midwifery team and GP. A follow-up telephone call was made to each woman 48 hours after discharge from the service to ensure that community midwives had conducted their initial visit.
- Nursing staff raised concerns that agency midwives did not have access to the electronic patient database. This had an impact, particularly in relation to discharge of postnatal women to the care of the community midwife.
- Women discharged home were provided with detailed information on the signs and symptoms that they should look for in case of any complications and how to seek advice.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospitals consent for examination and treatment policy supported making the patient's best interests central to the process of obtaining consent. We witnessed consent being obtained for a caesarean section. We saw that the procedure of consent was reviewed prior to any surgical procedure by the consultant performing the operation, which was good practice.
- Women gave verbal consent for their routine care and treatment and this was clearly documented in their records. We observed staff asking for consent prior to undertaking care and treatment, such as blood tests and physiological examinations.
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) formed part of mandatory training programme for staff across the service. Staff we spoke with had a good understanding of their role and responsibility in ensuring patients had sufficient capacity to consent.

Are maternity services caring?

Good

Compassionate care

Good

Maternity

- In the monthly inpatient survey for September 2016, 82% of 39 women reported that they would recommend the maternity service. A further 97% of women had confidence and trust in their respective consultant obstetrician. The report also showed that 87% of women had confidence and trust in the midwives and a further 84% of women were satisfied with the overall quality of their care.
- All of the five women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. They felt well supported and that their care was delivered in a professional way. Comments included "brilliant birth experience," all staff were "sensitive", "happy with every stage of the procedure" and "I had every confidence" in the staff. We spoke with five patients on the postnatal ward who all reported they felt cared for by skilled staff and felt safe in their care.
- We observed positive patient interactions from all levels of staff, from ward domestics to consultants. Staff were seen to be calm and compassionate, altering their communication style depending on the situation. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.
- Services were provided in single rooms with en-suite facilities which ensured privacy and dignity for patients receiving care. We observed staff respecting the privacy and dignity of women by knocking on doors and waiting to be invited into the patient's room.

Understanding and involvement of patients and those close to them

- Women told us that they felt well informed and able to ask staff if they were not sure about something. One patient told us that she felt the staff took her pregnancy complications "seriously" and involved her in all reviews of her care.
- Pregnancy open days provided parents to be with the opportunity to visit and tour the facilities, including delivery suites and postnatal bedrooms. The hospital offered a 'meet and greet' appointment with a midwife which gave women the opportunity to discuss their antenatal and birth options.
- Partners of maternity patients described feeling involved in the care provided. One father told us that he was involved in all decisions. He cut the cord at the birth and "felt part of the team". Partners also valued the ability to stay overnight.
- The postnatal ward's 24-hour nursery was staffed with nursery nurses, who provided new parents with newborn care advice, including baby bath demonstrations. Using a mobile bathing station, the nursery nurses provided bathing demonstrations in the patient's room should they prefer. These one-on-one sessions enabled women to ask staff questions they had about caring for their child.
- The hospital ensured that all patients were telephoned by a member of the team within 48 hours of discharge to ensure that they had not had any issues since returning home. This gave patients the chance to ask any questions they may have had about caring for their baby or recovery after giving birth.

Emotional support

- The hospital did not employ a specialist bereavement midwife but bereavement support was offered. Staff supported women who had experienced a late miscarriage or still birth. All midwifery staff were responsible for ensuring bereavement facilities were adequate and that all literature was up-to-date for supporting families. Bespoke bereavement documentation packages were available for both early and late pregnancy losses. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were assembled for parents who suffered pregnancy loss.
- The psychological service offered psychotherapeutic intervention for women receiving antenatal and postnatal care, their partners and their children, in the event of perinatal loss from 14 weeks gestation until birth.
- Multidenominational chaplaincy and spiritual support was available 24 hours a day and seven days per week to provide emotional support to women and those important to them.
- Women we spoke with told us that that they were asked at all stages of their pregnancy about their emotional

and psychological wellbeing. This was reflected in all of the notes that we looked at. The hospital provided continuity of care to those returning women who requested the same midwife for subsequent deliveries.

- We saw evidence of examples of sensitive and compassionate bespoke care planning for women in complex or difficult circumstances. For example, the service provided tailored and considered care to women from overseas who chose to have their babies adopted, or were surrogates. Appropriate post-discharge arrangements were put in place for both women and babies following delivery to ensure that appropriate support mechanisms were in place.

Are maternity services responsive?

Good

Service planning and delivery to meet the needs of local people

- Women could access the maternity services either by contacting the consultant obstetricians directly, or for midwife-led care, they could contact the hospital antenatal clinic.
- Both midwife-led and consultant-led care packages offered a full range of birthing options. Women were given an informed choice as to how they wished to give birth. The hospital did not provide a designated midwifery- led unit, although women who were deemed to be low risk did receive midwifery one-to-one care in labour within the consultant ward.
- All rooms on the ante and postnatal ward were equipped for a woman's partner or relative to stay overnight should they wish.
- The postnatal ward also offered a 24-hour nursery, which gave patients the opportunity of having their baby cared for by nursery nurses. These provided patients with the opportunity to rest when they required. Babies were returned to their parents, either when they felt more rested, or if the baby required feeding.
- Postnatal follow-up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The 'red book' was issued on transfer to the postnatal ward. This facilitated ongoing care and monitoring of the baby until five years of age.
- The hospital did not have a Maternity Services Liaison Committee (MSLC) or an equivalent. However, the hospital hosted post-natal reunion groups. These gathered the opinions of women who had a current or recent experience of maternity service, and considered them in the development and planning of future services.
- The hospital provided some information leaflets, such as how to store breast milk at home, which were available on the ward.
- For bereaved parents, leaflets produced by a nationally recognised stillbirth and neonatal death charity were available.

Access and flow

- Women could access the maternity service via their consultant or by direct referral. Consultant-led care was available for women, irrespective of risk. The consultant obstetrician arranged the hospital booking for delivery and offered an informed choice on all types of birth, from normal deliveries to caesarean sections.
- Women booked under the care of a consultant obstetrician attended the midwifery booking clinic. Here, advice was provided on nutrition, health and well-being throughout pregnancy, as well as giving women the opportunity to discuss birth plans.
- Women could also elect for midwife-led care. This package included all antenatal appointments, ultrasound scans, routine blood tests and a 24-hour stay post-delivery.
- There were elective caesarean section lists on each day per week. Routinely, there were two operations on each list. As caesareans sections were performed by individual consultant obstetricians, there was no risk of the procedure being delayed.

Good

Maternity

- Midwives told us that there were no problems with discharging women from the postnatal ward. Discharge could be arranged to fit with parental requirements. Newborn initial examination (NIPE) was performed by a consultant paediatrician or the paediatric RMO.
- Inpatient survey results in September 2016 indicated that 42% of the 39 women who responded were dissatisfied with the organisation of discharge process. This was in terms of the length of time taken to complete the process. Senior staff on the ante and postnatal ward told us that they were considering introducing a discharge coordinator to streamline the process.
- The hospital did not collect bed occupancy figures for maternity wards.

Meeting people's individual needs

- The birth centre birthing rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour. A birth pool was located in one of the rooms for women who wished to use water immersion for pain relief in labour.
- A telemetry cardiotocography (CTG) machine was available which meant that women were able to be mobile in labour, whilst still being monitored. This was particularly beneficial for those women requiring continuous fetal heart rate monitoring.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was on-site neonatal unit.
- The hospital offered a wide range of childbirth preparation classes including hypno-birthing and preparation for caesarean section. A birth reflections service was also available. Women were also able to access integrated therapies such as physiotherapy and dietitians for nutritional advice and support.
- Patients with complex care needs were reviewed by a multidisciplinary group. This meant that care could be tailored to address specific needs. For example, arrangements were in place for women with a multiple pregnancy to have a discussion by 24 weeks gestation of the risks, signs and symptoms of preterm labour and possible outcomes of preterm birth.
- On site Arabic interpreters were available Monday to Friday from 8.30am to 7.30pm. There was also an out-of-hours service. The hospital had signed up to a telephone interpretation service which was available 24 hours a day, seven days a week.
- There was no dedicated bereavement room in the delivery suite. Families were cared for in any single room in the delivery suite. The layout of the delivery suite was appropriate for this. Following delivery, women were transferred to the gynaecology ward on the fourth floor.
- The hospital ensured that arrangements for post-mortem examination met the legal requirements. All bereaved parents discussed recent events and future options with a consultant obstetrician and were provided with a patient information booklet entitled 'deciding about a post-mortem examination: information for parents'. The consultant responsible for obtaining the consent for a post-mortem liaised directly with the third party mortuary conducting the examination. Only doctors with detailed knowledge of the case were permitted to make first contact with the mortuary.

Learning from complaints and complaints

- Midwifery staff told us they aimed to resolve concerns in the first instance in a timely way to improve the patient experience and prevent a formal complaint. We saw hospital information leaflets for patients, informing them how to raise concerns or make formal complaints.
- The hospital's complaint procedure was to acknowledge formal complaints within two working days and to send a written response within 20 working days. If these time scales could not be achieved the complainant would be informed of the delay and anticipated time for response.
- Complaints were discussed at senior management team meetings and heads of department meetings on a monthly basis. The patient experience committee and integrated governance committee reviewed the handling of complaints, trends and actions taken. The patient experience committee monitored the follow-up and progress of these actions. Learning from complaints was disseminated to staff via newsletters and team meetings.

Good

Maternity

- Information from the hospital indicated that there had been 17 maternity formal complaints made between January and May 2016. The majority of these related to financial charges.
- Midwifery staff told us that the hospital had introduced dimmable lights in all of the postnatal bedrooms and delivery suites as a result of a patient complaint.

Are maternity services well-led?

Good

Leadership and Culture of service

- The service was run by the women's services and neonatal manager, who reported directly to the senior management team.
- Midwifery staff spoke positively about matrons at departmental level and the support that they offered. We saw good examples of leadership and teamwork at ward level. All matrons in the maternity service dedicated specific time to work clinical shifts in order to lead and support staff in their roles.
- Staff said that senior managers were visible, approachable and supportive. This meant that they were easily accessible to staff. Midwifery staff told us that the Women's Services and Neonatal Manager was very approachable. Staff felt listened to. We found the consultant body to be cohesive.
- The consultant labour ward lead reported a good working relationship with the women's services and neonatal manager, the business manager and the medical director. The labour ward lead could also go directly to the chief executive officer (CEO) to report any concerns when necessary.
- We saw that the women's services and neonatal manager had direct access to the hospital board. This meant that the board were informed and had oversight of any issues relating to maternity.
- Staff described a very supportive team culture and told us that there was a "real sense of team work within the maternity services". An open, transparent culture was evident with an emphasis on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred.
- We observed strong team working, with medical staff and midwives working cooperatively with respect for one another's roles. All staff spoke positively and were proud of the quality of care they delivered. A number of midwives commented to us that it was a "fantastic" unit to work in.
- While the hospital collected some data on equality and diversity, it did not include the four specific workforce metrics identified in the NHS Workforce Race Equality Standards (WRES) in order to demonstrate progress against a number of indicators of workforce equality.

Vision and strategy for this service

- The maternity service had a detailed maternity and neonatal services plan, which set out the strategy and plan for the coming year. This aligned with the HCA wide vision and strategy, which was to deliver exceptional care from exceptional people. Senior managers told us that quality of care was the main priority. Each staff member's appraisal included objectives relating to this vision. We found that staff could articulate the content and understood their role in delivering the objectives of the vision and strategy.

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure, which formed part of everyday practice. The governance strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor quality care was reported upon and improved.
- The governance quality and risk team had overall responsibility for monitoring patient safety, risk, compliance, audit guidelines and complaints. Incidents were discussed at a weekly clinical incident review group meeting and allocated to an incident manager if further investigation was required.
- Staff told us that they received feedback from incidents in various ways. These included weekly meetings, and a

quality and risk newsletter. If they submitted an incident form, staff received personal feedback on the incident reported. Performance issues were taken up with the individual staff member.

- We reviewed the minutes of the integrated governance meeting for maternity in both May 2016 and June 2016. The meetings followed a standing agenda. Issues were identified and actions were planned and reviewed.
- The maternity risk register was reviewed monthly at the integrated governance meeting. We saw that the risk register for October to December 2015 contained risks related to maternity. Risks were categorised using a red, amber and green flagging system. The number one risk for maternity was the use of agency midwives, which corresponded to what staff we spoke with raised as their main concern.
- The hospital used a maternity dashboard. Quality data was recorded monthly and reviewed at the governance group to identify trends and aid forward planning. Any outliers (services lying outside the expected range of performance) were reviewed and timely actions were taken. For example, all term babies unexpectedly admitted to the neonatal intensive care unit (NICU) were reviewed.
- Guidelines were kept under review by the quality patient safety team. We saw clear processes for reviewing guidelines in the women's health guidelines group. These were then ratified at the monthly integrated governance group meeting.
- We saw from the minutes of the integrated governance meeting (IGM) that the hospital had a perinatal mortality and morbidity meeting (M&M). A perinatal M&M is a multi-disciplinary meeting attended by paediatricians, obstetricians and midwives. At the hospital, M&M case reviews were facilitated through the paediatric sub-committee meeting and the obstetric and gynaecology sub-committee meeting every 12 weeks. We saw minutes and attendance records from these meetings which demonstrated that the case reviews were well attended and thorough.
- The women's services and neonatal manager was a member of the London Maternal Death Review Group. The intention of this London-wide process to review deaths related to maternity cases is to ensure objective investigation, consistency and learning from these tragic events, with the overarching aim of reducing, where possible, severe harm to women and ultimately reducing London's maternal death rate. Attendance at these meetings enabled the hospital to develop shared policies and practice in line with best guidance, to ensure consistency of quality across the region.

Public and Staff engagement

- The hospital held an open day every two months for women contemplating booking for delivery. There were spinal rorsal rhizotomy (SDR) open days where women were invited to share their experiences and make suggestions for improvements to the service. Selective dorsal rhizotomy (SDR) is an operation used to improve spasticity (muscle stiffness) in cerebral palsy.
- We saw examples of individual services auditing user satisfaction, such as the monthly inpatient survey. The results of these audits were utilised to drive change. For example, an issue raised within one of the surveys related to lack of a seven-day provision of newborn hearing screeners. As a result, a service level agreement (SLA) was made with NHS newborn screening and work was under way at the time of inspection to achieve a seven-day service.
- The hospital had launched a parenting magazine that was dedicated to providing advice and guidance for new parents. Staff members were encouraged to share their own positive experiences with all maternity users in this brochure.
- There was a 'postnatal reunion' group for those women who had delivered at the hospital. This group was used as an opportunity to gain feedback from users and provided a platform for new mothers and babies to support each other in the postnatal period.
- The service offered a weekly tour of the unit. The website also included useful information for all users of the service. For example, there was a listing and details of the antenatal classes offered.
- In all areas visited, staff were engaged and felt involved in service development and improvements. Staff reported that they felt empowered to make suggestions or raise concerns to the senior leadership team. They reported they could do this either in individual or staff meetings, or during the regular walk round by the senior team.

Good

Maternity

Innovation, improvement and sustainability

- All staff spoke passionately about the services they offered and the creative ways they worked to ensure they met the needs of women using services. For example, a midwife suggested to a woman in preterm labour (whose birthing partner was unable to attend) that she video call her birthing partner. This enabled her partner to give her vocal support and encouragement.
- Staff explained how their systems and processes were always in line with latest research and guidance. This included review in the women's health guidelines group. There was also a monitoring tool where staff could access a breakdown of incidents which occurred in their respective clinical area each month.

Good

Services for children and young people

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

Are services for children and young people safe?

Good

Incidents

- In the reporting period of November 2015 to October 2016, there were no never events in children's services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- Both junior and senior nurses as well as bank and agency staff were able to report incidents on the hospital electronic reporting system. Senior nurses were proud of the 'no blame' culture in the service and were encouraged to report all incidents no matter how minor. Junior nurses informed us that they were encouraged to report incidents, even non-clinical incidents.
- There were 410 incidents reported within the children's services between October 2015 and September 2016. The largest number of these incidents (18%) related to clinical assessments e.g. investigations, images and lab tests. These incidents resulted in no harm and were more to do with patient dissatisfaction with waiting times. Overall, 71.5% of incidents resulted in no harm and 28% resulted in low harm. Nurses and doctors were able to clearly describe mechanisms in place in order to reduce waiting times for lab results and diagnostic imaging. In the outpatients department, appointments were staggered to ensure there were not too many patients waiting at once.
- In the year prior to inspection, one incident the CYP service was the result of an expected death. Hospital policy stated that all incidents of a serious nature were subject to a full root cause analysis (RCA) investigation, after which, action plans were developed where areas for improvement had been identified. We saw evidence that RCAs were carried out in such cases, and evidence that action plans were followed to change practice in the hospital where concerns had been identified.
- Prior to our inspection there was an incident that resulted in a patient death. This patient death was not recorded in the hospital incident data as it occurred in a hospice after the patient was transferred.The death resulted in a police investigation that was still on-going at the time of our inspection. We will monitor the outcome of this investigation and any further subsequent inquiries about the incident.
- Feedback from all incidents, including action points and learning, was shared with appropriate staff via the hospital intranet, a weekly staff email and the monthly ward meetings. We saw evidence of bulletins and emails that had been shared with staff following incidents, which alerted them to changes in practice or updates to policies.
- When incidents occurred that resulted in patient harm, staff were well supported in the investigation process and spoke highly of their managers who assisted them

with learning from these incidents. Both junior and senior staff were able to share examples of learning from incidents and changes in practice as the result of an incident.

- The hospital had an incident debrief information leaflet which was given to staff who had been involved in a serious incident. The leaflet informed staff how to get support and the process for investigation going forward.
- The hospital had clinical and non-clinical incident review meetings (CIRM and NCIRM) that took place every week. We observed a CIRM and found that the progress of investigations, incidents and lessons learned were all discussed. We reviewed minutes of a review group meeting and found it to be attended by the chair of clinical governance, the CNO, the head of quality and the risk manager. The agenda topics included incident statistics, the duty of candour, complaints and the risk register. A summary of this meeting along with lessons learned were printed out every week and placed in staff rooms. An example of a lesson learned from the paediatric service was "nursing and therapy staff should ensure safe practice with regards to the transport of patient notes".
- As per the hospital policy, the paediatric sub-committee meeting, case reviewed mortality and morbidity (M&M) every three months. A standardised M&M presentation template was completed and each case was discussed. We reviewed the minutes of the last M&M meeting and found it to be thorough with recommendations for improvement. The M&M minutes also contained actions for each member of staff involved and actions on how to improve practices.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. Both junior and senior staff showed an awareness of duty of candour and could define it when asked. Staff explained that patients should be informed in the event that an incident occurred. Staff outlined that patients should receive an apology and an investigation should take place. We saw evidence of written letters of apology from the hospital when incidents that met the threshold had occurred.

Clinical Quality Dashboard

- As it is an independent provider, the hospital did not use the NHS safety thermometer. (This is a tool to measure harm which may be associated with patient care). However, the hospital had developed their own dashboard which monitored pressure ulcers, moisture lesions, pain, extravasation and early warning score escalation and completion. The rates of these were all very low within the CYP service.

Cleanliness, infection control and hygiene

- There was a hospital wide infection prevention and control lead who coordinated and managed the infection control service. The hospital wide infection control clinical nurse specialist (CNS) supported this role. There was also a consultant microbiologist in place.
- All areas throughout the children's service were clean, well organised and free from clutter. 'I am clean' stickers were used throughout the hospital to indicate that equipment had been cleaned. The stickers were also used on the floor and through surfaces in the department. Throughout the inspection we observed that all stickers had been placed within the previous 12 hours. The play specialists cleaned the toys in the play rooms daily and in house housekeeping cleaned the rooms themselves. The toy cleaning schedule was displayed in the play rooms.
- All staff had a strict 'bare below the elbows' (BBE) policy and we observed both junior and senior nurses using antibacterial gel and hand washing facilities in between each patient. The patient rooms each had a basin within the room and antibacterial gel on the wall outside of the room.
- The service carried out a BBE audit. From April 2016 to June 2016, between 80% and 100% of staff in paediatric areas complied with the BBE policy.
- Monthly hand hygiene audits based on the World Health Organisation (WHO) 'five moments for hand hygiene' were completed. Between April 2016 and June 2016, the service had hand hygiene compliance rates of between 70% and 100%.
- The hospital carried out environment audits of all clinical areas as well as on equipment. The environment audits sought to audit the areas effectiveness in reducing the risk of cross infection to patients, staff and

visitors. Inpatient paediatric wards were between 60% and 100% compliant between April and June 2016. The equipment audit sought to assess the effectiveness of best practice being applied to prevent the transmission of infection. The inpatient paediatric wards were between 70% and 100% compliant with regards to general patient equipment. Paediatric outpatients achieved 100% compliance in equipment audits. Results published also received an action plan for improvement where compliance rates were less than 95%.

- Personal protective equipment (PPE) such as gloves and aprons were available in each of the patient rooms and discarded of in the bins in the patient rooms. Waste segregation was in line with the Department of Health 2011 safe management of waste guidelines.
- The day case unit had a dedicated link nurse for infection control. Clinical staff knew the name of the link nurse and how to contact her.
- In the reporting period of July 2015 to June 2016, there were zero cases of MRSA. MRSA is a bacteria that can be present on the skin and can cause serious infection. There was a hospital wide policy that stated that all patients admitted should be screened for MRSA prior to admission. All patient rooms on the wards were single occupancy, therefore isolation was not required.
- There was one incident of Meticillin Sensitive Staphylococcus Aureus (MSSA) in the same reporting period.
- In the same reporting period there were four cases of hospital acquired Clostridium Difficile (C.Diff) and Escherichia Coli. C.Diff is a bacterium that can infect the bowel and cause diarrhoea and most commonly affects those people who have been recently treated with antibiotics.
- Between July 2015 and June 2016, there were two incidences of surgical site infection during orthopedic surgeries. This was above the rate of other independent acute hospitals.
- Infection control was part of the mandatory training programme which all staff were required to attend. Within children's services between 75% and 100% of staff had attended training within the year before our inspection. The hospital target for compliance was 90%.

Environment and equipment

- All children and young people on inpatient wards were cared for in single rooms. These rooms were en-suite with a television. There was also a draw-down bed located in one of the cupboards for a parent of the patient to stay with them if need be.
- The recovery area in the theatres was separate for paediatric patients.
- An external company maintained and serviced equipment through an annual contract. All equipment throughout the service was safety tested. The specialist equipment such as the audiological equipment was calibrated each day by a member of the team and yearly by an outsourced specialist company. In outpatients, the biomedical team checked all the equipment. We reviewed the logs of these checks and found them to be thorough and complete.
- Nurses could request new equipment via an online system that was reviewed by the children's services manager and chief financial officer (CFO). One senior nurse informed us that if she required equipment immediately she could discuss the matter directly with the CFO who was very supportive.
- The resuscitation trolleys throughout the CYP service contained both adult and paediatric medication. When staff were questioned about this, they informed us that this was risk assessed to ensure best practice and well managed. We observed a copy of these risk assessments.
- In all outpatients departments including at The Shard, there was a grab bag for both adults and children located on each floor. These were checked daily and audited. Within the paediatric therapies department there was a resuscitation trolley that was also checked daily.
- The 'Hug and Kisses' security system ensured that patients were tracked and monitored throughout their pathway. All lifts and doors to clinical areas were protected by a key card system.

Medicines

- We observed controlled drugs (CDs) cupboards in all children's services areas and found that they were stored and managed appropriately throughout the

service. The CDs were checked twice a day by two nursing staff each time. CDs that patients brought into inpatient areas were also kept in the locked cupboard. CDs were audited every month and feedback was given to staff at ward meetings. We observed CD cupboards and found them to all be in order. We also reviewed CD audits and found they were consistent and well organised.

- Other medications were stored in accordance with the hospital policy. All medicine storage cupboards, fridges and freezers were locked when not being accessed. Medicines stored at room temperature were stored between 15 and 25 Celsius. We observed this whilst on inspection. Patients own drugs were stored in designated patient bedside medicine cupboards or in the ward medicine cupboard.
- An in-house pharmacist checked the medicines every week to ensure they were not expired. Evidence of this was audited and placed on the cupboard door. Pharmacists were available every weekday from 8.30am to 7pm. On call pharmacists for all inpatient areas was available from 7pm to 8pm every weekday. On Saturdays, the pharmacy service was available from 9am to 1pm. Outpatients could source their prescription medicines from a community pharmacy with private prescriptions provided.
- On call pharmacy services were available out of hours and the RMO and duty manager were able to access the pharmacy for urgent medications. A paediatric pharmacist was available on the day case ward round.
- Fridge temperatures throughout the service were monitored by an online system. This immediately alerted the site manager if the fridge temperature went out of range.
- Upon discharge patients were provided with medicines to take out (TTOs) checklist label and pharmacy card. The cards were available in Arabic and contained the number for the pharmacy team.
- The service carried out audits into the number of prescriptions processed and the average waiting time for TTOs and outpatients. From January 2016 to June 2016, between 80% and 100% of outpatient prescriptions met target time. The target for outpatient prescriptions being received on time was 85%. In the same reporting period, between 60% and 85% of TTOs met their target time, against a hospital aim of 80%.
- Of the 2205 TTO inpatient prescriptions dispensed, 104 were not required urgently. Of the 2134 outpatient prescriptions, 50 were not required urgently.
- We observed a missed doses audit from September – December 2016. The audit was carried out every six months by the pharmacy team. Of the 200 doses audited, only 11 (5.5%) were omitted. All omitted doses had the appropriate documentation on both the drug chart and the patient's medical notes. Of these omitted doses, all were pre-planned or clinically appropriate. During our inspection we observed no missed doses in patient prescription charts.
- On the paediatric intensive care unit (PICU), a medicines management champion assessed the audit results every month along with the pharmacist.
- All staff undertook medicines management training as part of the initial clinical induction and orientation. This was renewed every two years. At the time of our inspection there was 95% compliance with this training within the service.

Records

- Patient records were stored securely in all departments we visited across children's services. Medical records were kept in hard copy in locked cupboards in the nurses' room. Risk assessments and care plans were kept on an online system and observations were kept a separate online system available via hand held devices.
- We reviewed four medical care records across both Paediatric Intensive Care Unit (PICU) and neonatal intensive care unit (NICU) and found them to be complete with the name and grade of the doctor/nurse reviewing clearly documented.
- We reviewed 14 medical records across the inpatient wards and found that all of them had an adequate diagnosis and management plan documented and signed. We observed the standard of record keeping to be good. Appropriate risk assessments were completed,

patient information was present and the notes were legible and comprehensive. As none of the patients were on palliative pathways, none of the records contained Do Not Attempt Resuscitation (DNAR) forms.

- Complex patients all had multidisciplinary team (MDT) input and a copy of the MDT notes were placed in the medical records that we observed.
- The service complied with the Nursing & Midwifery Council (NMC) guidance on good record keeping. They also carried out monthly audits in clinical areas. The aim of the audit was to demonstrate that nursing records met the professional standard required. The target for compliance was 100%. In the reporting period January 2016 to June 2016 the service had between 81% and 100% compliance. The audits maintained action plans for improvement for any clinical area that was not at 100% compliance.
- Information Governance was part of the mandatory training programme which all staff were required to attend. Within children's services between 75% and 100% of staff had attended training in the year before our inspection against the hospital's target of 90%.

Safeguarding

- The chief nursing officer, the children and young people services manager and clinical matron for maternity were the nominated leads for child safeguarding.
- Both junior and senior nurses were aware of their roles and responsibilities to safeguard children and young people. Staff were able to explain potential signs of abuse and could identify the processes for raising a concern. All staff we spoke with informed us that safeguarding policy was available on the hospital intranet.
- Between January 2016 and December 2016 the service had made 13 safeguarding referrals. The provider was involved in quarterly local safeguarding boards. In 2016, the hospital was involved in a child protection conference for a particular case. We observed the minutes from this conference and found that the service took appropriate and timely action.
- National guidance specifies that all clinical staff working closely with children and young people should receive training in level 3 safeguarding. Data provided demonstrated that between 91% and 100% of all staff had taken part in Safeguarding Children Level 3 training.
- The chief nursing officer along with nine other members of staff were trained to safeguarding level 4. This ensured that there was an individual on shift with a level 4 safeguarding qualification 24 hours a day, seven days a week. Junior nurses we spoke with were aware of who to contact should they have a safeguarding concern.
- An external national society for children provided level 4 safeguarding training. We observed the course book for the training session and found it to be thorough and up to date. The course included training on female genital mutilation (FGM) awareness, child sexual exploitation and making a referral.
- Safeguarding was part of the mandatory training programme and different levels of training were provided for different roles. Within children's services between 86% and 100% of staff had attended level 1 and 2 safeguarding training in the year before our inspection against the hospital target of 90%.

Mandatory training

- Senior members of staff informed us that they monitored rates of mandatory training on an online tracking system. When a member of staff had a training session due to expire the session flashed on the system. Both junior and senior nurses told us that this system was "easy to use".
- The mandatory training target set by the hospital was 90% and the mandatory training programme included the following: health and safety, manual handling, infection control, fire safety, ethics and code of conduct, information governance, equality and diversity, safeguarding children level 1, 2 & 3, safeguarding vulnerable adults level 3, basic and paediatric life support and disability awareness.
- All staff within the paediatric unit had between 75% and 100% compliance with mandatory training. Play specialists, dietitians, clinical nurse specialists and inpatient matrons were all 100% compliant with mandatory training.

- All resident medical officers (RMOs), paediatric site practitioners (PSPs) and senior/charge nurses in PICU had European Paediatric Advanced Life Support (EPALS).

Assessing and responding to patient risk

- The service had a pre-assessment clinic that assessed the patients fitness for surgery. The tests carried out were in line with NICE guidelines. The pre-assessment centre took an MRSA swab from the patient's nose, armpit and groin. The pre-assessment team called overseas patients prior to admission.
- The service had an inclusion and exclusion criteria that outlined the different exclusion criteria for their inpatients, outpatients and day surgery paediatric patients. Within this policy there was also a generic exclusion policy that included the following patient groups: patients representatives who are unable to meet the financial implications of the treatment, a patients where a safeguarding concern is indicated, patients requiring oncology or specialist cardiac care and patients requiring admission to a secure unit. The service did not accept surgical emergencies and all patients were elective.
- Both junior and senior nurses informed us that they were supported by doctors and resident medical officers (RMO) when dealing with deteriorating patients. The service carried out comprehensive risk assessments on all inpatients. We observed evidence of electronic risk assessments and found them to be consistent and accurate. The RMOs possessed hand held electronic devices with up-to-date risk assessments for their patients.
- All nursing staff were trained in the use of Paediatric Early Warning Score (PEWS). Observations were recorded using an electronic system which alerted relevant members of staff if a patient's condition deteriorated. If a patient did deteriorate then the RMO would be alerted automatically. We observed staff using the PEWS during handovers and safety huddles to plan patient care and treatment. Of the 14 care records we reviewed, we found all PEWS to be recorded accurately.
- The paediatric site practitioners (PSPs) provided support to the wards twenty four hours a day, seven days a week to assist with the assessment and management of a deteriorating child. If a deteriorating child required transfer, the PICU catered for HDU level 2 and intensive care level 1 children. This process was formalised in the admissions policy.
- Both basic life support and paediatric basic life support were part of the mandatory training programme which all staff were required to attend. Within CYP between 91% and 100% of staff had attended training.
- The hospital audited 20 patients a month to assess compliance with the WHO Five steps to safer surgery, including the surgical safety checklist. The audit identified compliance with three steps; sign in, time out and sign out. The aim of the audit was to see 100% compliance at each step. In the reporting period of January to June 2016, there was between 89% and 100% compliance with the checklist.
- The service used the provider-wide 'sepsis six' policy. The policy outlined the clinical response to sepsis in six steps and the process for escalation if sepsis was suspected. Patients being discharged from the service were provided with a patient information sheet outlining the signs of sepsis and how to seek medical help. The policy defined guidelines for differentiating between infection, sepsis, severe sepsis and septic shock. The policy was dated, signed and due to be updated in 2018. Although staff had not received training in sepsis they were aware of the key identifiers and where to access the policy.

Nursing staffing

- On the intensive care wards there was 1:1 nursing care in place, with one runner and one nurse in charge.
- In the reporting period October 2015 to September 2016 the service used between 21% and 43% of bank and agency staff. Agency nurses had an induction and shadowed a permanent member of staff when on their first shift. During our inspection we observed an agency nurse receiving an introduction to one of the inpatient wards. The introduction was thorough and interactive.
- There were two clinical nurse specialists especially for paediatrics. Their specialties were: complex care and urology. There was also an orthopaedic and tissue viability CNS who worked across paediatrics and adults.

Good

Services for children and young people

- The hospital aim for 2016 was to keep staff sickness to below 2%. The paediatric service had sickness rates of 2.5%.
- The vacancy rate within the service was 19.5%. The service mitigated against this high rate by using regular agency staff.
- Data provided by the hospital showed that 52% of PICU staff were PICU trained and 87% of PICU staff were paediatric nurses.
- Of the nurses in the neonatal intensive care unit (NICU), 89% were NICU trained. At the time of our inspection there was a member of staff completing the NICU training which would have taken the percentage of NICU trained nurses up to 100%.
- Throughout our inspection we had no concerns that there were not enough adequately trained staff.
- As shifts were monitored daily via the onsite bank co-ordinator there were no unfilled shifts in the 12 months prior to our inspection.

Medical staffing

- Care of patients within children's services was consultant led. Records we viewed confirmed that consultants reviewed all patients on a daily basis. There were 302 consultant paediatricians with practising privileges at the time of our inspection.
- Medical staff worked under a practising privileges arrangement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital.
- Both paediatric consultants and consultant neonatologists provided cover for their inpatients 24 hours a day, seven days a week.
- There were three resident medical officers (RMOs) at the Portland hospital. RMOs are doctors of varying experience that are full time hospital employees. The RMOs provided medical cover in case patients needed to be seen urgently due to a deteriorating condition.
- One RMO worked exclusively in the PICU and the other two were paediatric RMOs and worked within the paediatric service. There was RMO cover 24 hours a day, seven days a week. RMOs led daily ward rounds and took charge of hand held devices with up to date observation records for each patient.

Emergency awareness and training

- The hospital had a business continuity management plan approved by the senior team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services. We observed this plan and found it to contain thorough explanations of what to do in the event of specific emergencies.
- The duty manager had overall responsibility to maintain an overview of all the incidents which could have the potential to affect the hospital. In the event of an emergency the duty manager oversaw the emergency control room and be in charge of the response. Both junior and senior nurses were aware that if there was an emergency the duty manager would be informed in the first instance.
- Staff were also provided with annual scenario training that tested their response to different emergency situations.
- Fire safety formed part of the mandatory training programme. Within children's services between 91% and 100% of staff had received this training in the year before our inspection. This was above the training target of 90%.

Are services for children and young people effective?

Good

Evidence-based care and treatment

- The selection of clinical policies and procedures we reviewed all referenced relevant NICE and Royal College guidelines. Evidence was seen of recent activity in reviewing policy and guidance and all policies were up to date.
- Staff demonstrated how they accessed guidance, policies and procedures on the hospital intranet. Staff

told us the guidelines were clear and comprehensive and updated frequently. For example a member of staff showed us how to access the paediatric 'sepsis six' policy.

- The PICU at the Portland Hospital started contributing data to the Paediatric Intensive Care Audit Network (PICANet) in October 2013. This enabled the hospital to compare their performance against the national benchmark provided by PICANet.
- Some of the local audits the service undertook included: environment and equipment, hand hygiene and bare below the elbows, pain control and record keeping. These all formed part of an annual clinical audit programme the service had in place.

Pain relief

- The paediatric site practitioners (PSPs) worked with the pain management clinical nurse specialist (CNS) to provide support to all paediatric inpatient floors 24 hours a day, seven days week. The PSP team undertook twice daily pain rounds identifying patients with uncontrolled pain as well as providing support for patients on epidurals.
- The CNS reviewed all patients with continuous epidural infusions, patient controlled analgesia and continuous analgesic infusions. The CNS also worked in collaboration with the consultants to reduce the incidence of post-operative complications.
- Pain scores were assessed using a variety of methods including Face, Legs, Activity, Cry, Consolability scale (FLACC). This is a tool used to assess pain in children from two months to seven years. A revised FLACC was used for complex patients.
- Pain management was audited on a monthly basis. Between January 2016 and May 2016, 92% of patients records showed evidence of the pain scoring tool being consistently used. A pain score was documented in every set of observations for 94% of patients.
- Play specialists were used to assist children in preparing for procedures. Distraction and relaxation techniques were used to help children manage their pain prior to receiving an injection.

Nutrition and hydration

- A child's height and weight was recorded on an online system. This system was unable to use the screening tool for the assessment of malnutrition in paediatrics (STAMP). The service therefore used a modified Malnutrition Universal Screening Tool (MUST) to assess malnutrition. MUST tools are usually used for adults but the service informed us that this has been risk assessed and found to be suitable.
- Dietitians formed part of the multidisciplinary team (MDT) meeting and maintained regular input into the care plans of children who were at risk of malnutrition.
- A variety of food choices were available to children, which included a selection of snacks. Of all the records we observed we found complete food and fluid charts throughout.
- There were provisions in place for breast feeding mothers in the NICU and fridges in place to store breast milk for new-borns.

Patient outcomes

- The paediatric intensive care unit submitted data to the Paediatric Intensive care Audit (PICANet), a national audit on all children admitted to intensive care units across the UK. The PICANet data showed that the service saw children with a lower mortality index when compared with other national units. This means that the patients the Portland sees were indexed as having conditions less likely to result in mortality.
- The service complied with national key performance indicator (KPI) monitoring, which included recording numbers of unplanned readmissions, unplanned returns to theatre and unplanned transfers.
- Between December 2015 and December 2016 there were 11 unplanned readmissions, six unplanned returns to theatre and four unplanned transfers to other hospitals.
- The paediatric speech and language therapy (SALT) service monitored outcomes based on key descriptors and found that 29% of patients improved, 65% stayed the same and 6% got worse. These percentage were to be expected as the patients the SALTs were working with were often highly complex and worked mainly to prevent further deterioration.

- The hospital data provided to us showed that between February and July 2016 66% of paediatric scans that had play specialist input went successfully.

Competent staff

- There were systems to ensure staff (RMOs and nurses) was competent to carry out their role. This included an induction programme that ensured new staff were familiar with local policies and procedures.
- Practitioners submitted written applications to the hospital to request practising privileges. Application included details of revalidation information and relevant certificates. The CEO considered the application before progressing it to the medical advisory committee (MAC). The MAC was defined as representing the professional and clinical views of consultants to the hospital executives. The MAC involved the CEO, medical director, chairman of the medical governance committee, the head of clinical governance, the lead RMO, the Chief Nursing Officer and representatives of the main specialities of the hospital. The MAC reviewed practising privileges regularly.
- The hospital had a target of 100% of staff being appraised annually. Therapies staff were appraised each year and had goals set every six months. Of staff within the service, 100% had received an appraisal in the last 12 months and 97% of nursing staff had completed their NMC revalidation. Of all staff, 3% were undergoing revalidation.
- Skills and drills sessions were held for nurses on inpatient wards. These saw nurses having their key clinical competencies tested and were held every month.
- The nurse in charge of each shift checked the skill mix and competencies of their team before allocating work at handover. In the PICU, 87% of nurses were paediatric trained. Data provided by the hospital showed that 52% of PICU staff were PICU trained. All but one nurse in NICU was trained in neo-natal paediatric care as the nurse was receiving the training at the time of our inspection.
- Medical staff used regular meetings, such as unit meetings and governance meetings, to review practice guidelines and identify areas of good practice and areas of improvement.
- External courses could be requested by staff to further their learning and competencies. In the past staff had requested and received additional training in: ventilation, pain, neuroscience and European paediatric advanced life support (EPALS). During our inspection, 92 staff had undertaken external educational programmes, with eight staff studying at Masters level.
- Consultants we spoke with informed us that there were post graduate meetings held for RMOs and doctors. At these quarterly forums they brought in guest speakers and had open discussions on competencies.
- During our inspection we spoke with the managing director of the outsourced company who trained the Portland staff in resuscitation. He informed us that they also offered simulation training for nursing staff in the paediatric service.

Multidisciplinary working

- Throughout the inspection we observed a high level of integrated collaborative working between specialities.
- Multidisciplinary team (MDT) working at the Portland Hospital was good. All disciplines worked closely with each other and no specialty was excluded. Everyone we spoke with was committed to delivering the best possible outcomes and care. We spoke with physiotherapists, speech and language therapist, the family liaison officer and discharge planner, cleaners, porters, and all levels of nurses and doctors.
- The service had an array of diagnostic imaging services including MRI & CT, X-ray, interventional radiology, scanning and neurophysiology.
- We observed a paediatric rehabilitation meeting with discharge planning. This meeting was well attended by 14 members of staff. The inpatient therapy manager chaired the meeting that was attended by dietitians, occupational therapists play therapists, CNS, speech and language therapists, physiotherapists and members of the psychology and international team. The meeting was interactive and holistic. Members of the meeting said it was “great – really helps us keep track of what we need and who does what”.
- On inpatient wards, the RMO conducted daily ward rounds accompanied by the paediatric site practitioner, the matron and two senior nurses. There was also a

daily bed management meeting attended by senior nurses and managers. During inspection we observed two ward rounds and the bed meeting and found them each to be highly interactive, thorough sessions.

- There were varied therapies that supported the service including: physiotherapy, dietetics, occupational therapy, speech and language therapy and the play specialist team.
- There was a recently appointed pharmacist in the paediatric site practitioner (PSP) team. This ensured that all pharmacy based queries could be answered 24 hours a day, seven days a week. This member of staff undertook additional training including non- medical prescribing, advanced paediatric life support and assessment of the deteriorating child, to support and monitor safe nursing practices in both outpatients and inpatients.
- Representatives from the therapies team attended the ward round in PICU every week.
- The service had an agreement with a nearby NHS hospital that ensured access to a hydrotherapy pool for the therapies team especially for neuro-rehabilitation patients.
- The service had access to psychology support Monday to Friday who was also happy to work weekends.
- The MDT managed transition of patients from children's to adults' services. There were clear up-to-date patient transition policies and guidelines available for children over 14 years old.

Seven-day services

- The paediatric service had access to a wide range of allied health professionals including: dietetics, physiotherapy, occupational therapy, speech and language therapy, play therapy, music therapy, neuropsychology and clinical psychology. Most of these services were available Monday to Saturday but were happy to work around the individual patient if they were required out of hours or on a Sunday. There was no formal arrangement for this.
- Diagnostic imaging services were open from 8am to 7pm, Monday to Friday and from 9am to 1pm on Saturday.
- The hearing and balance department offered audiometry, electrophysiological testing and vestibular testing available from 9am to 5pm, Monday to Friday.
- There was a member of staff with level 4 safeguarding training available 24 hours a day, seven days a week.
- The pharmacy department were available from 8.30 to 7pm, Monday to Friday. On Saturdays they were available from 9am to 1pm. On bank holidays they were available from 9am to 12pm.
- Consultants visited the children they cared for on a daily basis. Consultants made their own informal arrangements to ensure adequate cover during periods of absence. Although there was no formal agreement for this process, the elective nature of the service meant that consultants ensured they were available for the length of their patient's stay.

Access to information

- Patients were not admitted to inpatient wards until all relevant information was received from patients prior to treatment. The complex care CNS and the international team worked together to ensure that international patients brought all their medical records before admission.
- In the outpatient departments, patients were provided with a letter of care and treatment from their consultant. If patients were to be admitted after attendance in an outpatient clinic, their electronic medical records were automatically updated.
- Discharge was communicated to GPs by way of a folder kept in the patient's room. The nurses and clinical nurse specialists would build up the folders with relevant MDT minutes and scans. The parents were then able to take the folder away and share a copy with their GP. If the patient was being discharged to another hospital, a copy of the materials in the folder was sent with the patient to ensure continuity of care.

Consent

- The consent process for patients was well-structured, with written information provided before consent was given. Staff adhered to the systems in place to protect people from the risks associated with providing care and treatment without appropriate consent.

Good

Services for children and young people

- The hospital carried out monthly consent audits. Between March and July 2016, 100% of patients had signed a consent form. For older children this would be signed by the patients themselves but in most instances the forms were signed by parents.
- We found that consent to treatment for patients was obtained following the correct guidelines and procedures. All staff spoken with were aware of the providers consent procedure and could describe the legislative requirements regarding consent in young people.
- Staff were able to describe Gillick competencies and the requirements for seeking consent from children and young people when they had been assessed as competent to make decisions about their care and treatment. The Gillick competence is a test in medical law to decide whether a child of 16 or younger is competent to consent to medical examination or treatment without the need for parental permission.
- We spoke with staff, who confirmed that patient/ parents' consent would be sought prior to any procedures or tests being undertaken. Parents we spoke with told us that they had been involved in decisions relating to the treatment offered to them.

Are services for children and young people caring?

Good

Compassionate care

- Services were provided in single rooms with en-suite facilities which ensured privacy and dignity for patients receiving care. One parent was able to stay with the patient and this was encouraged by staff.
- Over the course of our inspection we spoke with seven patients or patient relatives/family members. All parents spoke very highly of the service. One parent informed us that she called a consultant who was able to see her child that day. She felt "very valued and listened to".
- A parent of a young child explained that she had her child at the hospital a year before and found the care so "amazing" that she decided to have her child treated at the facility. The staff "genuinely care".
- We heard examples from staff and patients of staff going the above and beyond the call of duty for their patients. Patients had cakes made by the head chef for their birthday, visits from their favourite companies and day trips to the zoo are careful planning by the staff at the hospital.
- We observed the pathway of a child going for day surgery, parents were able to accompany their child to theatre and recovery areas and ward staff informed them when their child was out of theatre and they were able to re-join their child in recovery to help lessen anxieties. During the whole process, we observed that staff were caring and were compassionate towards the child and parental needs.
- During our inspection we observed an adolescent patient being provided with pain medication. Three nurses were involved in the procedure – two permanent members of staff and one bank nurse providing 1:1 care. The interaction was very warm and supportive and the patient was provided with options of pain medication based on preference.
- Hospital wide inpatient survey scores ranged from 98% to 100%. Patients parents typically carried out inpatient surveys. The response rate on average was 11%. The service had plans to increase the response rate by adopting an electronic system fit for children.
- Patients and their parents were treated with dignity, respect and compassion throughout the service but this proved difficult in the neonatal intensive care unit (NICU). The NICU was very cramped and staff would have to draw a small curtain around parents if they needed privacy. There was a family room adjacent to the NICU room that parents were able to utilise if need be.

Understanding and involvement of patients and those close to them

- Through an interpreter an Arabic speaking parent informed us, "care is very good here, the MDT staff tell us everything we need to know and ask our opinion".
- We noted good practice by a play specialist who explained pre-operation procedures to small children

via storybooks showing them airways and other equipment with use of dolls to help lessen anxiety and helped to prepare children psychologically for theatre and procedures.

- The complex care clinical nurse specialist (CNS) informed us that all patients with MDT input received a copy of the MDTs for their personal notes. These notes were kept in the patient's room. The parents of the patient told us that they were always invited to the MDTs. International patients were provided with two copies of notes, one for themselves and the other for their doctor back at home in their home language.

Emotional support

- Patients who were considered complex were provided with a named complex care CNS. The complex care CNS acted as a key worker for patients on the therapies pathway. She was their first point of call and arranged any additional support that they required. Complex care applied to patients who were very unwell and required medical care from a number of different professionals. At the Portland, this included children with global development delay or a neurodevelopmental disorder. The CNS was involved at every stage of the patient pathway.
- A music therapist engaged children with complex disabilities and neurological disorders in the imaginative world of music therapy. These sessions were offered through one to one sessions, joint sessions, group work or a combination of all three.
- Psychological support services including counselling and alternative therapies were available to patients and their families.
- The NICU ran a parent support group every Thursday chaired by a psychologist. This was an opportunity for parents to meet other parents going through the same journey.
- We observed an example of a play specialist calming down a child before their procedure. The patient's parents were happy with the extra support.
- A multi-faith chaplain was available 24 hours a day, seven days a week and parents/ patients were encouraged to bring their own chaplain or Imam if required.

Are services for children and young people responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

- We observed that the environments of both the wards and the outpatients department were fit to meet the needs of young children. There was a play room on one of the inpatient wards and one within the day case unit. There were a wide variety of toys and video games for older children.
- The hospital's international office managed all aspects of care for international patients. The team was designed to meet the needs of the large number of international patients that used the service. The team assisted international patients every step of the way throughout their pathway. A member of the team sat in on MDTs and bed management meetings. The international team were highly involved in all international patients care plans.
- Services were planned around the needs of the patients and parents. Evening clinics were held in outpatient departments in order to facilitate children coming from school.
- The autistic spectrum disorder service was consultant led and took place on weekends to cater for working parents.
- The special care baby unit (SCBU) had a weekly parent forum run by a clinical psychologist. Due to the limited amount of patients at the time of our visit (one patient) we were unable to assess the implications of this forum. The parent we spoke with in NICU was aware of the forum.
- The hospital did not have a dedicated prayer room. When senior staff were asked about this we were informed that patients and their parents preferred the privacy of patient rooms in which to pray. We spoke with two family members that informed us that it would be good to have a prayer room but they often prayed in the patient room.

Good

Services for children and young people

- Outpatient services were planned by consultants and appointment times were staggered to ensure that patients didn't have to wait long for their appointment slots. One parent we spoke with said "I called the consultant this morning and was able to see her by 12pm".
- The waiting areas, clinical areas and therapy areas were all suitable for both children and young people. The play rooms had toys and games suitable for both young children and adolescents.

Access and flow

- The hospital did not specifically collect waiting time audit data as children were able to be seen, assessed and admitted to the service in accordance with their personal circumstances.
- Paediatric bed management meetings were held every day at 3pm. The meetings were attended by the nurse in charge for each area including the paediatric site practitioner on duty for the day. The meeting was used to discuss patient flow in the department on that day. There was also a plan made for the night shift. The meeting covered discharge planning for patients due to leave the service that day.
- Bed occupancy and patient flow was very well managed with the head of agency staff attending each bed management meeting to ensure that there were enough staff on shift for one to one care. The head of agency staff was responsible for the allocation of all agency staff.
- Within the outpatients departments the consultant's secretaries liaised with the reception team to book appointments for patients. There was no formal system to inform patients if consultant lists were running behind schedule but consultants within outpatients that we spoke with were confident that patients did not wait very long. This was verified by patients parents we spoke with in the outpatient departments who informed us that seeing a doctor was "seamless" and "quick". All patients who did not attend for an appointment were rescheduled at a time suitable for them. The children's outpatient matron reviewed the records of non-attendance on a weekly basis.
- Within the reporting period of July 2015 to June 2016 there were 1,464 NICU bed days available with a bed occupancy rate of 95%.
- During that same reporting period there were 3,660 PICU bed days available within the service with a bed occupancy rate of 17%.
- Inpatient wards had an exclusion criteria that included: cardiac complaints, patients requiring chemotherapy or organ transplants and acute emergencies that had not already been diagnosed or treated.
- The surgical paediatric service ran a Saturday waiting list from 8am to 4pm.

Meeting people's individual needs

- Throughout the children's services all areas we visited were child friendly with age appropriate toys and suitable decorations.
- Each patient was admitted under the care of a named consultant. Patients admitted for surgical procedures were admitted under the care of a consultant paediatric surgeon and where they had complex needs they would also have a named consultant paediatrician.
- Pharmacy ensured that they tailored prescription plans to provide patients with vegan medicines to meet with specific patients cultural and religious needs.
- There were two clinical nurse specialists especially for paediatrics. Their specialties were: complex care and urology. There was also an orthopaedic and tissue viability CNS who worked across paediatrics and adults. The complex care CNS worked with complex patients throughout their pathway in the hospital.
- There were teachers available to all long term patients. Arabic special needs patients were provided with a special educational needs (SEN) teacher. The SEN teacher provided individual learning reviews with each patient upon admission and worked with the patient regularly. The service was for children aged three and above. The service operated from Monday to Thursday from 9am to 5pm.
- On site Arabic interpreters were available Monday to Friday from 8.30am to 7.30pm. There was an out of hours service. We observed interpreter interactions with

Arabic speaking patients and found that the interpreters had a fantastic rapport with patients. The hospital had signed up to a telephone interpretation service which was available 24 hours a day, seven days a week.

- There were specialist therapy and rehabilitation programmes for inpatients that included: acute neuro-rehabilitation, complex care and Selective Dorsal Rhizotomy (SDR). SDR is a surgical procedure that involves dividing some of the nerves that contribute to the spasticity in the lower limbs. Children in outpatients had access to a sensory motor gym, sensory room, playroom, gym and off site hydrotherapy pool.
- As well as care plans being managed by specialist consultants, there was a range of therapies including: physiotherapists, occupational therapists, speech and language therapists, dietitians, psychologists and music specialists. We observed all of these specialists taking part in adapting and evolving the care plans of the children both on inpatient wards and in the outpatient departments.
- Leaflets on different procedures and after care post hospital were available throughout the service both in the inpatient wards and the outpatient departments. Upon discharge patients were provided with a TTO (to take out) checklist label and pharmacy card. The cards were available in Arabic and contained the number for the pharmacy team.
- There was a play area on each inpatient ward. Patients' parents were informed that they had to accompany their child to the play area each time they wanted to make use of it.
- The therapies team were able to provide female only sessions when using the hydrotherapy pool at a neighbouring NHS trust.
- The chef catered for the needs of patients with specific dietary needs for religious, cultural or medical reasons. We saw examples of patient menus with varied food options available.
- There was a family room located on one of the inpatient wards. Family members could go there to have lunch or dinner and even use the room for private conversations. A family waiting area outside theatres was created in response to parent feedback.
- A breast feeding room was available on the PICU. There were breast feeding facilities in the outpatient department and day case unit. The service also had a feeding clinic run by a paediatric gastroenterologist supported by a team of various therapies. Patients who were referred were able to receive an individualised treatment and management plan. They were also able to tailor milk provided to patients with vegan needs. The core members of the team included: a consultant paediatric gastroenterologist, a senior paediatric dietitian, a senior speech and language therapist, and a clinical nurse specialist in gastroenterology. A clinical psychologist was also available to attend the feeding clinic where there were significant concerns regarding a child's behaviour and relationship with feeding.
- On the neonatal intensive care unit there was very limited space. Parents wanting privacy had to request a pull around curtain. There was also no dedicated family room located on the unit and staff informed us that parents had to have personal conversations in an empty room on the opposite ward.

Learning from complaints and concerns

- Nursing staff told us they aimed to resolve concerns in the first instance in a timely way to improve the patient experience and prevent a formal complaint. Formal complaints were managed through the CNO with support from the children's services manager. Feedback was given to staff at the ward meetings.
- Every month the service issued a patient experience newsletter. The newsletter provided feedback and action plans for various patient concerns and complaints. For example, in June 2016 a patient's parent informed the service that they were not always aware of the financial implications of treatment. This was difficult as they were self-pay. The service then began to provide a leaflet which detailed self-pay rates and was provided to the patient before they booked an appointment. This was evident during our inspection as a parent we spoke with informed us that they had been briefed on the cost structure before their child was admitted.
- The hospital had a target of acknowledging all formal complaints within 48 hours of receipt. The HCA wide expectation is that complaints were then responded to within 20 working days.

Good

Services for children and young people

- Between October 2015 and September 2016 there were 51 complaints received by the service. Overall, 41 of these complaints were responded to within the hospital target of 20 days. There were no trends in complaints.

Are services for children and young people well-led?

Good

Leadership / culture of service

- The children's services manager had overall responsibility to ensure the clinical safety of the service. The children's services manager reported to the CNO who was also the deputy CEO.
- The medical director was a consultant paediatric orthopaedic surgeon who was a part of the senior management team. This role also sat within the medical advisory committee (MAC). The MAC was responsible for reviewing consultant practising privileges renewals and acceptance of applications for new clinicians.
- Both the CNO and CEO attended the inductions of new staff. A new nurse on the ward informed us that she found it "surprising and great" to have the CEO present at the induction. Several members of staff stated "the CEO knows my name and really cares". All nursing staff we spoke with spoke highly of the CNO and many staff members told us that if they had a problem they felt comfortable going directly to the CNO if their managers were not available.
- All staff spoke very highly of their CEO and CNO. Both nursing staff and consultants felt as though their leadership team were highly responsive to their needs. One junior nurse described the service as having a "family feel" and a senior nurse who was new to her post informed us that the service had a "friendly culture".
- All staff we spoke with spoke highly of the responsiveness of managers and the executive team. A senior nurse on an inpatient ward said "I feel like I can get anything I need for my patients. Nothing is difficult. This is so good because it means there are no barriers to me providing the very best care I can".
- Consultants we spoke with were most proud of the access to the wide variety of sub-specialities. They felt as though they could go above and beyond for their patients' clinical care.
- Equality and diversity formed part of the mandatory training programme that all staff were required to attend. Within children's services between 86% and 100% of staff had received this training in the year before our inspection, against a target of 90%. While the hospital collected some data on equality and diversity, it did not include the four specific workforce metrics identified in the NHS Workforce Race Equality Standards (WRES) in order to demonstrate progress against a number of indicators of workforce equality.

Vision and strategy

- The HCA vision was 'exceptional people, exceptional care'. When staff were asked about the vision all were able to repeat the HCA vision and appreciated the hospitals strategy for being excellent.
- Ward staff knew how their work contributed to the wider vision of the hospital and were aware of the hospital values.
- The NICU had their own vision and strategy. They were working towards taking on infants from 28 week gestation. Everyone in the service was aware of this strategy.

Governance, risk management and quality measurement for this core service

- There was a defined governance and risk management structure from corporate level to hospital and department level. There were a number of localised committees, including: patient experience group, blood committee, medicines management committee, safeguarding committee and infection control committee. These groups reported to the hospitals integrated governance committee (IGC) and senior management team meeting.
- The registered manager and medical advisory committee (MAC) followed a process to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake

the treatment they were performing at the hospital. The registered manager reviewed the competencies and skills biannually. This included review of outcomes, appraisal and revalidation.

- Incident review meetings were held every week in the CNO's office. The incident review meeting reported to the integrated governance committee. The CNO chaired the meeting, with the CEO taking overall authority, along with the chair of clinical governance, chair of the MAC and the medical director.
- Both the paediatric and theatre services employed quality and risk matrons. The matrons maintained the risk registers as a live document. There were eight active risks on the paediatric risk register. Both staffing levels and space restrictions were on the risk register.
- The service's main concern was the recruitment of RMOs. In order to mitigate against falling short with RMO recruitment, the service teamed up with academic institutions and supported RMOs through their PhDs.
- The service worked collaboratively across the HCA group. The CNO informed us that she met with CNOs across HCA every month to share learning and establish potential links.

Public and staff engagement

- Senior nurses and matrons performed a daily ward round to gauge patient and family views towards care and treatment.
- Prior to discharge, patients and their parents were asked to fill out feedback forms. The patient feedback working group monitored responses and reported on them monthly.
- The patient experience newsletter provided to staff each month outlined staff and consultant commendations. Here the service published all praise received from patients for everyone to see.
- During our inspection the staff were preparing to host their annual prematurity day. This was a day for all previous premature patients to come back to the hospital with their parents. This was a social event that included the staff that had cared for them.
- The therapies team maintained an accessibility register. The purpose of this tool was to ensure that staff could anonymously add any ideas or queries they had regarding their department. They could upload these comments to the register and receive a response from the therapies manager. All staff we spoke with were aware of this register and had used it in the past. They informed us that it was a positive initiative that ensured that staff voices were heard and responded to.
- Staff satisfaction survey of 2016 showed that 95% of staff felt committed to doing their very best for HCA. A further 67% of respondents felt overall satisfied working for HCA and 53% were not planning to leave HCA in the next 12 months. The survey demonstrated a slight decline in all points compared with results two years ago.
- The head chef was very engaged with patients. The catering team often met with parents to contribute to menu items that were more engaging with their children's needs and culture. The head chef also had baking sessions for the children in the CYP service.

Innovation, improvement and sustainability

- The service benefited from an extensive therapies team. All staff we spoke with in therapies explained the innovations coming out of their department with pride. The Autism Spectrum Disorder (ASD) assessment service was a new development that provided a two stage assessment that provided parents with a definitive diagnosis. This process enabled the consultant and speech therapist or psychologist to provide the family with a diagnosis and further information.
- The Selective Dorsal Rhizotomy Service was developed in July 2015. The service provides a pathway that simultaneously covers both inpatient and outpatient and starts with an MDT assessment. The service enables patients to be fast-tracked for surgery followed by intensive physiotherapy.
- Several members of the therapies team presented innovative ideas at different conferences throughout the year. A physiotherapist presented at the International Brain Injury Association (IBIA) with regards to a patient who achieved significantly positive results in the service after an acute brain injury.
- The hospital had adapted the 'Hugs and Kisses' security system to manage the security of all children and young people in the hospital. An electronic tag was placed on

all patients on admission and alarm if they left the ward area. The tag would have to be disabled by one of the nursing team when the patient was done with treatment.

- Both junior and senior nurses described the creation of the paediatric site practitioners (PSPs) as an overwhelming assistance to carrying out their clinical practice.
- The service had plans to develop the dialysis service in order to transfer patients from a local NHS trust to the Portland for treatment. In order to do this, the service had hired a clinical development facilitator who was developing the education programme for dialysis.
- The outpatient creation and design of a sensory motor gym was in response to being able to provide specialist and imaginative care for children with sensory processing disorders. The use of this bright and colourful stimulating environment provided children with complex needs an opportunity to explore their environment more independently.
- The service had implemented a specialist, sensitive birthmark screening and treatment program. This service worked in collaboration with families and their affected children through their diagnosis and treatment. The team included: a CNS, a consultant dermatologist, a consultant paediatric interventional radiologist and a multidisciplinary team (MDT) consisting of an ophthalmologist, an ENT surgeon, a plastic surgeon and a paediatrician.

Outstanding ☆

Outpatients and diagnostic imaging

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

Are outpatients and diagnostic imaging services safe?

Good

Incidents

- There was one never event reported during the period of July 2015 to June 2016. This was specific to the colposcopy outpatients procedure. The event related to the procedure being undertaken on the wrong patient; the event did not result in harm to the patient. Learning and action have been undertaken, however local patient identification policies had not been revised to include the new identification practices put in place as result from the incident learning. However, when this was highlighted to the senior sister we were told that the written policies would be revised as soon as possible.
- There were 96 clinical incidents reported in the period of July 2015 to June 2016. The department had a rate of 0.1 incidents per 100 outpatient attendances; this rate was lower than the average rate of other independent acute hospitals during the same reporting period.
- There were 47 non-clinical incidents reported in the period of July 2015 to June 2016. The department had a rate of 0.1 incidents per 100 outpatient attendances; this rate was similar to the average rate of other independent acute hospitals during the same reporting period.
- There were three radiation incidents reported in the period of July 2015 to June 2016. These incidents were not reportable to the CQC or HSE.
- Incidents were reported using an electronic reporting system. Staff could describe how to report incidents and told us the reporter always received feedback.
- Incidents were discussed at monthly governance meetings and information and lessons learnt were disseminated to staff via a learning grid discussed at staff meetings. Staff could describe examples of previous incidents that had occurred across the hospital.
- All staff we spoke to were aware of duty of candour and could describe circumstances when it would be exercised.

Cleanliness, infection control and hygiene

- The clinical and waiting areas we visited were visibly clean and tidy.
- The clinical areas we visited were suitable for their purpose and designed following infection control guidance. The majority of consulting rooms had an en-suite examination/treatment room separated by a door; this removed the need for curtains.
- Completed cleaning checklists were observed in outpatients and radiology.
- The hospital conducted an infection control audit with compliance target of 95%. The data we were provided showed compliance rates in quarter one of 2016 for general infection control in all areas of the audiology, therapies, outpatients and imaging departments were between 92% and 100%. Compliance rates in quarter two of 2016 for the above mentioned departments were between 87% and 100%. Compliance rates in quarter three of 2016 were between 79% and 100%. Service

managers told us that these audits were designed to show departments where improvement was necessary, results were discussed in staff meetings and all staff were reminded follow compliance procedures.

- Clean utility infection control audit was conducted with compliance target of 95%. The data we were provided showed compliance rates in quarter one of 2016 for the outpatients and imaging departments were 100% and 70% respectively. Compliance rates in quarter two of 2016 were 100% and 96% respectively. Compliance rates in quarter three of 2016 were 90% and 100% respectively.
- In all areas we visited we observed that there were signs to say that toilets were cleaned regularly and a phone number was present to contact the housekeeping team if a toilet needed urgent attention. However, all toilets we checked did not contain a cleaning schedule or signing sheet.
- A staff/visitor toilets infection control audit was conducted with compliance calculated at 95%. The data we were provided showed compliance rates in quarter one of 2016 for the audiology, outpatients and imaging departments were between 70% and 100%. Compliance rates in quarter two of 2016 for those departments were between 96% and 100%, and in quarter three of 2016 were between 96% and 100%.
- Policies and protocols for the prevention and control of infection were in place and all staff we observed in clinical areas adhered to 'bare below the elbow' (BBE) guidelines.
- Hospital data provided showed us that the hospital target for BBE compliance was 95%. Compliance rates in quarter one of 2016 for the audiology, therapies, outpatients and imaging departments ranged from 80% and 100%. Compliance rates in quarter two of 2016 for those departments were from 90% to 100% and in quarter three of 2016 were 100% for all areas.
- There were sufficient hand washing facilities including basin, hand wash, hand gels and moisturiser and we observed staff being compliant with the recommended hand hygiene practices.
- Hand hygiene audit data provided showed us that the hospital target for hand hygiene compliance was 95%. Compliance rates in quarter one of 2016 for the audiology, therapies, outpatients and imaging departments ranged from 80% and 100%. Compliance rates in quarter two of 2016 for those departments ranged from 85% and 100%, and in quarter three of 2016 for ranged from 90% and 100%.
- Stickers were placed on equipment to inform staff when equipment was cleaned and we saw evidence of this being used across all departments we visited.
- All staff we spoke with were aware of their procedure to decontaminate clinic areas after each patient.
- Arrangements were in place for the handling, storage and disposal of clinical waste. Sharps bins were noted to have been signed and dated when assembled and were disposed of immediately when full.

Environment and equipment

- All departments we visited were adequate for their purpose and well maintained. Patient waiting areas were clean with sufficient seating for patients and relatives.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Safety testing for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the radiology departments to warn people about potential radiation exposure.
- Monthly quality assurance logs were provided for the X-ray units, MRI and CT scanners for the period of May 2016 to October 2016. We were assured that procedures were in place for the safety testing of all diagnostic imaging machines on a daily, monthly and annual basis.
- All clinical staff we observed in the radiology departments had valid in-date radiation monitoring badges.
- Personal protective equipment (PPE) was available in all clinical areas we observed. Hospital PPE audit data showed that the target for PPE availability was 95%,

compliance rates for April to September 2016 for the audiology, therapies, outpatients and imaging departments were 100%, 100%, 83% and 92% respectively.

- Emergency resuscitation equipment was in place in all areas of the outpatients, audiology, therapies and imaging departments and followed national resuscitation council guidelines. Trolleys we reviewed were checked on a daily and weekly schedule and had their seals intact; trolleys that were asked to be opened had all the required equipment and medication that was valid and in-date.
- Due to the limited space available in 212 Great Portland Street outpatients department, the hospital used basic life support bags on each floor instead of trolleys. There were two defibrillators available for the building held on the ground and first floors.
- Due to the layout of the 212 Great Portland Street outpatient services being away from the main hospital the resuscitation policy was different. In the case of a patient becoming acutely unwell, a resuscitation call was placed using the emergency number to the main hospital along with calling '999'. The resuscitation team would travel from the main hospital in order to stabilise the patient until they could be transferred to a NHS service.
- There were working emergency call bells in every clinic room and toilet. We observed the weekly checking process and reviewed the testing logs for September 2016 in the outpatients department.

Medicines

- Staff we spoke with were aware of medicine management policies and the systems in place to monitor stock control and report medication errors.
- All medicines in outpatients were found to be in date and stored securely in locked cupboards as appropriate, and in line with legislation. The keys were kept in a secure area with a keypad lock.
- Any medicines the outpatient department stored were delivered by the hospital's own pharmacy. We saw evidence of regular medication audits. Medicine near expiration was flagged and replaced once out of date.
- No drugs requiring temperature control were stored in the outpatients or diagnostic departments.
- No controlled drugs (CDs) were stored in the outpatients, radiology and audiology departments. The neonatal ultrasound service held controlled drugs which were stored appropriately in a locked safe and the keys were held by the service lead.
- Records containing relevant patient details were maintained regarding any administered drugs or contrast media in the outpatients and radiology departments. The records were signed and checked by two nurses or radiographers.
- Prescription pads were stored securely and their usage was tracked.

Records

- The hospital used an electronic patient record (EPR) which ensured availability of medical records for outpatient's clinic. New patients arrived with all relevant records from their referring clinicians and if on occasion this was not available administrative staff would contact the clinicians to source the required details. We were assured patients were not seen without relevant records.
- We reviewed 10 sets of patient records in the outpatients department. All contained details of past medical history, allergies, infection control, medicines and discharge planning. Evidence of consent was also observed as appropriate.
- Records could be viewed off site in any HCA hospital due to the EPR. In such cases where physical records needed to be moved off site for continuity of patient care, then copies were made and the notes were tracked. Medical record bags were available for transport.
- The radiology department conducted quarterly audits on request form completion with the aim to monitor and ensure national legislation and best practice guidelines were followed. The audit results from the period of July 2016 to September 2016 showed that there was 100% compliance out of a sample of 50 forms.
- The therapies department conducted a monthly documentation audit to ensure compliance of best practice guidelines with a target of being 100% compliant. Compliance rates for documentation for the

months of July 2016 to September 2016 ranged from 76% to 86% respectively. These rates were due to a lower amount administrative staff available and a small number of staff not adhering to working practices. We saw evidence of learning being shared and an action plan created.

Safeguarding

- Safeguarding policies and procedures were in place. These were available electronically for staff to refer to. Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- The hospital target for completion of safeguarding training was 95%. Hospital data showed that compliance rates for safeguarding level one and two for children in the outpatients and radiology departments were 98% and 100% respectively. The compliance rate for safeguarding level three for children in both the outpatients and radiology departments was 83%; service managers told us that this percentage was due to some staff scheduled to complete their training in the upcoming months.
- Compliance rates for safeguarding adults in the outpatients and radiology departments were 97% and 100% respectively; this was in line with the hospital target.
- Nursing staff we spoke with told us that female genital mutilation training was provided within the safeguarding training they conducted .
- Safeguarding flow charts to help staff escalate concerns correctly were on display in the outpatients and radiology departments.
- There was a chaperone policy and we saw signs in both English and Arabic throughout the outpatient, audiology and diagnostic imaging departments advising patient how to access a chaperone should they wish to do so.
- All staff spoken with were aware of the hospital's whistleblowing policy. They told us that they would feel happy using this policy to raise concerns if necessary.

Mandatory training

- There was a mandatory training policy that detailed which training staff were required to attend. The training included health & safety, manual handling, infection control, fire safety, information governance, basic life support, paediatric basic life support, ethics, diversity training, safeguarding and mental capacity act training. The training records showed attendance was monitored and managers were required to take action to ensure that staff attended all mandatory training.
- Mandatory training completion was linked to staff annual appraisal system; failure to complete mandatory training would not allow staff to receive their pay award.
- Data showed that mandatory training rates in outpatients did not meet the hospital target of 95% compliance; data showed that mandatory training rates in outpatients ranged from 71% to 98% for all courses. This was explained by the senior nursing staff to be due to new staff starting.
- Data showed that mandatory training rates in radiology were 100% for all courses except 'infection control' and 'paediatric basic life support' which were 83% and 80% respectively; the radiology manager told us that the three staff members outstanding were due to attend these courses in the near future.
- We were told medical staff with practising privileges at the hospital completed mandatory training at the hospital they spent most of their time at. For example those working mainly at an NHS trust would complete this training at their respective trusts and were required to submit copies of their training record to the hospital management team, who would then submit this data to the central HCA team who monitored consultant validation and training across all HCA sites.

Assessing and responding to patient risk

- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- The six point identification check was used in radiology as required by the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000). In addition we saw staff check patients against their scanning area and also asked patients what procedure they were there for.
- Staff told us they checked female patients' pregnancy status in the radiology department before initialising any imaging procedure. We saw evidence of this on their pre-scan questionnaire and referral forms.

Outpatients and diagnostic imaging

- The radiology department used a patient safety questionnaire for MRI in order to ascertain if the patient had any metal objects inside their body, the radiographers would then assess whether it was safe for the patient to have the scan. The department also had questionnaire for patients prior to administration of contrast media to ascertain if the patient suffered from any relevant allergies or conditions which put them at risk of anaphylaxis.
- Two radiation protection supervisors were appointed for the hospital. Further support was noted in the radiology department's local rules.
- Staff were able to describe the procedure of what to do if a patient was suspected of suffering from a cardiac arrest or anaphylaxis. All staff knew the hospital internal resuscitation team number. All staff in the outlying outpatient services were aware of the policy to call both the resuscitation team and '999'.
- World Health Organisation (WHO) safer surgical checklists were in use before any interventional radiology procedures.
- The midwife led outpatient service conducted meet and greet sessions for all patients prior to using the midwife led services where the patient would have their full medical history taken and risk assessed.

Nursing and Allied Health Professional staffing

- The gynaecology outpatient department had a total of 17 clinical staff members which included: two clinical nurse specialists, one sister, ten staff nurses of mixed seniority and four health care assistants. The department had a division of 76% qualified nursing staff to 24% assistant staff.
- The midwife led outpatient service had a total of six clinical staff members which included; five midwives and one sister.
- The therapies department staffing data which included: the audiology, dietetics, psychology , speech & language, and occupational therapy departments showed that there were 24 clinical members of staff which included; three managers, two clinical lead physiotherapists, nine physiotherapists, three play specialists, two dietitians, four audiology scientists, one cochlear implant co-ordinator, one speech and language therapist, one neuropsychologist, two occupational therapists and two therapies assistants.
- The diagnostic imaging department had a total of 18 clinical staff members which included: two managers for imaging and ultrasound, two superintendent radiographers, six radiographers, one sonographer, six radiology department assistants and one health care assistant.
- Service managers told us that the outpatients, therapies and radiology departments did not use agency staff where possible and instead preferred long term bank staff employed by HCA cross site programme.
- Bank staff use and vacancy rates in the outpatients department was high during the reporting period of July 2015 to June 2016. However, staffing issues had since resolved and the department was adequately staffed at the time of inspection. The vacancy rate in September 2016 was 11%, with two vacancies in total for a health care assistant and staff nurse. The outpatient matron told us during the inspection that there were no vacancies in outpatients.
- The vacancy rate for radiology in September 2016 was 5.3%, with one vacancy in total for a senior sonographer. The imaging manager told us during the inspection that this role had been offered to a candidate.

Medical staffing

- There were approximately 598 consultants with practising privileges attending the hospital, however not all of them regularly saw patients in outpatient clinics. We were not given information regarding the number of consultants who worked in the outpatients' clinic and diagnostic imaging department.
- There was a process in place for granting practising privileges, via the medical advisory committee (MAC). This process included interviewing, obtaining references and Disclosure and Barring Service (DBS) checks on all applicants.
- The hospital employed 16.8 full time equivalent (FTE) resident medical officers (RMOs) based on a 40 hour week. RMOs are doctors of varying experience that are

full time hospital employees. The RMOs only provided medical cover in the case of patients requiring to be seen urgently or in need of prescriptions if their consultant was unavailable.

Emergency awareness and training

- The hospital had a business continuity management plan which had been approved by the management team. The plan established a strategic and operational framework to ensure the hospital was resilient to a disruption, interruption or loss of services.
- The hospital major incident plan covered major incidents such as loss of electricity, flooding, loss of frontline system for patient information, loss of information technology systems and internet access, loss of staffing, loss of water supply and terrorist attack. Senior staff told us that the hospital was not required to assist the NHS in an emergency situation; however they felt it was their moral duty to assist.
- Service managers told us that staff members would be expected to contact their line managers or hospital duty manager in regards to attending work following a major incident.
- Staff in the outpatients and imaging departments told us they could identify the designated fire marshals in their own departments.

Are outpatients and diagnostic imaging services effective?

Evidence-based care and treatment

- Care and treatment within the outpatient and diagnostic imaging department was delivered in line with evidence-based practice. Policies and procedures followed recognisable and approved guidelines such as the National Institute for Health and Care Excellence (NICE).
- Professional guidelines were discussed in the monthly guidelines and audit committee meeting which was attended by service managers, matrons, consultants and the risk matron. The clinical governance lead disseminated guidelines information to the relevant service leads who then discussed and implemented the relevant guidelines within their own departments.
- Radiology dose reference level audit results were available for staff to read. The department's 2015 results were significantly lower than the national dose level.
- Audits of compliance with IR(ME)R 2000 were completed. We saw evidence that there were annual radiation safety audits conducted by the medical physics expert and that the relevant findings were action planned appropriately.
- Radiation safety committee meetings were held tri-annually to monitor radiation safety throughout the hospital. We saw minutes of the last three meetings held in 2016, which showed a variety of topics were discussed including: incident learning, reviewing current procedures, implementation of new regulations, and equipment.
- We saw evidence in the form of an audit calendar that showed all areas we visited conducted both corporate and local audits. We saw evidence that findings from these audits were analysed, learning disseminated and action plans were created.
- The radiology department conducted a WHO surgical safety checklist audit for patients that had an interventional radiology procedure in the period of October 2015 to September 2016. The department target for compliance was 100%. However, data for the audit period showed that 'sign in', 'timeout' and 'sign out' compliance rates were 99%, 96% and 87% respectively. Even though the department did not meet its own target, we saw evidence of learning and an action plan was created to improve compliance.
- The radiology department conducted quarterly image quality audits with the aim to monitor and improve upon the use of best practice guidelines in order to produce higher quality images. Audit results from the period of July 2016 to September 2016 showed that the department needed to improve upon its use of radiological markers when imaging, we saw evidence of learning being disseminated and an action plan created.
- Staff meetings were held in outpatients and radiology to share information and promote shared learning.
- A weekly departmental teaching session was held in physiotherapy and we also saw evidence of outpatient and inpatient nurses co-learning sessions.

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

Pain relief

- Nursing staff we spoke with told us consultants would normally prescribe relevant pain medication for patients under their care. In an urgent scenario, if the consultant was unavailable, the RMO could be used to assess the patient and prescribe the relevant pain relief.

Patient outcomes

- The imaging manager told us that the Imaging Service Accreditation Scheme (ISAS) accreditation process had been initiated; we saw evidence of an implementation plan with the aim of having the first site visit and assessment by quarter one of 2018.
- The maternity outpatients and neonatal ultrasound services were accredited by 'Caspe Healthcare Knowledge Systems' (CHKS) for ISO 9001:2015 quality management system.
- In the radiology department the x-ray, ultrasound and MRI scanner units were accredited by an external body; this accreditation scheme required the department to ensure they followed nationally set quality standards.
- The hospital policy was that all images be reported on within 24 hours. The imaging manager told us that all images were usually reported on the same day unless the referrer requested the report of a specific consultant which may be because of their expertise which may result in a wait of more than 24 hours. Hospital data showed that in June 2016, 78% of CT scans and 73% of MRI scans were reported within 24 hours.
- The radiology department conducted a monthly audit of image rejections analysing how many images were of unacceptable quality, the departmental target was to have no more than 5% of images rejected. The audit data showed that between April 2016 and September 2016 the department performed positively with a rejection percentage ranging from 1% to 2.7%.

Competent staff

- All areas we visited had appointed suitably qualified members of staff. Any staff members without formal qualifications were appropriately supervised when undertaking clinical responsibilities.
- Managers and staff told us performance and practice was continually assessed during their mid-year reviews and end of year appraisal. Staff we spoke with confirmed they received regular appraisals.
- Hospital data showed that all staff in all staffing groups had completed their appraisals in the outpatients, audiology and radiology departments.
- Nursing and allied health professional staff we spoke with confirmed they were encouraged to undertake continual professional development (CPD) and were given opportunities to develop their skills and knowledge through training relevant to their role. This included completing competency frameworks for areas of development and they were also supported to undertake specialist courses.
- Evidence was provided to show all staff in the outpatients and radiology departments had CPD and competency records for their specific role.
- The registered manager and medical advisory committee (MAC) followed a process to ensure all consultants who had practising privileges at the hospital had the relevant competencies and skills to undertake the treatment they were performing at the hospital. The registered manager reviewed the competencies and skills biannually. This included review of outcomes, appraisal and revalidation.
- Managers told us they had procedures in place for the induction of new staff and all staff, including bank staff completed hospital and departmental induction before commencing their role. We saw evidence of attendance at these induction sessions.
- The neonatal ultrasound unit participated in an annual audit of nuchal translucency procedure; this is where the sonographers must submit their scan data and imaging logbooks to be certified by the Fetal Medicine Foundation. All sonographers were certified until 2017.
- We saw examples of a detailed and comprehensive induction and competency framework being used in the radiology department. This covered all areas including x-ray, ultrasound, CT and MRI.

Outpatients and diagnostic imaging

- We were shown evidence of staff competencies completed in the audiology department; these were inclusive of all procedures the department conducted.

Multidisciplinary working

- Multidisciplinary working was evident throughout the outpatients and imaging departments.
- We were told by managers that there were consultant led multidisciplinary team (MDT) meetings held to discuss cancer patients based on their treatment area. We were told by managers that nursing staff, allied health professionals and managers were encouraged to attend.
- Internal MDT meetings regularly took place for differing core services. An example of the paediatric services was given where different allied health professionals, nursing staff and consultants would discuss ongoing patient issues.
- Cross-site MDT working occurred in specific services such women's health, in which the team from the Portland Hospital shared learning and assisted in the development of services at the HCA London Bridge Hospital.

Seven-day services

- The outpatient department did not provide a seven day service. The outpatient service was provided Monday to Friday 8am to 8pm and a Saturday service was available 8am to 1pm.
- The radiology department did not provide a seven day service. The service was available Monday to Friday 8am to 7pm. A Saturday ultrasound service was available 9am to 1pm.
- The radiology department provided 24 hours a day, seven day a week on-call services.

Access to information

- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet.
- The radiology department used a nationally recognised system to report and store patient images. The system was used across the hospital and allowed local and regional access to images.
- The hospital was in the process of implementing a system where they could quickly transfer and view images to and from the NHS.
- All clinic rooms had computer terminals enabling staff to access patient information such as x-rays, blood results, medical records and physiotherapy records via the EPR.
- Staff room areas we visited had notice boards with hospital wide communication, monitored area specific data and audit results.
- All patients we spoke with confirmed that they had received previous correspondence between their consultant and GP. Patients that had previous diagnostic procedures confirmed that they had received the results or imaging report along with a copy of the scan if they requested. This was in line with hospital policy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with were aware of the Mental Capacity Act 2008 (MCA) and Deprivation of Liberty Safeguards (DoLS) and its implications for their practice.
- Hospital data showed that completion rates for MCA and DoLS training in the outpatients and radiology departments were 84% and 100% respectively.
- Staff told us they were aware of the hospital's consent policy. Consent was sought from patients prior to the delivery of care and treatment. In the diagnostic imaging department, radiographers obtained written consent from all patients before commencing any procedure. Patients we spoke with confirmed they were given enough time and received the relevant written and verbal information to make informed consent.
- Consent forms for patients lacking capacity were available in outpatients and diagnostic imaging departments, but we did not observe any completed forms as staff explained that patients requiring these forms were rare.
- We reviewed 10 sets of patient records which all showed evidence of an appropriate consent process.

Outstanding ☆

Outpatients and diagnostic imaging

Are outpatients and diagnostic imaging services caring?

Outstanding ☆

Compassionate care

- We observed staff assisting patients in the department, approaching them rather than waiting for requests for assistance. For example, asking them if they needed help and pointing people in the right direction.
- Patients' privacy was respected and they were addressed and treated respectfully by all staff. Staff were observed to knock on consulting room doors before entering. Consulting rooms had a separate private area for patients to be examined and change clothing if required.
- The environment and the consulting rooms in all departments we visited allowed for confidential conversations.
- All patients we spoke with consistently gave very positive accounts of their experiences with staff and the hospital. .
- We saw greeting cards, positive messages and comments to staff by patients on display in staff rooms and department offices.
- The outpatient survey for quarter two of 2016 demonstrated 98% of patients provided a positive opinion on the quality of care they received and 85% of respondents rated the care as 'excellent'. This was with a total of 125 respondents.
- The outpatient survey for quarter three of 2016 demonstrated 95% of patients provided a positive opinion on the quality of care they received; 82% of respondents rated the care as 'excellent'. This was with a total of 140 respondents.
- Friends and family data for quarter two of 2016 demonstrated 98% of patients would recommend the service. This was with a total of 127 respondents.
- Friends and family data for quarter three of 2016 demonstrated 99% of patients would recommend the service. This was with a total of 139 respondents
- We were shown evidence of activities and excursions organised by the therapies department to support parents and children's psychosocial wellbeing that were planned based on individual patient needs. Stimulating trips to venues such as Regents Park and London Zoo were arranged to meet specific patient goals.

Understanding and involvement of patients and those close to them

- We saw staff spent time with patients, explaining care pathways and treatment plans. All patients we spoke with told us they fully understood why they were attending the hospital and had been involved in discussions about their care and treatment.
- The outpatients feedback results for quarter two of 2016 showed that 97% of patients felt they received all the information they needed before deciding their treatment plan, as outlined by the feedback questionnaire, this was with a total of 121 respondents. The results for quarter three of 2016 for the same parameter showed that 95% of patients positively agreed. This was with a total of 142 respondents.
- Outpatients feedback results for quarter two of 2016 showed that 97% of patients felt 'completely' involved in deciding their treatment plan, as outlined by the feedback questionnaire, this was with a total of 113 respondents. The results for quarter three of 2016 for the same parameter showed that 89% positively agreed. This was with a total of 121 respondents.
- Patients told us they were given time to make decisions and staff made sure they understood the treatment options available to them.
- Patients attending for any outpatient's service, including diagnostic imaging, were encouraged to fill in the outpatient questionnaire. However, the radiology and audiology departments were in the process of developing their own questionnaire to capture more service specific information.
- The midwife led outpatient services held meet and greet clinics for patients interested in the hospital maternity services. These free sessions allowed the patients to have a tour of the facilities and ask any questions they may have.

Emotional support

Outstanding ☆

Outpatients and diagnostic imaging

- Nursing and allied health professional staff provided practical and emotional support to patients in all of the clinics. Staff told us how they supported patients who had been given bad news about their condition, and offered them sufficient time and space to come to terms with the information they were given.
- We observed that the high nurse to patient ratio in the outpatient departments allowed staff to quickly provide chaperone services and also allowed staff to spend extra time with patients requiring emotional support.
- Patients reported that if they had any concerns, they were given the time to ask questions. Staff made sure that patients understood any information given to them before they left the clinic.
- The outpatients feedback results for quarter two of 2016 showed that 98% of patients agreed they were given all 'the time and attention they needed', as outlined by the feedback questionnaire. This was with a total of 122 respondents. The results for quarter three of 2016 for the same parameter showed again that 98% of patients positively agreed. This was with a total of 143 respondents.
- Outpatient's feedback results for quarter three of 2016 showed that 98% of patients felt that they were treated courteously by their clinician. This was with a total of 143 respondents.
- Psychological and counselling services were available for patients and their relatives.
- A clinical nurse specialist for endometriosis was recently appointed to lead the patient care pathway; one of their duties would be to provide advanced emotional support to those patients.

Are outpatients and diagnostic imaging services responsive?

Outstanding ☆

Service planning and delivery to meet the needs of local people

- The hospital had a dedicated international patient centre (IPC) staffed by liaison officers. This service was designed to meet the needs of the large demographic of international patients the hospital received. The centre assisted and escorted patients through their hospital journey, liaising with insurance companies and embassies if required. The centre also provided translation, accommodation booking and travel booking.
- Services were planned around the needs and demands of patients. Outpatient clinics were arranged in line with the demand for each speciality. If consulting space was available, consultants could arrange unscheduled appointments to meet patient needs.
- We observed that there was adequate signposting in the outpatients and imaging departments. All signs were written in English and international patients were escorted around the hospital by IPC or reception staff.
- Patients told us they received instructions over the telephone when booking the appointments for outpatient or diagnostic appointments.
- All waiting areas seen within the hospital were clean and contained adequate comfortable seating with access to toilets, a selection of free hot beverages and refreshments, a water dispenser and a selection of current newspapers and magazines.

Access and flow

- We were told by service managers that patients booked their initial and subsequent appointments with their consultant through the consultant's private secretaries. All patients we spoke with confirmed this and told us that they did not have any issues regarding waiting to see their consultants.
- Patients we spoke with said they were informed of how to book an appointment at the clinic and they knew how to access other services such as blood tests and diagnostic imaging.
- Outpatient managers, nursing staff and reception staff told us waiting times in the department were kept minimal, and any delays were managed appropriately. All patients we spoke with agreed with this and spoke positively regarding waiting times.
- The outpatient services aimed to see patients within 15 minutes target of their arrival or appointment time. An audit of the gynaecology outpatient service showed in August 2016 that 74% of patients were seen within

target. In September 2016, the department saw 80% of patients within target. We saw evidence to show that learning was disseminated and an action plan created which included: reiterating to staff the importance of informing patients regarding delays and the adjustment of consultant clinics to allocate longer time for appointments.

- The ultrasound service aimed to see patients within 15 minute target of their appointment time. An audit of the waiting times showed in quarter one of 2016, 100% of patients were seen within target, with an average wait time of three minutes. Data showed in quarters two and three of 2016, 85% of patients were seen within target, with an average wait time of eight minutes. Data showed in quarter four of 2016, 64% of patients were seen within target, with an average wait time of 13 minutes. The ultrasound lead explained that these increased wait times are down to seasonal work load increases, consultants having to leave their clinics to deliver babies, and to walk-in patients adding to the patient list. We were shown evidence to show that these results were analysed and learning was disseminated, action has been taken to resolve this by approving a new sonographer post to cope with increased demand and by adjusting consultant clinic times to allow more time for appointments.
- The imaging department aimed to see patients within 15 minute target of their appointment time. The department recently conducted an audit of waiting time data which showed in October 2016 that 89% of patients were seen within target. The average wait time for all patients was below 15 minutes. The main reason for target breach was patients arriving late for their appointment. The audit was due to be repeated quarterly.
- Consultants provided direct referral patients and post-operative follow-up appointments within hours or days for most outpatient appointments and radiological diagnostics. All patients we spoke to confirmed this and also told us they had timely access to diagnostic investigations and minor treatment within a few days of their appointment at the hospital.
- Hospital data showed that in the period of June 2016 to September 2016, a total of 11 outpatient clinics started later than scheduled. Five of these clinics started with a maximum delay of 15 minutes and six of these clinics started with a delay ranging between 16 to 30 minutes. We were not provided with data regarding the total number of clinics in this period.
- Outpatient managers and reception staff told us that clinic cancelations were rare and if there were any cancellations that it was the consultant's responsibility to ensure they were covered. The hospital did not collect data regarding clinic cancellations.
- The outpatient services collected monthly data regarding how many patients did not attend their appointments. Data showed that in gynaecology outpatient service during the period of July 2016 to September 2016 a total of 387 patients did not attend. Data showed that in hearing and balance outpatient service during the period of July 2016 to September 2016 a total of 51 patients did not attend. Data showed that in radiology during the period of July 2016 to September 2016, a total of 15 patients did not attend.
- The pharmacy aimed to process and turn around outpatient prescriptions within 30 minutes of receiving the prescription in the dispensary. The pharmacy had a target of 85% of prescriptions to meet this timescale. An audit of turnaround times in the period of January 2016 to June 2016 showed that the pharmacy continuously exceeded the target in all months, except May 2016, where 83% of prescriptions met the timescale. We saw evidence to show that the results were analysed, learning shared and an action plan created.
- The outpatient department ran a colposcopy service. If a patient was found to have a discrepancy in their result, the case was referred to a MDT. If the patient was diagnosed with cancer, they were then referred on to an independent or NHS oncology service.

Meeting people's individual needs

- Staff told us the provisions they would make for patients living with learning difficulties or dementia such as a special needs assessment and fast track service. However, staff said that these types of patients were rare.
- In house interpreters were available for Arabic and Russian. A language line telephone number was available for all other languages.

Outstanding ☆

Outpatients and diagnostic imaging

- There was no specific provision made for bariatric patients as they were a very rare demographic for the hospital. Managers told us that arrangements could be made for patients with individual requirements, such as the consultant seeing the patients in easier to access consulting rooms. Specialist equipment could be hired for the patient at no extra charge.
- Within the outpatient, audiology, therapies and diagnostic imaging main waiting areas, there was a range of information leaflets and literature available for patients to read about a variety of conditions and support services available. The information we observed was given in English, with some Arabic leaflets available. Staff told us that all information was able to be received in any print size, language, braille and audio loops.
- Patients booked appointments directly with their consultant's secretary and were able to freely choose appointments to a suitable time.
- The radiology department provided patients with a selection of music or audio of religious books for patients to listen whilst having a diagnostic procedure. Patients were also able to use their own music or audio.
- The radiology department had slots available to fit in patients that require imaging the same day in order to meet their individual needs.
- The ultrasound neonatal service provided same day walk-in appointments for patients wanting advice or a procedure.
- Due to the nature of cochlear implants, the audiology department provided a responsive service by advising patients regarding different brands at differing price points and ordering test products for the patients to try out. Patients we spoke with felt that the department helped them in making the correct decision and they felt that ample time was given for their decision. Patients were given the opportunity to either buy through the department or negotiate directly with the manufacturer. All cochlear implant patients were given after care free of charge.

Learning from complaints and concerns

- The hospital's complaint procedure set a target to acknowledge formal complaints within two working days and to send a written response within 20 working days. If these time scales could not be achieved the complainant would be informed of the delay and anticipated time for response.
- In the period of July 2015 to June 2016, there were 16 formal complaints regarding the outpatients and radiology departments. Ten of those complaints were related to payment or insurance cover. We saw evidence that all formal complaints were logged and action was taken appropriately within the targets.
- Initial complaints were dealt with by staff in the outpatients and diagnostics departments in an attempt to resolve issues locally. However, if this was unsuccessful staff escalated it to the department manager who then started the complaints process.
- Patients told us they knew how to make a complaint if needed. Reception staff told us that they gave patients a leaflet on how to make a formal complaint if requested.
- Details of complaints were discussed with staff in monthly team meetings. We saw minutes of meetings to demonstrate that learning from complaints had taken place; there was evidence to show that action had taken place to address the issues in a timely manner.

Are outpatients and diagnostic imaging services well-led?

Outstanding ☆

Leadership & Culture within the service

- The outpatients, therapies and radiology department operated in a similar management structure. The outpatient department had sisters leading specific areas, who reported to matrons leading either paediatric or adult outpatient services. They in turn were managed by the women's services and neonatal manager, who reported to the CNO. The therapies department leads reported to the deputy therapy managers specific to the sub specialties. They then reported to the head of therapies and rehabilitation, who was directly managed by the CEO. The radiology

department operated in a similar model, with superintendent radiographers managed by the diagnostic service manager, who also managed the audiology department, in turn reporting to the CEO.

- Managers had a sound knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service.
- It was evident from talking to managers and staff, and from our observations, that managers in all departments we visited had genuine good rapport with staff.
- It was clear from our conversations and the information we reviewed that staff felt supported and valued in their role. They told us they felt supported and valued by colleagues, line managers and the executive team.
- Staff told us that they were happy to escalate matters to the executive team and felt that they were confident that they would be listened to.
- All staff we spoke with told us that the CEO and other executive members did regular walk rounds and were very approachable. Staff felt they had a rapport with the executive team and could talk to them easily.
- All staff we met with spoke highly of their local managers and the CEO.
- We found the care and service delivered in the outpatients, audiology and imaging departments showed a strong cohesive team approach to patient care. It was clear that an open, transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.
- During our inspection we noted staff being positive and caring towards patients who used the service. We also observed that staff had a caring and respectful nature towards each other, their immediate teams and the organisation as a whole.
- While the hospital collected some data on equality and diversity, it did not include the four specific workforce metrics identified in the NHS Workforce Race Equality Standards (WRES) in order to demonstrate progress against a number of indicators of workforce equality.

Vision and strategy for this service

- All staff we spoke with could recall the hospital's vision and values that included delivering exceptional care by exceptional people. All staff we spoke with stated quality of care and patient experience was a key priority for the hospital.
- All staff told us the hospital was constantly improving and spoke passionately about the service they provided and were proud of the facilities.
- We found the radiology department had a clear vision and strategy for future development, all radiology staff we spoke with confirmed that they knew of these plans. The imaging manager explained that in the short to medium term the department was looking to consolidate its ISAS-IQIPS accreditation process with the aim of having an assessment completed by quarter one of 2018. The department was also in the process of implementing a new system to allow diagnostic images to be transferred and seen to and from the NHS. Other plans involved the renovation and extension of the department to meet increased demand. We saw evidence in the form of a service plan which outlined that the adjacent building had been acquired and would soon be prepared to house the new upgraded x-ray and fluoroscopy suites, aimed to be completed by mid-2017. The department was also aiming to increase the availability of the sclerotherapy service for the treatment of vascular masses to a weekly basis in the next 12 months. The service plans we were shown also outlined that the department will streamline the CT and MRI referral pathways looking into NHS contracts within the next 12 months.
- The ultrasound lead explained the service was planning to hire and consolidate the role of a new sonographer to meet the increased demand. Other short term goals included the solidifying the ultrasound training programme for radiology department assistants, in order for them to take a more active role within the department. Long term plans for the department included integration with the maternity service and utilising a shared space for both departments to provide a seamless patient pathway.
- The gynaecology outpatient service plan outlined the department goals for the upcoming year. The goals included: growing the service by 30%, recruiting new

consultants, achieving endometriosis accreditation and improving the patient satisfaction score. The outpatient matrons were very passionate about the new endometriosis clinical nurse specialist (CNS) role that was recently filled. They explained that this service was a particular interest for the department and the focus was to consolidate the role into the patient pathway. Other plans included the promotion of colposcopy services and integrating this service into the wider HCA cancer network. Nursing staff we spoke with were enthusiastic about introducing a nurse led colposcopy service and keen to talk about the innovations made at regional conferences. The department was also completing the objective of ensuring all nursing staff were qualified for smear testing.

- Senior Managers explained that there were plans underway to further integrate the HCA sister hospital oncology pathways with the longer term goal to create a cross HCA cancer network allowing the current separate services to work more closely together. This was especially prominent for the hospital as the hospital was also looking to build its gynae-oncology services and promote its colposcopy services. The reasoning behind this strategic development was to provide a seamless consistent level of care for female patients using the service.

Governance, risk management and quality measurement

- There were defined governance and reporting structures within the hospital. Senior staff told us that quality measurement was carried out via department to board framework. There were several monthly committee meetings which reported on patient safety, patient experience and hospital performance. These committee meetings fed into the integrated governance committee (IGC) and medical advisory committee (MAC).
- Incidents and learning's were fed into the governance structure from local staff meetings to the IGC and similarly learning and outcomes from other hospital areas were cascaded down through the same channels to share lessons learnt throughout the hospital.
- We saw outpatient and therapies department's clinical governance meetings minutes ranging from April 2016 to September 2016. These meetings standardly discussed regulations, incidents and learning, audits, department performance, departmental goals and staffing. We saw that outcomes and actions from these meetings were shared with the rest of the team.
- We saw evidence that there were regular departmental team meetings in the outpatients, therapies, audiology and radiology departments. Monthly departmental meeting minutes had a standard agenda for each of the services which included incident learning, performance and improvements. Outcomes of department meetings were fed up to divisional clinical governance meetings.
- Radiation safety committee meetings were held tri-annually to ensure that clinical radiation procedures and supporting activities in the outpatient services and radiology department were undertaken in compliance with ionising and non-ionising radiation legislation.
- Each department had their own risk register which fed into the main hospital risk register. We looked at risk registers in each department and saw that these were updated regularly. The majority of the risk registers we saw did not contain any major risks apart from general hospital associated risks, with the exception of radiology which contained the risk of flooding due to aging water infrastructure in the surrounding area. This was also present in the hospital risk register.

Public & Staff engagement

- The views of patients were actively sought within outpatients, therapies, audiology and diagnostic imaging departments. Patients were given a general outpatient's feedback questionnaire and encouraged to fill it out. The imaging and audiology departments explained that department specific questionnaires were being developed.
- The outpatient matrons told us that feedback questionnaire return rates were lower than they would like. However, there were plans being considered to increase the return rates including the use of electronic resources and use of touchscreen interfaces. Data provided to us did show an improvement in response rate over quarter two and three of 2016.
- Data from the outpatient patient feedback audits for 2016 have consistently been positive with quarter three results showing that 99% of patients would recommend

the service to friends or family. All staff we spoke with agreed that the hospitals main goal was to provide an excellent patient experience and all departments were encouraged to seek patient feedback.

- The midwife led outpatient service operated pregnancy open days and free of charge meet and greet sessions for patients interested in the hospital services. These sessions gave the hospital an opportunity to engage with patients and relatives to help improve their hospital journey.
- All staff we spoke with told us they felt they could approach and talk to the CEO or other executive members any time.
- Service managers from the outpatients, audiology and radiology departments told us they had monthly meetings with the CEO or CNO where issues were actively discussed and best practice was encouraged to be implemented. Managers felt they could engage with the CEO and felt they could raise issues on behalf of their staff and that there would be action.
- Engagement indicators used by the hospital showed that 95% of staff in 2016 were committed to doing their best for HCA and 70% of staff in 2016 would recommend the hospital as an employer to friends or family. This was with a total number of 177 respondents.
- The ultrasound service provided a positive example of staff engagement. A radiology department assistant had showed interest in becoming a qualified sonographer, so the departmental lead then attained the CEO's support in providing the staff member with the funding for the necessary qualifications and an active training programme was initiated.
- We were provided with other positive examples of staff development, which included a member of catering staff identified by the CEO as wanting to join the nursing team. The staff member was supported and provided funding to complete qualifications allowing her to join the gynaecology department.

Innovation, improvement and sustainability

- The gynaecology outpatient sister, who was also a qualified colposcopist, innovated a new training and practice device. This device was sponsored and developed in partnership with a medical equipment manufacturer. The device was designed to be a colposcopy simulator which had since aided in the training and development of skills for doctors and nurses in both the NHS and independent sectors.
- The governance team conducted a comprehensive qualitative research study into the 'Use of Team Debriefing Following a Serious Incident'. Hospital staff and consultants were engaged in participating in gathering the evidence for this research project. This project resulted in the development and implementation of the HCA Corporate Debriefing policy and staff information leaflet, which facilitated supportive incident debriefing across all HCA sites.
- As part of improvement of the outpatient service, nursing staff of various levels were trained and a competency assessment undertaken in order to provide an outpatient hysteroscopy service, which had conducted 48 procedures in the period between January 2016 to June 2016.
- The radiology department used a lot of innovative techniques to ensure a smooth process of paediatric diagnostic procedure including the implementation of play therapist support and 'feed and wrap' scans to negate the need of anaesthesia for children.
- Senior managers explained to us they were committed to see the hospital work collaboratively with other organisations. An example was provided to us showing a service level agreement for specialised MRI screening for patients from a London based NHS trust.
- An number of consultants representing the hospital voluntarily provided continued professional development through master classes for GPs . They delivered training conferences four times a year for up to 200 doctors in order to educate and train GPs in issues relating to paediatric and women's health.
- The hospital facilitates the training placements for student midwives and student nurses from a London based university. This collaboration has resulted in staff developing their teaching skills and students successfully completing their second year with experience in the independent sector.

Termination of pregnancy

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are termination of pregnancy services safe?

Incidents

- There were no never events reported within the termination of pregnancy service (TOPS) between July 2015 and the time of the inspection (November 2016). Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event has the potential to cause serious harm but neither need have happened for an incident to be a never event.
- There were no incidents reported for termination of pregnancy services (TOPS) between July 2015 and June 2016. However, all staff we spoke with on the delivery unit, gynaecology ward and theatres spoke confidently about hospital-wide systems to report and record safety incidents and near misses. They were able to give examples of when they had used the system to report appropriate incidents.
- A weekly incident review meeting group was held to discuss recent incidents and learning in the hospital. The chief nurse led these meetings. The chair of clinical governance, head of governance, and the risk manager attended. A summary of lessons learned was distributed to all staff through weekly newsletters, team meetings and incident debriefings. This was not specific to TOPS.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw that the hospital had a duty of candour policy and that staff understood the principles and processes. The process they described in communicating with patients and their relatives reflected openness and transparency. There had been no incidents relating to TOPS that met duty of candour requirements during 2016.

Cleanliness, infection control and hygiene

- Both theatres and wards were well lit, tidy and well organised and visibly clean. We observed that personal protective equipment (PPE) was readily available in all areas and worn appropriately by staff.
- There was a hospital wide Infection Prevention and Control (IPC) policy and an IPC Lead who coordinated and managed the infection control service. The infection control clinical nurse specialist (CNS) supported this role. There was also a consultant microbiologist in place. All staff received mandatory training on infection control. Compliance was 100% on the ward and 95% in theatres.
- Green 'I am clean' stickers were used throughout clinical areas to inform colleagues at a glance that equipment had been cleaned and was ready for use.
- All patients were accommodated in single rooms with en-suite bathrooms which helped control the spread of infection.
- There were hand-washing basins in all patient rooms. Hand disinfection foam dispensers were available throughout the ward and theatre department. We observed staff making use of them regularly and in between seeing patients.
- We observed that nurses and doctors adhered to the hospital 'bare below the elbows' (BBE) policy. The hospital-wide BBE audit from April 2015 to June 2016 showed 85% to 100% compliance for wards and 90% to 100% for theatres.

Termination of pregnancy

- The hospital had reported one case of MSSA and none of MRSA two cases of Escherichia coli (E. coli) and four cases of Clostridium difficile between July 2015 and June 2016. The information provided was not broken down by department.
- In theatres, patients were prepared for surgery in accordance with National Institute for Health and Care Excellence (NICE) guidelines.
- There were no surgical site infections (SSIs) relating to TOPS between July 2015 and June 2016.
- All portable equipment we checked had been recently tested and serviced. Items were labelled to indicate the next check or service date.
- Resuscitation trolleys were available on wards. Nurses carried out daily checks to ensure that equipment was safe and fit for use and we found no omissions in the checklists. Emergency drugs were available and within the use-by date.
- The operating theatre environment was suitably laid out, with separate areas for preparation of clean surgical items and a dirty utility room. The three theatre suites shared a recovery area.
- The theatres and the recovery area contained a difficult intubation trolley and a postpartum haemorrhage trolley with the correct equipment for these types of emergency. Operating theatre equipment, including the anaesthetic machine and emergency items had been checked daily, and were all ready for use. These checks met required standard operating procedures (RSOP) 22.
- There was no possibility that a patient having a termination of pregnancy would come into contact with women with babies on the ward or in recovery.
- Anaesthetic equipment was stored in drawers and cupboards in the anaesthetic rooms adjacent to each theatre. Equipment was well stocked and organised.
- We saw the locked storage arrangements for pregnancy remains which were kept refrigerated in individual containers for up to three months after each procedure. There were appropriate service level agreements for disposal in line with the wishes of the patient.

Medicines

- We found that medicines were managed and stored appropriately, in locked cupboards and refrigerators, within locked rooms. Fridge temperatures were within acceptable ranges. There were systems for checking stock levels and expired medicines. All the medicines we looked at were in date and correctly stored, in line with manufacturers' instructions.
- Wards used paper-based prescription and medication administration charts. A pharmacist reviewed prescription charts every weekday.
- The Royal College of Nursing (RCN) guidance on abortion care for nurses and midwives (2008) sets out good practice on abortion care. A nurse or midwife may administer the drugs used for medical abortion at any gestation, once these have been prescribed by the doctor with overall responsibility. We found that abortifacient medicines were administered in accordance with Nursing and Midwifery Council (NMC) standards for medicines management.
- We saw evidence from patient notes that patients were informed, if relevant to them, that Misoprostol was an unlicensed drug. In the UK drugs need a licence before they can be marketed. Misosprostol has a licence for treating ulcers in the stomach. A side effect of this medicine is to produce contractions in the womb. However doctors can prescribe a medicine without a licence if there is no suitable licensed alternative and its use is likely to benefit the patient. In termination of pregnancy Misoprostol is used to induce labour, even though does not have a licence for use in these circumstances.
- RSOP 2 relates to medical terminations including early medical abortion (EMA), delegation of duties and protocols. This also relates to the provision of terminations at different gestation including early medical abortion (EMA). We were told different methods were available to terminate a pregnancy, depending on the pregnancy gestation. The medical method involved the use of the abortifacient drug Mifegyne (mifepristone, also known as RU486). Nurses had undertaken the relevant training and approval to administer medicines under a Patient Group Direction (PGD). PGDs provide a legal framework which allows some registered health professionals to supply and/or administer specified medicines to a predefined group of patients.

Termination of pregnancy

- Gynaecology nurses administered misoprostol for cervical preparation, after prescription by a doctor. This is in accordance with the Abortion Act, which requires that only a registered medical practitioner (RMP) may carry out an abortion.
- The service conducted regular audits to maintain high standards of medicines management and storage across all clinical areas. There was an up-to-date medicines management policy.
- Medicines used in the operating theatre and recovery were managed safely and in accordance with guidelines. This included stock checks, monitoring, and recording of prescribed medicines.
- We observed oxygen cylinders were stored correctly.

Records

- A combination of paper and electronic records were used. Paper records were locked away and electronic records were password protected.
- We saw an audit of nursing documentation from January to June 2016. Results showed between 98% and 100% compliance for the surgical ward, against a target of 100%.
- The hospital audited records of all TOP procedures monthly to ensure that each document had a patient barcode, information about number of admissions, a valid consent form, theatre notes and a pharmacy chart.
- We reviewed 20 sets of patient records and found that they were well maintained and completed with clear dates, times and the designation of the person documenting. Records contained information relevant to risk assessment, allergies, medical and surgical history.

Safeguarding

- The Chief Nursing Officer (CNO) was the lead for safeguarding. Staff also had access to the HCAUK corporate safeguarding lead for advice and support. The up-to-date safeguarding policy was available on the intranet.
- The hospital did not provide TOP to any patients under the age of 16 years. There had only been one 16 year old patient in 2016. The hospital policy was that patients between 16 and 18 years old must be looked after by the gynaecology service with the support of the children and young people's nursing service. Under hospital policy gynaecologists would refer a young person under 16 years of age to the NHS.
- Safeguarding was part of the hospital's annual mandatory staff training. Between 91% and 100% of ward and theatre staff had completed safeguarding adults training and levels 1 and 2 of child safeguarding. Only 70% of theatre staff had completed level 3 safeguarding compared to a hospital target of 90%. All appropriate nurses had completed safeguarding children level 3 training.
- Two of the three gynaecologists who referred young people under 18 for termination of pregnancy had certified level 3 safeguarding training, which was in date at the time of inspection. The third gynaecologist was booked on update training in January 2017 because the course they had earlier planned to attend had been cancelled.
- Staff demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse.
- There was awareness of female genital mutilation (FGM) and child sexual exploitation amongst both junior and senior staff and this was included in safeguarding training.

Mandatory training

- The mandatory training target set by the hospital was 90%. The training programme included: health & safety, deprivation of liberty, duty of candour, infection control and manual handling. Mandatory training compliance rates varied between 85% and 100% for theatre staff, and 92% to 100% for nursing staff in the gynaecology ward and outpatients. Training was a mixture of face-to-face and e-learning.
- Senior nurses were responsible for ensuring that staff they supervised were up-to-date with their mandatory training. Compliance with training was discussed in mid-year reviews and end year appraisal discussions.

Assessing and responding to patient risk

- The hospital was licenced to provide terminations up to 23 weeks plus six days gestation. However, termination after 12 weeks 6 days was offered only to patients with

fetal abnormality which must have first been confirmed by ultrasound and a genetic report from the UK. Patients were referred from other hospitals for this procedure, as well as from the Portland Hospital.

- Consultants referring patients to the hospital for termination were required to review the patient's medical history and current medication, and identify known allergies, including an assessment of contraindications to abortifacient drugs before recommending termination of pregnancy. An ultrasound scan confirming pregnancy dates was routinely used to assess gestation.
- We also saw some evidence in both nursing notes and the nursing checklist that pre-operative checks had been conducted on admission to the ward. However, pre-assessment checks were only available on two days each week. An audit between October 2015 and September 2016 indicated that only 22% of TOPS patients had a pre-assessment. The lack of pre-assessment had been noted as a risk by gynaecology nurses for patients attending for a range of gynaecology procedures. A full-time pre-assessment nurse was starting in January 2017 to ensure all patients had pre-operative assessments in order to anticipate clinical risks and plan appropriate care.
- Before undergoing a termination of pregnancy, hospital policy required all patients to have a blood test to identify their blood group and the need for anti-D. The blood tests, usually carried out in the outpatient department included a full blood count, blood group and Rhesus factor (Rh). It is important that any patient undergoing an abortion who has an Rh negative blood group receives treatment with an injection of anti-D immunoglobulin. This treatment protects against complications, should the patient have future pregnancies. The records we reviewed showed all the patients had received a blood test before the termination procedure, and all those who had an Rh negative blood factor had received an anti-D injection.
- On admission to hospital, ward nurses measured a patient's vital signs, including blood pressure, pulse and temperature. Staff used the national early warning score (NEWS) tool to identify patients at risk of deterioration, or those needing urgent review. Observations were entered into an electronic recording system which automatically calculated the level of risk and alerted relevant members of staff if a patient's condition deteriorated. We saw evidence from reviewing records that this was carried out appropriately.
- We saw evidence staff complied with the National Institute for Health and Care Excellence (NICE) quality standard on risk assessments for venous thromboembolism (VTE) and its management. Of patients who attended for surgical abortion, 100% were assessed for their risk of developing venous thromboembolisms (VTE) or blood clots. Precautionary medicines were given to patients who required these. Anti-embolic stockings were supplied where necessary.
- Theatre staff followed processes to reduce the risks to patients undergoing surgery. These included the use of The World Health Organisation (WHO) 'five steps to safer surgery' checklist. These are safety steps staff are expected to follow before, during and after surgery, to check patient safety throughout their surgical pathway. This checklist was developed to reduce errors and adverse events, and increase teamwork and communication in surgery. The April to August 2016 observational audit of the surgical checklist demonstrated compliance scores of 100%.
- A registered nurse monitored patients in the immediate post-operative period in the theatre recovery area until they were fit to return to the ward. A systematic and regular assessment of the patient's condition was undertaken, which included recording their blood pressure and heart rate, as well as monitoring for pain during this period. We observed records of this in patient notes.
- Post-procedure antibiotics were prescribed to reduce the risk of infection.
- Basic life support training was part of the annual mandatory training programme. All gynaecology staff had completed both basic life support and intermediate life support training. The RMOs had all completed advanced life support training.
- There were appropriate procedures are in place to deal with any medical emergency which occurred during or as a result of the termination.This included a standing arrangement for transfer of patients to another hospital run by the same provider should a patient need ITU

level 3 intensive care. No patients undergoing a TOP procedure had been transferred to another healthcare provider for further management in the 12 months before our inspection.

Nursing Staffing

- The Portland Hospital followed the recommendations of the Royal College of Nursing (RCN) and Royal College of Midwives (RCM) for staffing within the nursing and midwifery services. The ratio of nurse to patients varied from 1:3 or 1:4. The gynaecology ward had an establishment of seven full time nursing posts and there were five staff in post including the ward sister. Bank and agency nurses covered remaining shifts. Where possible the ward used long term bank staff employed by the provider's cross-site programme.
- During our inspection the gynaecology ward had enough nurses to protect patients from avoidable harm. Staffing was reviewed twice daily against both patient numbers and patient dependency level.
- Managers told us they had procedures in place for the induction of new staff and all staff, including bank staff, completed hospital and departmental induction before commencing their role. We saw evidence of attendance at these induction sessions.
- Patients having a termination over 13 weeks had one-to-one nursing care.
- The hospital was recruiting a gynaecology nurse for pre-assessment so they could offer this daily. At the time of inspection ward nurses offered pre- assessment two days a week and did not have scope to offer this five days a week.
- Theatres had 40 whole time equivalent (WTE) staff. Staffing levels complied with the recommendations from the Association for peri-operative practice (AFPP).
- The use of bank and agency staff in theatre departments was lower than the average of other independent acute hospitals we hold this type of data for from July 2015 to June 2016.
- Agency staff were sometimes involved in caring for patients on ward who were undergoing a TOP procedure. The provider had Service Level Agreements in place with nursing agencies for requiring the agency to provide a core level of basic nursing competence for their staff. Local competency assessments were also used. There was a regular audit of compliance on completion of orientation checklists which showed that agency nurses received induction to the ward.
- There were no healthcare assistants in the gynaecology ward.

Medical staffing

- Consultant gynaecologists, who also carried out surgical terminations, also referred relevant patients to the hospital for medical terminations.
- A total of 32 gynaecologists had practising privileges to carry out termination of pregnancy. All the consultants operated under a practising privileges agreement. The granting of practising privileges is an established process whereby a medical practitioner is granted permission to work within an independent hospital. The medical advisory committee (MAC) reviewed each application for practicing privileges and advised the hospital chief executive officer (CEO). Each surgeon used their regular consultant anaesthetist, who also operated under a practising privileges agreement.
- There were consultants who were suitably qualified, skilled and experienced in the termination of pregnancy over the 20th week of gestation. This enabled the hospital to comply with Regulation 20(2) in relation to very late terminations.
- There was 24-hour cover from a resident medical officer (RMO). All RMOs had experience of gynaecology and were trained at ST3 level or above. They were required to have a current advanced life support certificate. The referring consultants were available for advice by telephone. Senior nurses told us no TOP procedures took place out of hours.
- RMOs reviewed patients before they were discharged after TOP procedures. If they had any concerns they could contact the consultant by telephone.

Major incident awareness and training

- The hospital had a contingency business plans in case of an emergency. Staff we spoke with were aware of the procedure for managing major incidents, including a fire. Fire safety was part of mandatory training. Within gynaecology, 96% of theatre staff and 98% of ward staff had received this training.

Termination of pregnancy

Are termination of pregnancy services effective?

Evidence-based care and treatment

- The medical advisory committee (MAC) reviewed policies and guidance, as well as patient outcomes and advised on effective care and treatments. The TOP procedures were clearly set out in the policy.
- The TOP policy was current and appropriately referenced relevant Royal College of Obstetricians and Gynaecologists guidelines, those from the Department of Health Required Standard Operating Procedures (RSOP) and Nursing and Midwifery Council (NMC) guidelines. The policy had been revised in August 2016. The policy relating to the sensitive disposal of pregnancy remains had been updated in July 2016. The policies were cross-referenced to other policies, such as consent to treatment and corporate incident reporting policies.
- The RCOG document entitled 'The Care of Patients Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7' provides detailed guidance and professional recommendations with respect to the treatment and care pathway which were followed. Although not required by the RCOG, the hospital required a clinic letter or ultrasound scan to determine the gestation, and most appropriate method for termination.
- In line with the RCOG 7, doctors informed patients that infection of varying degrees of severity may occur after medical or surgical abortion and was usually caused by pre-existing infection. Prophylactic antibiotic prescribing was carried out to reduce this risk. Blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to patients who were found to be rhesus negative. This was also in line with RCOG 'guideline 7'.
- RSOP 9 relates to the gestational limits with respect to termination. Professional guidance indicates two main methods for surgical termination: vacuum aspiration, up to 14 weeks gestation and dilatation and evacuation (D&E), where gestation is greater than 14 weeks. The hospital did not accept admission past 23 weeks and two days to provide a margin of safety to remain within the law. The hospital's policy was that feticide should be performed after 21 weeks six days in line with RCOG guidance. This procedure was not carried out at the Portland Hospital; there were arrangements for this with another registered healthcare provider.
- We found nurses screened patients for the risk of venous thromboembolism (VTE), in accordance with RCOG guidelines. There had been 100% compliance with VTE screening since January 2016 and there had been no incidents in the hospital of hospital acquired VTE or pulmonary embolism (PE) in the reporting period July 2015 to June 2016.
- The service complied with the Royal College of Anaesthetists recommended fasting time of six hours for food and two hours for clear fluids for surgical patients. This was recorded in patient notes so could be audited.
- The service had a comprehensive audit programme in line with RSOP 16. This included some audits not specifically for patients undergoing a TOP procedure, such as Venous thromboembolism (VTE) assessment rates, completion of falls risk assessments, pain scores, discharge times, and compliance with National Early Warning Score (NEWS).
- RCOG guidance and RSOP 13: 'Contraception and Sexually Transmitted Infection (STI) Screening' provide that information about the prevention of sexually transmitted infections (STI) should be made available. We were told that sexual health screening was carried out at the discretion of the admitting consultant and in agreement with the patient. We saw evidence of this in patients' notes.
- Methods of contraception should be discussed at the initial assessment and a plan should be agreed for contraception after the abortion. Patient notes showed that consultants provided such information during the consultation and encouraged patients to choose between contraceptive methods. These included long acting reversible methods of contraception (LARC), which are considered to be most effective by the National Collaborating Treatment unit for Women and Children's Health. Only 17 patients had intra-uterine devices inserted in the past year. Staff said most patients favoured the contraceptive pill.
- Patients were given verbal and written information on what to expect following a TOP procedure. They were

given contact details for the ward, and for the consultant's secretary. Patients were told that they could ring the ward at any time. If the ward was closed they would be transferred to the hospital's duty manager. A member of the ward was always on call in this case and was trained in dealing with TOP. Nurses told us that they felt confident dealing with enquiries relating to post-procedure complications and would seek the advice of the resident medical officer (RMO), admitting consultant or specialist gynaecology nurse, if necessary. Counselling was available to all patients before, during and after they had received treatment. This was the responsibility of the consultant.

- The monthly (hospital -wide) MRSA screening audit demonstrated varied compliance rates from 88% to 93% for the hospital from October 2015 to September 2016. This was below the target of 100%. This was one of the reasons the hospital was planning to expand their pre-admission service.

Pain relief

- Pre and post procedural pain relief was prescribed on medication records. Best practice was followed as non-steroidal anti-inflammatory drugs (NSAIDs) were usually prescribed for patients after a termination because they are recognised as being effective for the pain experienced during the termination of pregnancy. Nurses told us, and records showed, that they asked patients about their level of pain regularly as part of their observation record, and gave analgesics as needed to make patients more comfortable.
- Nurses explained to patients that they might experience some discomfort after a TOP procedure and gave them advice on discharge about the type of pain relief to take.
- We reviewed a pain audit from January to May 2016 which showed that the main action for the gynaecology nurses was to ensure there was documented evidence of a review of analgesia when a patient's pain was not controlled.

Patient outcomes

- There were no unplanned transfers or readmissions of patients undergoing TOP procedures between July 2015 and June 2016. The small number of patients admitted ensured that waiting times, complaints and any patients with complications, repeat terminations or failure rates were easy to monitor.
- The hospital audited records of all TOP procedures monthly to ensure that all Required Standard Operating Procedures (RSOPs) were met, and monitored the quality of documentation to identify gaps. This involved reviewing the consultant TOP checklist and the nurse TOP checklist, as well as admission records.
- The hospital could not measure the number of patients who did not proceed to a termination following consultation, or the number of patients returning for follow-up appointment, as these took place at another registered location.

Competent staff

- The medical advisory committee (MAC) reviewed each application for practising privileges and advised the hospital chief executive officer (CEO). The advisory function covered granting, renewal, restriction, suspension and withdrawal of practicing privileges. Consultant credentials were reviewed through a monthly report provided to the CEO through the Centralised Credentialing and Registration Service based within the Corporate Office.
- Most consultants (95%) were appraised through their NHS trust. The remaining consultants with no NHS affiliation were required to report to the Responsible Officer in the hospital. Records showed 100% completion rates of validation of registration for doctors working with practicing privileges.
- The hospital ran a four day induction programme for new staff to ensure they became familiar with hospital policies and procedures.
- Gynaecology nurses had training specifically on TOPs so that they could care for and give advice to patients. Staff attended a half day study day each year.
- The hospital had processes to ensure nurses had regular appraisals, and these were linked to pay. All the nurses we spoke with told us they had received an appraisal in the last year to assess their continuing professional

development (CPD) needs and set future goals. Records confirmed that 100% of nurses caring for patients undergoing a TOP procedure had completed an annual appraisal.

- Nursing revalidation is the new process by which registered nurses are required to demonstrate every three years that they are up-to-date with professional development and are fit to practice. The hospital had run open sessions around what the process involved and how to collate portfolio evidence. At the hospital, 97% of nursing staff had completed their NMC revalidation.
- RSOP14 on Counselling said that all staff who offered counselling should be trained to diploma level. Independent counsellors who were members of the UK Council for Psychotherapy (UKCP) provided counselling as required.
- All patients were given information leaflets on admission with details of the counselling service

Multidisciplinary working (related to this core service)

- There were no multidisciplinary team (MDT) meetings specifically for termination of pregnancy.
- Staff told us MDT meetings were held occasionally to review complex pelvic floor and gynaecology cases. In theory, any patients undergoing a TOP procedure could be discussed in this meeting, although staff could not think of an occasion when a termination of pregnancy case had been discussed.
- Where pre- assessment took place we saw evidence of direct liaison with the patient's consultant, team members, RMOs and theatre staff. Patients were given discharge letters which they could share with other medical professionals if they chose to.

Seven-day services

- The wards were open seven days a week. Theatres operated Monday to Saturday.
- An RMO rota ensured that a doctor was always available for inpatients, including TOP day cases. Gynaecologists, like other doctors with practising privileges, were required to be available to visit their patients if they needed urgent review, seven days a week, 24 hours a day (or to have pre-agreed cover).
- Patients could call the ward any time after discharge, 24 hours per day, seven days a week. Ward nurses then performed triage and gave advice.
- There was an on-site pharmacy service in operation Monday to Friday from 8:30am to 7pm and on Saturday from 9am to 1pm. Out of hours there was a dedicated on-call pharmacist.

Access to information

- All staff had access to policies, procedures, NICE guidance and e-learning on the hospital's intranet. There were sufficient computers for staff to access patients' current medical records and diagnostic results, such as blood tests and imaging. This supported staff to care for patients safely. Admission documents and assessments were available at least four hours before a patient's admission for a TOP procedure.
- Most patient records were electronic. Agency staff kept manual records which were later scanned into the patient's record. We saw examples of this. However, the lack of access to the electronic patient record system meant agency staff could not easily obtain information from the electronic charts. Agency staff were also unable to access policies and procedures online. They had to be logged in by permanent staff member who would shadow their access to ensure safe information security procedures were adhered to. This had been recognised by management as a risk.
- Patients were given a letter on discharge which outlined their treatment in in case they deteriorated and went directly to a GP or another provider.
- GPs were sent copies of discharge letters where a patient gave permission for the sharing of such information. RSOP 3, which relates to post-procedure care, states that staff must respect a patient's decision if they do not want their GP to be informed. Records indicated that this was the case.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The initial consultation process for TOP took place off-site, although with a doctor with practising privileges at the hospital. We were told consent would be discussed at this stage, and again when the patient came to the hospital. We saw a copy of the standard HCA consent form that was used. The hospital ensured

that all necessary documentation was completed before a referral for admission was accepted. The hospital's processes were in line with RSOP 8, consent. Written consent was required for all medical abortions, surgical procedures, and contraception fitting or removal under general anaesthetic.

- We asked about the consent process and staff demonstrated clear and accurate explanations of the options for termination of pregnancy and for contraception, corroborated by evidence in records. Patients were asked for consent privately so they could not be influenced by family members. Any patients whose first language was not English was provided with an interpreter.
- Theatre staff audited consent daily for all patients in the main theatres.
- Although none of the staff we spoke to, or records we reviewed, indicated that a patient undergoing a TOP procedure lacked capacity, all staff were aware of their roles and responsibilities under the Mental Capacity Act 2005 (MCA). All staff we spoke to had MCA training in order to ensure they were competent to manage any patients undergoing treatment who may have a learning disability. MCA was part of the mandatory training programme and records showed completion rates were over 90%.
- We saw the 'Targeting Complex Care Cases in Gynaecology' guideline that identified learning disability as an increased risk factor at preassessment. The care pathway identified both the preassessment and escalation processes for any high risk patient admitted to the Gynaecology ward.

Are termination of pregnancy services caring?

Compassionate care

- There were no patients undergoing a TOP procedure at the time of inspection, so we were not able to speak to patients directly. Nurses demonstrated a good knowledge of maintaining patient dignity and knew how to make patients feel relaxed and comfortable before a procedure.
- We observed nurses being sensitive and professional in their dealings with patients in the gynaecology ward and in outpatients. Nurses were non-judgemental in caring for patients having terminations of pregnancy and accepted their right to choice.
- Patient feedback was monitored through daily rounding by a senior member of staff. A third party collected patient experience data, with trends over time reviewed and actioned as needed. Inpatient survey scores were mainly 99% or higher in the period January 2016 to June 2016. Response rates averaged at 25%, with 99% of patients saying that they would recommend the hospital. This data was from patients hospital-wide and not specific to TOPS.

Understanding and involvement of patients and those close to them

- Notes we examined showed the admitting consultant had offered the patient choices for the method of termination and information about success and complication rates.
- Nurses completed a checklist before a patient had a TOP procedure. This included checking that she had been given the opportunity to raise concerns or doubts, and that she was happy to continue with procedure.
- Patients were asked if they wanted to share information with family members and their responses were established and respected.
- It was the responsibility of the consultant to explain to patients that an individual return was made to the Department of Health for each termination of pregnancy conducted (HSA4) but that this data was anonymised.

Emotional support

- There was access to advice and counselling before and after their treatment. Both the consultant and nurses gave support to patients. Records indicated that emotional support was offered to patients at the initial consultation and was available throughout their pathway of care. A gynaecology clinical nurse specialist was available on the ward to offer patients and staff additional support.

Termination of pregnancy

- Bereavement support from midwives was offered to patients who had late terminations. Memory boxes were provided if parents wanted them and we saw this was recorded in patients' notes.
- Multidenominational chaplaincy and spiritual support was available 24 hours a day, seven days per week, to provide emotional support to women and those important to them.

Are termination of pregnancy services responsive?

Service planning and delivery to meet the needs of local people

- The hospital was easily accessible by public transport. There was step-free access in the theatres and wards. All inpatient rooms had step-free access to bathrooms.
- Admissions for TOP were spread throughout the day, with a maximum of four procedures scheduled in any one day. The limit was to ensure sufficient staff were available on wards, and to avoid too many late additions to theatre lists.
- Interpretation and translation services were readily available for those whose first language was not English. Some international patients were Arabic speaking and the hospital had Arabic interpreters on site. We did not see leaflets in other languages but staff said translations could be provided.
- The catering menu contained a wide range of options including halal, kosher, vegetarian and vegan options.
- Patients' privacy was maintained throughout their stay, as they were admitted to single occupancy rooms.

Access and flow

- The referring consultant booked appointments for patients through the reservations department of the hospital. For patients undergoing medical termination, the inpatient booking for the second stage had to be made before the first stage in outpatients was commenced to ensure that a nurse and a room was available on the ward because the administration of the drugs was time critical. Patients having surgical terminations were booked into the gynaecology ward. No surgical terminations were performed after 6pm.
- The consultant provided a referral letter with medical history, documented evidence of their initial assessment and the HSA1 form, with the signatures of two doctors who supported termination of pregnancy on at least one and the same grounds. This was in addition to an ultrasound scan report and a completed drug chart for abortifacient drugs if needed. All this information was provided no less than four hours before admission to the hospital for the TOP procedure. The gynaecology outpatient department, ward or theatre staff as appropriate, received the admission information to enable them to prepare for the patient. A bed meeting was held at 10am each morning, in which staff were alerted to any patient undergoing a TOP procedure that day.
- Patients were admitted for surgical termination an hour and a half before the procedure to allow time for preparation.
- RSOP 11: Access to Timely Abortion Services indicates patients should be offered an appointment within five working days of referral and should be offered treatment within five working days of the decision to proceed. Senior staff told us, that most patients were admitted immediately following a referral from an admitting consultant and often treatment began the same day. The records that we reviewed confirmed this.
- Gynaecology nurses in the gynaecology outpatient department were trained to administer the first medication dose and patients were required to remain in the department for 30 minutes after administration of this medicine to ensure that the tablet was ingested.
- An inpatient gynaecology nurse administered the second dose of abortifacient medication 24/36 hours after the first dose in the gynaecology ward. Patients having a medical abortion remained on the ward for an hour after the expulsion of pregnancy remains, to ensure there was no risk of haemorrhage.
- Patients who chose a surgical procedure, vacuum aspiration, had this performed by the gynaecologist in theatre. The patient would then be transferred to the gynaecology ward until discharge.
- Late medical terminations (over 18 weeks), or terminations on patients with a high risk were carried

out in the delivery suite (first floor). A midwife would accompany the patient. The patient later transferred to the gynaecology ward (fourth floor) with the same midwife responsible for her care.

- All patients choosing surgical termination were admitted for TOP as day surgery. There had been no TOP cancellations in 2016. Patients were always discharged with a relative or friend to ensure their safety.

Meeting people's individual needs

- Termination of pregnancy for fetal anomaly (TOPFA) was available to patients where the gestation period was up to 23 weeks plus six days. Patients were given information verbally as well as in writing.
- Staff adhered to strict confidentiality rules for patients undergoing termination of pregnancy, both during the process and for data collection.
- A female doctor could be provided if requested by the patient. Female staff members could be present at all stages of the TOP pathway.
- Leaflets and information were given to patients to inform them what to expect after treatment. This included the number of the ward to ring for telephone advice up to48 hours after the procedure, and the contact details of counsellors.
- The Human Tissue Authority (HTA) publish guidance about the handling of pregnancy remains following pregnancy loss or termination. This was followed by RCN Guidance on pregnancy that ended before the 24th week of gestation, including medically or surgically induced termination of pregnancy. The hospital policy was in line with this guidance.
- The hospital policy stated, and staff told us, that patients were given three options about disposal of pregnancy remains which the midwife or nurse discussed with the patient before discharge. Patients received an information leaflet in advance, allowing sufficient time for them to ask any questions. The first option was for the hospital to arrange a cremation without a service. The second option was a cremation arranged by local undertakers which the patient could attend if they wished.. There was a 10 day period where the patient could change her mind about attending the service. Thirdly, patients could choose to make their own arrangements. Patients signed a 'Cremation consent form for less than 24 weeks gestation' indicating their wishes. We saw copies of these. We saw from patients' notes that some patients chose to have a funeral.
- Cremation would be delayed until after a post mortem had taken place, if this was requested. Post mortems took place at an NHS trust. The hospital had a policy on the use of fetal remains for medical research.
- Patients for whom this was appropriate could receive bereavement support.
- Ward staff made follow up telephone calls to all gynaecology inpatients the day after discharge to check on their wellbeing. We saw that some patients asked not to have a telephone call.

Learning from complaints and concerns

- There was an up-to-date corporate complaints policy available on the intranet. Information on how to raise concerns or make a formal complaint was displayed in each patient room on the ward. Comment cards were also available, which patients were encouraged to use to share any feedback.
- All formal complaints were recorded promptly on the hospital reporting system. Formal complaints were acknowledged within 48 hours, with a target of responding fully in 20 working days. Details of complaints were discussed with staff in monthly team meetings. We saw minutes of meetings to demonstrate that learning from complaints had taken place; there was evidence to show that action had taken place to address the issues in a timely manner.
- Staff told us all complaints are also treated as an opportunity to improve the service. There had been no complaints about termination of pregnancy in 2016.

Are termination of pregnancy services well-led?

Leadership / culture of service

- The registered manager of the service was part of the gynaecology service.

Termination of pregnancy

- The ward sister, matrons and managers had a sound knowledge of their areas of responsibility, and understood the risks and challenges. The staff worked effectively together and we saw evidence of good team working in outpatients and on the ward.
- Theatre staff felt well supported by their manager and described her as "helpful and approachable".
- The gynaecology ward displayed the name of the nurse in charge of the day, who also looked after patients. There were no healthcare assistants on the ward. It was clear from discussions with nurses that they felt valued and supported by their colleagues, line managers and the executive team.
- Staff told us that they were happy to escalate matters to the executive team and felt that they were confident that they would be listened to.
- All staff we spoke with told us that the CEO and other executive members did regular walk rounds and were very approachable. Staff felt they could talk easily with senior managers, and speak up if they had concerns.
- The law requires that all non-NHS locations must display a certificate of approval for termination of pregnancy issued by the Department of Health. We saw the certificate of approval was on display in the hospital foyer.
- Theatre staff felt well supported by their managers. Any member of the theatre team with a conscientious objection was able to decline to participate in a termination of pregnancy and their wishes were respected.
- All staff we spoke with described the hospital leadership team as visible and approachable. Nurses said they felt able to speak up if they had concerns.
- Staff of all levels told us they were happy working at the hospital and felt they contributed to creating a positive work environment. The staff survey in 2016 showed 95% of staff felt committed to doing their best for HCA.

Vision and strategy for this this core service

- The hospital vision was to deliver exceptional care by exceptional people. Staff knew how their roles contributed to the strategy to realise this vision. All staff we spoke with were familiar with the vision and hospital strategy. Staff providing TOPS aimed to provide choice for patients, and a discreet service with a non-judgemental approach.

Governance, risk management and quality measurement for this core service

- There was a defined governance and risk management structure from corporate provider level to hospital and department levels, designed to promote sharing of key information upwards and downwards, and promote high quality care. We reviewed minutes of the main committees which reported on patient safety, patient experience and hospital performance. These committee meetings fed into the integrated governance committee (IAC) and medical advisory committee (MAC). We also looked at minutes of ward and theatre meetings which indicated good information flow. Minutes of these meetings were displayed on staff noticeboards once approved.
- Each department had their own risk register which fed into the main hospital risk register. We looked at risk registers in each department and saw that these were updated regularly. Most of the risk registers did not contain any major risk apart from general hospital associated risks. There were no risks relating to TOPS on the corporate or department risk registers.
- The annual TOP audit was shared with the Audit and Guidelines meeting and the Obstetrics and Gynaecology meeting, as well as with gynaecology nurses at the ward team meeting. One outcome of this had been to set up a process to check the list of patients coming to theatre daily to identify late additions and ensure face-to-face or telephone pre-assessment took place.
- An electronic database of all TOP patients was maintained. The completion of this was audited monthly.
- Legislation requires that for an abortion to be legal, two doctors must each independently reach an opinion in good faith as to whether one or more of the legal grounds for a termination is met. They must be in agreement that at least one and the same ground is met before they sign the form, for the termination to be lawful. The two doctors must then sign a form to indicate their agreement (HSA1 Form).

Termination of pregnancy

- The procedure for completing the HSA1 form was the responsibility of the consultant gynaecologist when the patient attended their consultation appointment at the consultant's rooms. The patient was counselled by the consultant and given information and advice about the procedure and the options available to them depending on their gestation and individual situation. We were told that many consultants had a buddy to whom they referred the case so a second doctor could independently reach their own opinion about the grounds for termination and sign the HSA1. We did see any forms being signed during the inspection.
- If necessary patients could have additional time to consider their decision and have a further consultation before reaching a decision. The consultant's secretary sent the completed HSA1 form to the ward with the patient's notes and consent form. These formed part of the TOP checklist which the consultant completed before admission. If this form was not completed, staff were aware that the procedure could not go ahead. The reservations office asked to have information no less than four hours before the patient's admission. This gave nurses the time to ensure that the procedure complied with the law.
- We saw the register of terminations that ward staff completed, which was kept locked on the gynaecology ward.
- The specialist nurse had introduced a checklist in June 2016, which indicated what information referring doctors should provide on booking. The checklist facilitated the monthly audit.
- There was also a checklist for nurses to use to ensure that the patient's notes contained information such as the HSA1 form, a completed consent form, confirmation of pregnancy through clinic letter or scan report, cremation consent form and blood results. The TOP register was completed.
- All HSA1 forms were present in the records we reviewed and had the signatures of two registered medical practitioners, usually on the same day. An audit completed in October 2016 confirmed that the form was present and correctly completed in 97% of cases. Staff confirmed that no procedure would have been carried out without an HSA1 form in place, but that sometimes they had been misfiled.
- The Required Standard Operating Procedure (RSOP) standard one requires the provider to ensure that the completion of legal paperwork (HSA1 and HSA4 forms) is undertaken in a timely manner. Processes were in place to ensure that the certificate(s) of opinion HSA1 were signed by two medical practitioners in line with the requirements of the Abortion Act 1967 and Abortion Regulations 1991.
- The doctor taking responsibility for an abortion is legally required to notify the Chief Medical Officer (CMO) within 14 days of the termination. This is done through the Department of Health, and includes the submission of data on the HSA4 form. The admitting consultant did the HSA4 submission.
- The audit had shown that only 85% of patients' notes contained a copy of the HSA4 form. The ward had therefore introduced a process whereby the ward clerk contacted the gynaecologists' secretaries to ensure they returned scanned HSA4 forms to the ward so they could complete their records.
- The clerk did not file patients' notes until they had confirmation that the form had been returned. This meant that the hospital was aware of any outstanding forms and could encourage timely submission of the forms.
- Emergency terminations were not performed at the hospital so HSA2 forms were not required. The Department of Health Form HSA2 was only completed in relation to abortion performed in an emergency under section 1 (4) of the Abortion Act.

Public and staff engagement

- Staff actively sought and reviewed the views of patients, and TOPS patients would be included in this.. Hospital patients in outpatients and inpatients were given feedback questionnaires and encouraged to fill them out. Staff were considering using touchscreen interfaces to improve the return rate of feedback.
- Engagement indicators used by the hospital showed that 95% of staff in 2016 were committed to doing their best for HCA and 70% of staff in 2016 would recommend the hospital as an employer to friends or family.
- The hospital produced a monthly governance newsletter informing staff about incidents and learning.

Termination of pregnancy

- There were staff recognition schemes such as 'employee of the quarter', and recognition of long service.

Outstanding practice and areas for improvement

Outstanding practice

- There were strong displays of innovative techniques from the hospital's paediatric therapies team. Staff were encouraged to input to innovative change within the service and this was evident in the celebration of new ideas from staff at all levels.
- Multidisciplinary input in paediatrics was well structured, well coordinated and attended by a wide variety of clinical specialities and therapies. The meetings were structured around the holistic needs of the patients.
- The hospital had implemented a specialist, sensitive birthmark screening and treatment program for paediatric outpatients.
- Services were tailored and planned to fit the needs of the patients using the services. There was an impressive degree of clinical input and care for complex patients.
- The security and safety of patients was important to the service. The service had put in additional measures to ensure that children in their service were protected from harm. The Hugs and Kisses security system tracked and monitored patients throughout their pathway.
- A new training and practice device was developed in the colposcopy service. This device was sponsored and developed in partnership with a medical equipment manufacturer. The device was designed to be a colposcopy simulator, which had since aided in the training and development of skills for doctors and nurses in both the NHS and independent sectors.
- The radiology department used a lot of innovative techniques to ensure a smooth process of paediatric diagnostic procedures. This included the implementation of play therapist support and 'feed and wrap' scans to negate the need of anaesthesia for children.
- Consultants representing the hospital regularly provided continued professional development through master classes for GPs . They delivered training conferences four times a year for up to 200 doctors in order to educate and train GPs in issues relating to paediatric and women's health.
- The hospital facilitated the training placements for student midwives and student nurses from a London based university. This collaboration has resulted in staff developing their teaching skills and students successfully completing their second year with experience in the independent sector.
- The governance team conducted a comprehensive qualitative research study into the 'Use of Team Debriefing Following a Serious Incident'. This project resulted in the development and implementation of the HCA Corporate Debriefing policy and staff information leaflet, which resulted in change of practice across all HCA sites.
- We were provided with a number of positive examples of staff development, which all included staff members from support services (identified by the CEO and other managers) as wanting to join clinical services. The staff members were supported and provided with funding to complete qualifications, allowing them to join as clinical staff.
- We were shown evidence of activities and excursions organised by the therapies department to support parents and children's psychosocial wellbeing that were planned based on individual patient needs. Trips to venues such as Regents Park and London Zoo were arranged to meet specific clinical patient goals.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should consider revising the system for patient records to ensure that all staff have access to them, including agency staff and RMOs. This should include agency midwives.
- The provider should consider how space can be utilised more efficiently in the wards across the main hospital building so that items are appropriately stored.
- The provider should introduce appropriate signage for medical gases on the door where they are stored in the labour ward.
- The provider should ensure that documentation of perineal repair by consultants conforms to NICE guidance.
- The provider should ensure that all midwives and appropriate maternity staff are trained in Safeguarding Children Level 3.
- The provider should consider how to address high nursing staff turnover within the surgery division.
- The provider should consider how to ensure that compliance rates of pre-assessment before surgery improve.
- The provider should consider how to collect further data in order to participate in national audits and benchmark itself against other providers.
- The provider should ensure any changes in working practices arising from incident learning are quickly embedded into written work instruction or policies in the outpatient department.
- The provider should ensure that mandatory training rates in the hospital meet the hospital target of 90%.
- The provider should ensure that consultants are all returning HSA4 forms to the Department of Health within 14 days.